DIGEST

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SB 110 Reengrossed 2023 Regular Session Talbot

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

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

Proposed law requires a health insurance issuer (issuer) to offer an expedited review to the provider requesting prior authorization for any service related to the diagnosis or treatment of cancer. Requires the issuer to communicate its decision of prior authorization as soon as possible, but no later than 48 hours from the receipt of the request for expedited review. Further provides that if the issuer needs and requests additional information to make its determination, the issuer is required to communicate its decision to the provider as soon as possible, but no later than 48 hours from the receipt of the additional information.

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, proposed law requires the issuer to communicate its decision on the prior authorization request no later than 5 days from the receipt of the request. Further provides that if the issuer needs additional information to make its determination, the issuer is required to communicate with the provider no later than 14 days from the receipt of the additional information.

Proposed law prohibits a health coverage plan 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 test is recommended by nationally recognized clinical practice guidelines or consensus statements for use in the diagnosis or treatment of the insured's specific type of cancer and clinical state.

Proposed law prohibits an issuer from denying coverage of a positron emission tomography or 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 from requiring 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 if the imaging is being requested for the diagnosis, treatment, or ongoing monitoring of cancer that is recommended by nationally recognized clinical practice guidelines or consensus statements, as a precedent to receiving a positron emission tomography, when the positron emission tomography is recommended by the guidelines of proposed law.

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, proposed law requires a health coverage plan to provide coverage for claims for any otherwise covered and authorized outpatient services to the patient for the treatment of cancer.

Proposed law authorizes a health coverage plan to apply annual deductibles, coinsurance, and copayment provisions as are consistent with those established under the health coverage plan.

Proposed law applies to any new policy, contract, program, or health coverage plan issued on and after Jan. 1, 2024, and requires any policy, contract, or health coverage plan in effect

prior to Jan. 1, 2024, to conform to the provisions of proposed law on or before the renewal date, but no later than Jan. 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.

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Insurance to the reengrossed bill:

1. Make technical changes.