SLS 23RS-352 **REENGROSSED**

2023 Regular Session

SENATE BILL NO. 110

BY SENATORS TALBOT, BARROW, BOUDREAUX, BOUIE, CARTER, CATHEY, CLOUD, CONNICK, CORTEZ, DUPLESSIS, FESI, HARRIS, HENRY, HENSGENS, HEWITT, JACKSON, MCMATH, MILLIGAN, FRED MILLS, ROBERT MILLS, MIZELL, MORRIS, PEACOCK, REESE, SMITH, STINE, TARVER, WHITE AND WOMACK

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, and 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 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.

(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 healthcare 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, healthcare services, procedures, or settings. Techniques, shall 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

A. For any services related to the diagnosis or treatment of cancer for which prior authorization is required under a health coverage plan, the health insurance issuer shall offer an expedited review to the provider requesting prior authorization. The health insurance issuer shall communicate its decision on the prior authorization request to the provider as soon as possible, but in all cases no later than forty-eight hours from the receipt of the request for expedited review. If additional information is needed and requested for the issuer to make its determination, the issuer shall communicate its decision to the provider as soon as possible, but no later than forty-eight hours from receipt of the additional information.

B. For any services related to the diagnosis or treatment of cancer for

which prior authorization is required under a health coverage plan and for which the health insurance issuer does not receive a request for expedited review from the provider, the issuer shall communicate its decision on the prior authorization request no later than five days from the receipt of the request. If additional information is needed and requested for the issuer to make its determination, the issuer shall communicate its decision to the provider no more than fourteen days from receipt of the additional information.

§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 prior authorization or the payment of a claim for any procedure, pharmaceutical, or diagnostic test to be provided or performed for the diagnosis and treatment of cancer if the procedure, pharmaceutical, or diagnostic test is recommended by nationally recognized clinical practice guidelines or consensus statements for use in the diagnosis or treatment for the insured's particular type of cancer and clinical state.

§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 imaging is being requested for the diagnosis, treatment, or ongoing surveillance of cancer and is recommended 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 imaging 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 otherwise covered and authorized 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.

Section 2. The provisions of this Act shall apply to any new policy, contract, program, or health coverage plan issued on and after January 1, 2024. Any policy, contract, or health coverage plan in effect prior to January 1, 2024, shall convert to conform to the provisions of this Act on or before the renewal date, but no later than January 1, 2025.

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

DIGEST

SB 110 Reengrossed 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 for any service related to the diagnosis or treatment of cancer which

requires prior authorization under the health coverage plan requires an expedited review to the provider requesting prior authorization, and requires the health insurance issuer to communicate its decision on the prior authorization request as soon as possible, but no later than 48 hours from the receipt of the request for expedited review. Provides that if the issuer needs additional information to make its determination, the proposed law requires the issuer to communicate with the provider as soon as possible, but no later than 48 hours from the receipt of the additional information.

Proposed law requires for any service related to the diagnosis or treatment of cancer which requires prior authorization under the health coverage plan and the provider did not request an expedited review, the issuer is required to communicate its decision on the prior authorization request no later than five days from the receipt of the request for expedited review. Provides that if the issuer needs additional information to make its determination, the proposed law requires the issuer to communicate with the provider no later than 14 days from the receipt of the additional information.

Proposed law prohibits a health insurance coverage plan that has coverage for cancer from denying a prior authorization or payment of claims for any procedure, pharmaceutical or diagnostic test to be provided or performed for the diagnosis and treatment of 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 for use in the diagnosis or treatment for the insured's particular type of cancer and clinical state.

Proposed law prohibits a health issuer 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 imaging is being requested for the diagnosis, treatment, or ongoing monitoring of cancer and is recommended by nationally recognized clinical practice guidelines or consensus statements.

Proposed law prohibits a health coverage plan that is renewed, delivered, or issued for delivery in this state shall undergo any imaging test for the purpose of diagnosis, treatment, appropriate management, restaging, or ongoing monitoring of an insured's disease or condition if the imaging is being requested for the diagnosis, treatment, or ongoing monitoring of cancer and is recommended by nationally recognized clinical practice guidelines or consensus statements as a precedent to receiving a positron emission tomography or other recommended imaging is recommended by the guidelines provided by the 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 otherwise covered and authorized 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.

The Act is effective for any new policy, contract, program, or health coverage plan in effect prior to January 1, 2024, and for any policy, contract, or health coverage plan in effect prior to January 1, 2024, the policy, contract, or health coverage in effect is required to conform

to the provisions of this Act on or before the renewal date, but no later than January 1, 2025.

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

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Clarifies that no plan shall deny a request for utilization review or payment of any procedure or test performed on an insured with a prior history of cancer.

2. Makes technical changes.

Senate Floor Amendments to engrossed bill

1. Changes the prior authorization time period for a request by a provider for an expedited review from 36 hours to 48 hours, and adds if the issuer needs additional information, the issuer is required to make its determination as soon as possible or no later than 48 hours from the receipt of the information.

2. Adds the prior authorization time period for a request by a provider that is not an expedited request is five days from the receipt of the request, and if the issuer needs additional information, no later than 14 days from the receipt of the information.

3. Changes from a utilization review to prior authorization.

4. Changes the conditions for a positron emission tomography (PET)test.

5. Adds imaging to tests that an insured would have to undergo for a PET test.

6. Adds otherwise covered and authorized for outpatient treatment.

7. The effective date is changed to January 1, 2024, for any new policy, contract, program, or health plan, and requires any policy, contract, program or health plan issued prior to January 1, 2024, to conform the provisions of this Act on or before the renewal date, but no later than January 1, 2025.