2023 Regular Session

ACT No. 333

ENROLLED

SENATE BILL NO. 188

BY SENATORS STINE, ABRAHAM, BERNARD, FESI, ROBERT MILLS, MORRIS AND TALBOT AND REPRESENTATIVES ROBERT OWEN AND PRESSLY

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

AN ACT

To enact R.S. 22:1020.62 and 1260.41(10), relative to health insurance; to provide for utilization review; to provide definitions; to provide for documentation and reports; to require items and services subject to prior authorizations to be posted on a health insurance issuer's website; to require applications and enrollment materials to include a health insurance issuer's web address for any of its health coverage plans; to provide for an effective date; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1020.62 is hereby enacted to read as follows:

§1020.62. Utilization review reports; definitions

A. For purposes of this Section, the following terms have the following meanings:

(1) "Health coverage plan" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract, or other agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type in this state, including a group insurance plan or self-insurance plan. "Health coverage plan" does not include a plan providing coverage for excepted benefits defined in R.S. 22:1061, excepted benefit health insurance plans, short-term policies that have a term of less than twelve months, or the office of group benefits. Notwithstanding excepted benefits as defined in R.S. 22:1061, a "health coverage plan" subject to the provisions of Part III of this Chapter includes dental insurance plans.

(2) "Health insurance issuer" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the

commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a sickness and accident insurance company, a health maintenance organization, a preferred provider organization or any similar entity, or any other entity providing a plan of health insurance or health benefits. Health insurance issuer does not include the office of group benefits.

(3) "Healthcare provider" or "provider" means a healthcare professional or a healthcare facility or the agent or assignee of the healthcare professional or healthcare facility.

(4) "Healthcare services" means services, items, supplies, or drugs for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(5) "Prior authorization" means a determination by a health insurance issuer or person contracting with a health insurance issuer that healthcare services ordered by the provider for an individual are medically necessary and appropriate.

B.(1) A health insurance issuer, on an annual basis and at a time and in a manner determined by the commissioner, shall submit a report to the department containing a quarterly breakdown of the following information:

(a) A list of all items and services that require prior authorization.

(b) The percentage of standard prior authorization requests that were approved, aggregated for all items and services.

(c) The percentage of standard prior authorization requests that were denied, aggregated for all items and services.

(d) The percentage of standard prior authorization requests that were approved after appeal, aggregated for all items and services.

(e) The percentage of prior authorization requests when the timeframe for review was extended, and the prior authorization request was approved, aggregated for all items and services.

(f) The percentage of expedited prior authorization requests that were

approved, aggregated for all items and services.

(g) The percentage of expedited prior authorization requests that were denied, aggregated for all items and services.

(h) The average and median time that elapsed between the submission of a request and a determination by the health insurance issuer for standard prior authorizations, aggregated for all items and services.

(i) The average and median time that elapsed between the submission of a request and a decision by the health insurance issuer for expedited prior authorizations, aggregated for all items and services.

(2) The commissioner shall submit an annual written report to the Senate Committee on Insurance and the House Committee on Insurance that includes the information submitted to the department in accordance with Subsection B of this Section.

C.(1) A health insurance issuer shall annually publish on the health insurance issuer's publicly available website a list of all items and services that are subject to a prior authorization request according to each health coverage plan. This list shall be published on the insurer's website prior to open enrollment. If a health insurance issuer changes the list of items and services that are subject to prior authorization, a health insurance issuer shall, in a timely manner, update its website to reflect the changes.

(2) A health insurance issuer shall include a current web address on any application or enrollment materials that are distributed by each health coverage plan.

D. A health insurance issuer shall provide, along with contract materials to any healthcare provider or supplier who seeks to participate under a health coverage plan a list of all items and services that are subject to prior authorization under the health coverage plan and any policies or procedures used by a health coverage plan for making determinations with regards to a prior authorization request. A health insurance issuer may refer such providers or suppliers to a listing or link on its website to comply with this Subsection.

Section 2. R.S. 22:1260.41(10) is hereby enacted to read as follows:

§1260.41. Definitions

For purposes of this Subpart, the following terms have the following meanings unless the context clearly indicates otherwise:

* * *

(10)(a) "Health insurance issuer" means the same as the term is defined in R.S. 22:1019.1, except as provided in Subparagraph (c) of this Paragraph.

(b) The provisions of this Subpart shall not apply to an entity that provides limited scope dental or vision benefits.

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Section 3. Section 2 of this Act shall become effective if and when the Act that originated as House Bill No. 468 of the 2023 Regular Session of the Legislature becomes effective. To the extent there is any conflict between the provisions of the Act that originated as House Bill No. 468 of the 2023 Regular Session of the Legislature and Section 2 of this Act, the provisions of this Act shall supercede and control.

Section 4. Section 1, 3, and this Section of this Act shall become effective January 1, 2024.

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PRESIDENT OF THE SENATE

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SPEAKER OF THE HOUSE OF REPRESENTATIVES

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GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____