2022 Regular Session **ENROLLED**

SENATE BILL NO. 165

BY SENATOR TALBOT

AN ACT

To amend and reenact R.S. 22:2436(C)(2)(a), (D)(2), (D)(3), and (E)(2) and 2437(C), to enact R.S. 22:2436(D)(4) and 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), (D)(2), (D)(3), and (E)(2) and 2437(C) are hereby amended and reenacted and R.S. 22:2436(D)(4) and 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 the request complete.

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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. Any notice or form required to be provided by this Paragraph may be provided electronically on the department's website.**

(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.~~ **This Paragraph shall not apply if the issuer's failure to provide documents or information is due to the covered person's failure to provide a signed form authorizing the issuer to proceed with an external review or to release the insured's personal health information to the independent review organization as required by federal law.**

(b) Within one business day after making the decision pursuant to 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 Paragraph (1) of this Subsection and not received from a health insurance issuer as expeditiously as is necessary for consideration in reaching a decision required in Subsection 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 Subsection E of this Section.

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§2439. Binding nature of external review decision

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D. For any decision by an independent review organization in favor of the covered person, a health insurance issuer may only subsequently deny coverage of the services that were the subject of review, if it is determined that the covered person was ineligible for coverage due to nonpayment of premiums or for suspected fraud or material misrepresentation of fact.

Section 2. R.S. 22:2436(E)(3) is hereby repealed.

Section 3. This Act shall become effective on January 1, 2023.

PRESIDENT OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____