SLS 22RS-249 **ORIGINAL**

2022 Regular Session

SENATE BILL NO. 112

BY SENATOR ROBERT MILLS

HEALTH/ACC INSURANCE. Requires health insurers that utilize prior authorization to reduce burdensome delays in approving and in making payments for covered healthcare services. (8/1/22)

AN ACT

To enact Subpart A-4 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1020.61 through 1020.73 and R.S. 22:1964(31), relative to health insurance; to provide for prior authorization for health insurance claims related to certain healthcare procedures; to provide for legislative intent and purposes; to provide for definitions; to provide for exemptions from prior authorization requirements related to certain healthcare services performed by certain healthcare providers; to provide for the duration of an exemption; to provide for denial or rescission of prior authorization exemption; to provide for an independent review of the elimination of certain exemptions; to provide for appeals; to provide for renewal of eligibility of an exemption; to provide for penalties; to define certain practices as unfair deceptive insurance practices; to provide for the promulgation of rules; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart A-4 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1020.61 through 1020.73, and R.S. 22:1964(31) are hereby enacted to read as follows:

SUBPART A-4. REDUCING ADMINISTRATIVE BURDENS IN HEALTH INSURANCE

§1020.61. Legislative intent and purpose

A. The intent of this Subpart is to reduce or eliminate cumbersome prior authorizations that unnecessarily delay the start or continuation of necessary medical treatment. Reducing or eliminating unnecessary delays in starting or continuing necessary medical treatment will reduce negative patient outcomes.

B. The purpose of this Subpart is to provide for the following:

(1) To require health insurance issuers that choose to utilize prior authorization to subsequently pay claims timely and without delay once the covered healthcare service has been performed.

(2) To require health insurance issuers that choose to utilize prior authorization to alleviate unnecessary delays in patient access to necessary medical treatment by exempting certain procedures performed by healthcare providers who have historically established themselves as high quality healthcare providers with regard to that particular medical procedure.

§1020.62. Definitions

Wherever used in this Subpart and unless the context otherwise indictates, the following terms shall have the following meanings:

(1) "Covered healthcare services" means healthcare procedures or treatments that are covered and payable under the terms of the health benefit plan issued by the health insurance issuer. "Covered healthcare services" shall not mean a treatment or procedure which is performed that is either not payable or not covered under the health benefit plan.

(2) "Covered person" shall have the same meaning as provided in R.S. 22:1019.1.

(3) "Exemption" means an exception granted to a prior authorized healthcare provider related to a particular covered healthcare service for which a prior authorized healthcare provider is not required to obtain permission in

advance to perform the covered healthcare service on a covered person in order to be paid under the terms of the health benefit plan.

(4) "Health benefit plan" shall have the same meaning as provided in R.S. 22:1019.1.

(5) "Health insurance issuer" shall have the same meaning as provided in R.S. 22:1019.1 except, as used in this Subpart, a "health insurance issuer" shall not include the Office of Group Benefits.

(6) "Healthcare provider" or "provider" means a healthcare professional licensed pursuant to Title 37 of the Louisiana Revised Statutes of 1950 or a healthcare facility licensed by the Louisiana Department of Health and subject to the provisions of R.S. 40:2006.

(7) "Prior authorization" or "prior authorized claim" means a determination by a health insurance issuer, or person contracting with a health insurance issuer, that covered healthcare services proposed to be provided to a covered person are medically necessary and appropriate.

(8) "Prior authorized healthcare provider" means a healthcare provider who has obtained the prior authorization of claims for not less than eighty percent of all prior authorization requests submitted for a particular covered healthcare service to the health insurance issuer in the prior twelve month period so that the provider need not submit a claim for prior authorization to receive payment under the health benefit plan for that particular covered healthcare service performed on the covered person.

§1020.63. Prior authorization of a claim, information required, limitations on denial of claim

A. If a health insurance issuer chooses to utilize prior authorization of a claim in the processing of health insurance claims, the health insurance issuer shall timely, and without delay, pay for the covered healthcare services once the services have been performed by the healthcare provider.

B.(1) A health insurance issuer shall not require any information to be

submitted with a request for a prior authorization of a claim unless that same information is required for submission of a claim for a covered healthcare service.

(2) For all healthcare procedures and treatments subjected to prior authorization by a health insurance issuer, the health insurance issuer shall conduct all eligibility and other medical policy coverage determinations for the prior authorization process for a covered person.

C. Once a health insurance issuer has issued a prior authorization for a particular covered healthcare service or once a particular covered healthcare service has been deemed prior authorized as provided for in R.S. 22:1020.64, the health insurance issuer shall not deny any claim subsequently submitted for healthcare services included in the prior authorization unless one of the following circumstances applies:

(1) The health insurance issuer's policy has a benefit limitation, like an annual maximum or a frequency limit, that was exhausted between the time of the prior authorization was granted and the date on which the service was performed by the healthcare provider.

(2) The documentation for the claim provided by the healthcare provider clearly fails to support the claim that was the subject of the prior authorized claim request.

(3) The covered healthcare service is provided to the patient when the patient's condition has changed to the degree that the prior authorized medical procedure or treatment is no longer considered medically necessary at the time it is performed. A healthcare service is considered medically necessary when based upon the prevailing standard of care at the time the medical procedure or treatment is performed.

(4) If, at the time the medical procedure or treatment is provided to a patient, the patient's condition has changed to the degree that if the prior authorization of a claim sought on the date that the procedure or treatment was

performed, it would have been denied under the terms and conditions for coverage under the patient's health benefit plan in effect at time of the granting of the prior authorization.

(5) Another payer is primarily responsible for payment under the terms and conditions for coverage under the patient's health insurance plan for which prior authorization of a claim is sought.

(6) The healthcare provider has already been paid for the covered healthcare service identified on the claim.

(7) The claim was submitted fraudulently or the prior authorization of a claim was based in whole or in part on erroneous information provided to the health insurance issuer by the healthcare provider, the patient, or other person not related to the health insurance issuer.

(8) The patient receiving the procedure or treatment was not eligible to receive the procedure or service on the date of service and the health insurance issuer did not know, and with the exercise of reasonable care could not have known, that the patient was ineligible under the health benefit plan.

§1020.64. Prior authorized healthcare provider; exemptions; expedited approval procedures

A. If a health insurance issuer utilizes prior authorization in the course and scope of approving payments for covered healthcare services, the health insurance issuer shall not require prior authorization for a particular covered healthcare service if provided by a prior authorized healthcare provider, as defined in R.S. 22:1020.62.

B. If a particular covered healthcare service is performed by a prior authorized healthcare provider, the covered healthcare service shall be deemed prior authorized under the terms of the health benefit plan and subject to the provisions of this Subpart.

C.(1) Once a healthcare provider has met the criteria and is determined to be a prior authorized healthcare provider as is defined in R.S. 22:1020.62, a

health insurance issuer may evaluate whether a provider continues to qualify to be exempt under this Section to be exempt from obtaining prior authorization for a particular covered healthcare service, as long as an evaluation is made no more often than annually.

(2) Nothing in this Section requires a health insurance issuer to reevaluate a prior authorized healthcare provider for a particular evaluation period and a health insurance issuer may continue an exemption without evaluating or reevaluating a prior authorized healthcare provider.

D. A healthcare provider is not required to request an exemption from the prior authorization process in order to qualify as a prior authorized healthcare provider. The designation as a prior authorized healthcare provider shall be based upon whether the healthcare provider meets the definition pursuant to R.S. 22:1020.62.

§1020.65. Duration of prior authorization exemption

A. An exemption from requirements of a prior authorization of a claim shall remain in effect and not be rescinded until one of the following takes place, whichever is later:

(1) The thirtieth day after the date the health insurance issuer notifies the provider of the health insurance issuer's determination to rescind the exemption or designation if the provider does not appeal the health insurance issuer's determination.

(2) If the provider appeals the determination, pursuant to R.S. 22:1020.66, then the fifth day after the date the independent review organization confirms in writing the health insurance issuer's determination to rescind the exemption or designation and written notice is given to the provider.

B. If a health insurance issuer does not finalize a rescission determination as specified in Subsection A of this Section, the provider is considered to have satisfied the criteria to continue to qualify for the exemption.

§1020.66. Denial or rescission of prior authorization exemption

A. A health insurance issuer may rescind an exemption from prior authorized healthcare provider upon satisfaction of all of the following items:

(1) Rescission shall only occur in January of each year.

(2) The health insurance issuer makes a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than twenty claims submitted by the provider during the most recent annual evaluation period, that less than eighty percent of the claims for the particular covered healthcare service satisfies the medical necessity criteria that would have been used by the health insurance issuer when conducting prior authorization review for the particular covered healthcare service during the relevant evaluation period.

B.(1) A final determination of a rescission may be made only by an individual licensed to practice medicine in Louisiana.

(2) If the provider is a physician, the determination shall be made by an individual licensed to practice medicine in Louisiana who has the same or similar specialty as the physician whose exemption is being rescinded.

(3) The health insurance issuer shall provide written notice to the prior authorized healthcare provider not less than twenty-five days before the proposed rescission is to take effect. This notice shall include all of the following:

(a) The sample information used to make the determination.

(b) A plain language explanation of how the provider may appeal and seek an independent review of the determination.

C. A health insurance issuer may deny an exemption from prior authorized healthcare provider only if one of the following conditions are met:

(1) The provider does not have the exemption at the time of the relevant evaluation period.

(2) The health insurance issuer provides the provider with actual statistics and data for the relevant prior authorization request evaluation period

and detailed information sufficient to demonstrate that the provider does not satisfy the criteria for an exemption from prior authorization requirements for the particular covered healthcare service.

§1020.67. Independent review of exemption determination

A. A provider shall have a right to review an adverse determination regarding a prior authorization exemption to be conducted by an independent review organization as defined in R.S. 22:2392. A health insurance issuer shall not require a provider to engage in an internal appeal process before requesting a review by an independent review organization under this Section.

B. A health insurance issuer shall pay for the following:

(1) The costs of any appeal or independent review of an adverse determination regarding a prior authorization exemption requested under this Section.

(2) The applicable fees established in R.S. 40:1165.1 for copies of medical records or other documents requested from a provider during an exemption rescission review requested under this Section.

C. An independent review organization shall complete an expedited review of an adverse determination regarding a prior authorization exemption not later than the thirtieth day after the date that a provider files the request for a review under this Section.

D. A provider may request that the independent review organization consider another random sample of not less than five and no more than twenty claims submitted to the health insurance issuer by the provider during the relevant evaluation period for the relevant covered healthcare service as part of its review. If the provider makes a request for review under this Subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the health insurance issuer under R.S. 22:1020.66 and reviewed under this Subsection.

§1020.68. Effect of appeal or independent review determination

A. A health insurance issuer is bound by an appeal or independent review determination that does not affirm the determination made by the health insurance issuer to rescind a prior authorization exemption.

B. A health insurance issuer shall not retroactively deny a covered healthcare service on the basis of a rescission of an exemption, nor if the health insurance issuer's determination to rescind the prior authorization exemption is affirmed by an independent review organization.

C. If a determination of a prior authorization exemption made by the health insurance issuer is overturned on review by an independent review organization, the health insurance issuer shall not attempt to rescind the exemption before the end of the next evaluation period that occurs and may rescind only the exemption after the health insurance issuer complies with R.S. 22:1020.66 and 1020.67.

§1020.69. Eligibility for exemption following rescission or denial

After a final determination or review affirming the rescission or denial of an exemption for a specific covered healthcare service, a provider is eligible for consideration of an exemption for the same healthcare service after the evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

§1020.70. Eligibility for exemption following rescission or denial

After a final determination or review affirming the rescission or denial of an exemption for a specific covered healthcare service, a provider is eligible for reconsideration of an exemption for the same covered healthcare service after the evaluation period that follows the evaluation period which formed the basis of the rescission or denial of an exemption.

§1020.71. Effect of prior authorization exemption

A. A health insurance issuer shall not deny or reduce payment to a prior authorized healthcare provider for a covered healthcare service for which the physician or provider has qualified for an exemption from prior authorization

requirements under R.S. 22:1020.64 based on medical necessity or appropriateness of care unless the physician or provider did either of the following:

(1) Knowingly and materially misrepresented the healthcare service in a request for payment submitted to the health insurance issuer with the specific intent to deceive and obtain an unlawful payment from the health insurance issuer.

(2) Failed to substantially perform the covered healthcare service.

B. A health insurance issuer shall not conduct a retrospective review of a covered healthcare service subject to an exemption except for the following:

(1) To determine if the physician or provider qualifies for an exemption under this Subpart.

(2) If the health insurance issuer has a reasonable cause to suspect a basis for denial under Subsection A.

C. Not later than five days after qualifying for an exemption from prior authorization requirements, a health insurance issuer shall provide to a provider a notice that includes:

(1) A statement that the physician or provider qualifies for an exemption from prior authorization requirements pursuant to this Subpart.

(2) A list of the covered healthcare services and health benefit plans to which the exemption applies.

(3) A statement of the duration of the exemption, provided the exemption is not granted for less than one year.

D. If a provider submits a prior authorization request for a covered healthcare service for which the physician or provider qualifies for an exemption, the health insurance issuer shall promptly provide notice to the provider that includes the information described by Subsection C of this Section and a notification of the health maintenance organization's or insurer's payment requirements.

E. Nothing in this Subpart shall be construed to authorize a healthcare provider to provide a healthcare service outside the scope of the provider's applicable license or require a health insurance issuer to pay for a healthcare service that is performed unlawfully.

§1020.72. Penalties

Any violation of the provisions of this Subpart shall be an unfair method of competition or an unfair or deceptive act or practice in the business of insurance and subject to the provisions of Part IV of Chapter 7 of this Title.

§1020.73. Rules

The Department of Insurance shall promulgate rules necessary to implement and enforce the provision of this Subpart.

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§1964. Methods, acts, and practices which are defined as unfair or deceptive

The following are declared to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

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(31) A violation of any provision of Subpart A-4 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950.

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

DIGEST

SB 112 Original 2022 Regular Session Robert Mills

Proposed law created the Reducing Administrative Burdens in Health Insurance Act and provides for legislative intent and purpose.

Proposed law prohibits a health insurance issuer from denying a claim subsequently submitted for health care services which are specifically listed in a prior authorization of a claim unless certain criteria apply, except under certain limited circumstances such as fraud or a change in the patient's condition that negates the need for the medical procedure or treatment.

Proposed law requires health insurance issuers to conduct all eligibility and other medical policy coverage determinations for all services and procedures subject to prior authorization as part of the prior authorization process.

Proposed law creates an exemption for a certain healthcare provider who is designated as prior authorized health care provider. Proposed law defines a "prior authorized healthcare provider" as a healthcare provider that is no longer required to seek prior authorization for a particular procedure or treatment if the health insurance issuer has approved not less than 80% of the prior authorization requests submitted by the provider for the particular health care treatment to that health insurance issuer.

Proposed law provides for the duration of an exemption for a prior authorized healthcare provider and sets forth requirements that must be satisfied in order for the health insurance issuer to deny or rescind an exemption.

Proposed law provides for a time period and content requirements for the mandatory notice that must be given by the health insurance issuer in order to rescind the exemption granted to the prior authorized healthcare provider.

Proposed law allows a healthcare provider to seek a review of a denial or rescission of a prior authorization exemption conducted by an independent review organization as defined by present law.

Proposed law further provides that the health insurance issuer shall pay any fees associated with the independent review of the adverse determination and for the copies of any applicable records associated with the rescission of the exemption.

Proposed law prohibits a health insurance issuer from conducting a retrospective review of a healthcare service subject to an exemption except to determine if the prior authorized healthcare provider still qualifies for an exemption or if the health insurance issuer has a reasonable cause to suspect a basis for denial exists under the provisions of proposed law.

Proposed law provides for timelines and content of the notice that must be given to any provider qualifying for an exemption under the provisions of proposed law.

Proposed law provides that violations of proposed law are considered to be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance and subject to the penalties under present law.

Proposed law provides that the Dept. of Insurance is to promulgate any rules that are necessary to implement and enforce the provisions of proposed law.

Effective August 1, 2022.

(Adds R.S. 22:1020.61 - 1020.73 and R.S. 22:1964(31))