SLS 23RS-352 **ORIGINAL**

2023 Regular Session

SENATE BILL NO. 110

BY SENATOR TALBOT

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

INSURANCE POLICIES. Provides for patient's right to prompt coverage. (8/1/23)

AN ACT

To enact Subpart B-2 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1060.11 through 1060.16, relative to health insurance; to provide for a short title; to provide for definitions; to provide for time periods for prior authorization determinations; to provide for insurance coverage for positron emission tomography imaging under certain conditions; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. Subpart B-2 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1060.11 through 1060.16, is hereby enacted to read as follows:

SUBPART B-2 Cancer Patient's Right to Prompt Coverage Act

§1060.11. Short title

This Subpart shall be known and may be cited as the "Cancer Patient's Right to Prompt Coverage Act".

§1060.12. Definitions

As used in this Subpart the following definitions apply unless the context

indicates otherwise:

(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 and the office of group benefits. "Health coverage plan" does not include a plan providing coverage for excepted benefits defined in R.S. 22:1061, limited benefit health insurance plans or, short-term policies that have a term of less than twelve months.

(2) "Health insurance issuer" means an entity subject to the Louisiana Insurance Code and applicable regulations, 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 health care 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.

(3) "Nationally recognized clinical practice guidelines" means evidence-based clinical guidelines developed by independent organizations or medical professional societies, including but not limited to National Comprehensive Cancer Network, the American Society of Clinical Oncology, or the American Society of Hematology, utilizing a transparent methodology and reporting structure and having policies against conflict-of-interest. The guidelines shall establish best practices informed by a systematic review of evidence and an assessment of the benefits and costs alternative care options and include recommendations intended to optimize patient care.

(4) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent

methodology and reporting structure and with a conflict-of-interest policy. The statements are aimed at specific clinical circumstances and based on the best available evidence for the purpose of optimizing the outcomes of clinical care.

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

(6) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include, but are not limited to, ambulatory review, prior authorization, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall not include elective requests for clarification of coverage.

(7) "Positron emission tomography" means an imaging test that uses radioactive substances to visualize and measure metabolic processes in the body to help reveal how tissue and organs are functioning.

§1060.13. Prior authorization; time periods

As expeditiously as required by the insured's health condition, but in all cases no later than thirty-six hours from the time a request for utilization review was submitted to a health insurance issuer by a health care provider requesting, a utilization review determination for any procedure, pharmaceutical or diagnostic test to be provided or performed for an insured with a history of cancer, symptoms that indicate the possibility of a cancer diagnosis, or has an ongoing case involving cancer and the procedure, pharmaceutical, or diagnostic test is related to that cancer, the health insurance issuer shall render a determination and communicate that determination to the health care provider.

§1060.14. Requirement to cover services consistent with nationally recognized

clinical practice guidelines or consensus statements

No health coverage plan that is renewed, delivered, or issued for delivery in this state that provides coverage for cancer in accordance with the Louisiana Insurance Code shall deny a request for utilization review or the payment of claim for any procedure, pharmaceutical or diagnostic test to be provided or performed for an insured with a history of cancer, symptoms that indicate the possibility of a cancer diagnosis, or has an ongoing case involving cancer if the procedure, pharmaceutical, or diagnostic test is related to that cancer, and the procedure, pharmaceutical, or diagnostic test is recommended by nationally recognized clinical practice guidelines or consensus statements.

§1060.15. Required coverage for positron emission tomography or other recommended imaging for cancer

A. No health insurance issuer shall deny coverage of a positron emission tomography or other recommended imaging for the purpose of diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of an individual's disease or condition if the insured has a prior history of cancer or the insured has symptoms that indicate the possibility of a cancer diagnosis, and the positron emission tomography or other recommended imaging is recommended for the diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of the patient's cancer diagnosis by nationally recognized clinical practice guidelines or consensus statements.

B. No health coverage plan that is renewed, delivered, or issued for delivery in this state shall require an insured to undergo any test for the purpose of diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of an insured's disease or condition of cancer that is not recommended by nationally recognized clinical practice guidelines or consensus statements as a condition precedent to receiving a positron emission tomography or other recommended imaging when the positron emission tomography or other recommended imaging is recommended by the guidelines

provided by this Subpart.

C. The coverage provided in this Section may be subject to annual deductibles, coinsurance, and copayment provisions as are consistent with those established under the health coverage plan.

§1060.16. Coverage for outpatient cancer treatments

A. All health coverage plans renewed, delivered, or issued for delivery in this state shall, in addition to providing coverage for an insured admitted on an inpatient basis to a licensed hospital providing rehabilitation, long-term acute care or skilled nursing services, provide coverage for claims for any outpatient services provided to the patient for the treatment of cancer.

B. The coverage provided in this Section may be subject to annual deductibles, coinsurance, and copayment provisions as are consistent with those established under the health coverage plan.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Beth O'Quin.

DIGEST

SB 110 Original 2023 Regular Session Talbot

Proposed law establishes the "Cancer Patient's Right to Prompt Coverage Act".

Proposed law adds definitions for health coverage plan, health insurance issuer, nationally recognized clinical practice guidelines, consensus statements, prior authorization, utilization review, and positron emission tomography.

Proposed law requires an expeditious review when an insured's health condition requires an expeditious review that in all cases is no later than 36 hours from the time a request for utilization review was submitted to a health insurance issuer from a health insurance provider requesting a utilization review determination for any procedure, pharmaceutical or diagnostic test to be provided or performed for an insured with a history of cancer, symptoms that indicate the possibility of a cancer diagnosis, or has an ongoing case involving cancer and the procedure, pharmaceutical, or diagnostic test is related to that cancer, the health insurance issuer shall render a determination and communicate that determination to the health care provider.

Proposed law prohibits a health insurance coverage plan that has coverage for cancer from denying a utilization review or payment of claims for any procedure, pharmaceutical or diagnostic test to be provided or performed for an insured with a history of cancer, symptoms that indicate the possibility of a cancer diagnosis, or has an ongoing case involving cancer if the procedure, pharmaceutical, or diagnostic test is related to that cancer, and the procedure, pharmaceutical, or diagnostic test is recommended by nationally recognized clinical practice guidelines or consensus statements.

Proposed law prohibits a health coverage plan that has coverage for cancer from denying a

request for utilization review or the payment of claim for any procedure, pharmaceutical or diagnostic test to be provided or performed for an insured with a history of cancer, symptoms that indicate the possibility of a cancer diagnosis, or has an ongoing case involving cancer if the procedure, pharmaceutical, or diagnostic test is related to that cancer, and the procedure, pharmaceutical, or diagnostic test is recommended by nationally recognized clinical practice guidelines or consensus statements.

Proposed law prohibits a health coverage plan that provides coverage for cancer to deny coverage of a positron emission tomography or other recommended imaging for the purpose of diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of an insured's disease or condition if the insured has a prior history of cancer or the insured's symptoms indicate the possibility of a cancer diagnosis, and the positron emission tomography or other recommended imaging is recommended for the diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of the patient's cancer diagnosis by nationally recognized clinical practice guidelines or consensus statements.

Proposed law prohibits a health coverage plan that provides coverage for cancer to require an insured to undergo any test for the purpose of diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of an insured's disease or condition of cancer that is not recommended by nationally recognized clinical practice guidelines or consensus statements as a condition precedent to receiving a positron emission tomography or other recommended imaging when the positron emission tomography or other recommended imaging is recommended by the guidelines provided by proposed law.

Proposed law provides a health insurance plan under this proposed law is authorized to apply annual deductibles, coinsurance, and copayment provisions as are consistent with those established under the health coverage plan.

Proposed law requires all health coverage plans under this proposed law to provide in addition to providing coverage for an insured admitted on an inpatient basis to a licensed hospital providing rehabilitation, long-term acute care or skilled nursing services, to provide coverage for claims for any outpatient services provided to the patient for the treatment of cancer.

Proposed law provides a health insurance plan under this proposed law is authorized to apply annual deductibles, coinsurance, and copayment provisions as are consistent with those established under the health coverage plan.

Effective August 1, 2023.

(Adds R.S. 22:1060.11-1060.16)