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 AND REPRESENTATIVE GAROFALO

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

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 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 the National Comprehensive Cancer Network, the American Society of Clinical Oncology, and the American Society of Hematology, utilizing a transparent methodology and reporting structure and having policies against conflicts of interest. The guidelines shall establish best practices informed by a systematic review of evidence, an assessment of the benefits and costs of alternative care options, and recommendations intended to optimize patient care.

(4) "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. The provisions of this Section shall not apply to non-melanomatous skin cancer.

(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 include but are not limited to ambulatory review, prior authorization, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review does not include elective requests for clarification of coverage.

§1060.13. Prior authorization; time periods

A. For any services typically covered under the plan and 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 two business days 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 typically covered under the plan and 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 two business days from receipt of the additional information.

C. The provisions of this Section shall apply only when the requesting provider clearly indicated that the request is related to the diagnosis or treatment of cancer.

D. The provisions of this Section shall not apply to non-melanomatous skin cancer.

§1060.14. Requirement to cover services consistent with nationally recognized clinical practice guidelines

A. 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 typically covered under the plan 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 for use in the diagnosis or treatment for the insured's particular type of cancer and clinical state.

B. The provisions of this Section shall not prohibit a health insurance issuer from requiring utilization review to assess the effectiveness of the procedure, pharmaceutical, or test for the insured's condition, but if the procedure, pharmaceutical, or test is what is recommended by nationally recognized clinical practice guidelines for use in the diagnosis or treatment for the insured's particular type of cancer and clinical state, then any associated prior authorization shall be approved within the time limit specified in R.S. 22:1060.13.

§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.

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, 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.

PRESIDENT OF THE SENATE

SPEAKER OF THE HOUSE OF REPRESENTATIVES

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____