2026 Regular Session

HOUSE BILL NO. 766

BY REPRESENTATIVE FREEMAN

INSURANCE/HEALTH: Provides relative to coverage for orally administered anti-cancer medications

AN ACT

To amend and reenact R.S. 22:999.1, relative to health insurance coverage; to establish guidelines for the coverage of orally administered anti-cancer medications; to ensure parity between orally administered and intravenously administered or injected anti-cancer medications; to impose prohibitions on cost-sharing, utilization management, and copayment adjustment programs; to provide for definitions; to provide for applicability; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:999.1 is hereby amended and reenacted to read as follows:

§999.1. Parity for orally administered anti-cancer medications with intravenously administered or injected anti-cancer medications

A. It is hereby declared that the public policy of this state is that every person within this state with a health ~~insurance~~ coverage plan that provides coverage for cancer treatment shall have access to the type of covered medication used to treat ~~his~~ the insured's cancer, as such a decision affects the person's overall, long-term health and quality of life. It is also declared that orally administered anti-cancer medications, although very effective in killing or slowing the growth of cancerous cells, have high out-of-pocket costs to the covered person, impacting the decision of physicians to prescribe such medications, thus restricting patient access to life-saving oral anti-cancer medications. It is further declared that physicians must be able to

make the best choice for their patients, considering the unique aspects of each patient and the progress of the disease.

B.(1) A health insurance issuer that provides coverage for cancer treatment shall provide ~~for~~ coverage ~~of~~ for prescribed orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected anti-cancer medications, as provided in this Section.

(2) ~~Health insurance coverage of orally administered anti-cancer medications shall not be subject to any prior authorization, dollar limit, copayment, deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected cancer medications, regardless of formulation or benefit category determination by the health insurance issuer.~~ A health coverage plan shall not impose any prior authorization, dollar limit, copayment, deductible, coinsurance, specialty tier placement, formulary classification, benefit category determination, or other cost-sharing or utilization management requirement on orally administered anti-cancer medications that results in greater out-of-pocket expense or more restrictive access than that imposed on intravenously administered or injected anti-cancer medications by the health insurance issuer.

(3) Cost-sharing for orally administered anti-cancer medications shall be applied toward the enrollee's deductible and annual out-of-pocket maximum in the same manner as other covered benefits under the health coverage plan.

(4) A health insurance issuer shall not reclassify or increase any type of cost-sharing to the covered person for anti-cancer medications in order to achieve compliance with this Section. ~~Any change in health insurance coverage that otherwise increases an out-of-pocket expense applied to anti-cancer medications shall also be applied to the majority of comparable medical or pharmaceutical benefits covered by the health insurance issuer.~~

~~(4)~~ (5) ~~A health insurance issuer that limits the total amount paid by a covered person through all cost-sharing requirements to no more than one hundred dollars per filled prescription for any orally administered anti-cancer medication~~

~~shall be considered in compliance with this Section. For purposes of this Paragraph, "cost-sharing requirements" shall include copayments, coinsurance, deductibles, and any other amounts paid by the covered person for that prescription.~~ A health insurance issuer shall not implement or utilize a copayment adjustment program, including but not limited to an accumulator adjustment program, maximizer program, or similar benefit design, that adjusts, reduces, excludes, or otherwise fails to credit the value of any manufacturer-sponsored or third-party payment, discount, voucher, coupon, or financial assistance toward an enrollee's deductible, cost-sharing obligation, or annual out-of-pocket maximum under the health coverage plan for anti-cancer medications.

C. As used in this Section:

(1) "Anti-cancer medications" means medications used to kill or slow the growth of cancer cells, including orally administered, self-administered, injected, or intravenously administered medications approved for the treatment of cancer.

(2) "Covered person" means a policyholder, subscriber, enrollee, or other individual enrolled in or insured by a health insurance issuer for a health ~~insurance~~ coverage plan.

(3) "Health ~~insurance~~ coverage plan" or "coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or through a network, and including services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer, including individual and group policies and plans.

(4) "Health insurance issuer" means any entity that offers a health ~~insurance~~ coverage plan through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Section, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government

plans subject to the provisions of Subpart B of this Part, and the Office of Group Benefits.

(5) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of covered persons to covered health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

(6) "Copayment adjustment program" means a benefit design, practice, or program implemented by a health insurance issuer or pharmacy benefit manager that adjusts, reduces, excludes, or otherwise fails to credit the value of any manufacturer-sponsored or third-party payment, discount, voucher, coupon, or financial assistance toward an enrollee's deductible, cost-sharing obligation, or annual out-of-pocket maximum under the health coverage plan.

(7) "Specialty tier" means a formulary tier within a health coverage plan that imposes a coinsurance percentage or other cost-sharing requirement that exceeds the lowest applicable cost-sharing tier for prescription drugs under the health coverage plan.

D. ~~The provisions of this Section shall not apply to the following:~~

~~(1) Limited benefit health insurance policies or contracts.~~

~~(2) High deductible health plans or policies that are qualified to be used in conjunction with a health savings account, a medical savings account, or other similar program authorized by 26 U.S.C. 220 et seq~~.

~~(3) Qualified health plans offered through a health benefit exchange.~~

(1) This Section shall apply to individual and group health coverage plans, high-deductible health plans, qualified health plans offered through a health benefit exchange, nonfederal governmental plans, and the Office of Group Benefits, to the maximum extent permitted under federal law.

(2) Nothing in this Section shall be construed to regulate self-funded employee benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA), except to the extent permitted under federal law.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

HB 766 Original 2026 Regular Session Freeman

Abstract: Establishes updated requirements governing health insurance coverage for orally administered anti-cancer medications.

Present law requires health insurance issuers that provide coverage for cancer treatment to provide coverage for orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications. Present law prohibits certain cost-sharing practices, authorizes a $100 per-prescription cap for compliance, and excludes high-deductible health plans, limited benefit policies, and qualified health plans offered through a health benefit exchange from applicability.

Proposed law modernizes and expands oral chemotherapy parity requirements:

(1) Requires coverage of prescribed orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected anti-cancer medications.

(2) Prohibits prior authorization, dollar limits, copayments, deductibles, coinsurance, specialty tier placement, formulary classification, benefit category determinations, or other cost-sharing or utilization management requirements that result in greater out-of-pocket expense or more restrictive access for orally administered anti-cancer medications.

(3) Requires cost-sharing for orally administered anti-cancer medications to be applied toward the enrollee's deductible and annual out-of-pocket maximum in the same manner as other covered benefits.

(4) Prohibits a health insurance issuer from reclassifying or increasing cost-sharing for anti-cancer medications to achieve compliance.

(5) Prohibits copayment adjustment programs, including accumulator and maximizer programs, that fail to credit manufacturer or third-party financial assistance toward an enrollee's deductible, cost-sharing obligation, or annual out-of-pocket maximum.

(6) Defines "anti-cancer medications", "covered person", "health coverage plan", "health insurance issuer", "network of providers", "copayment adjustment program", and "specialty tier".

(7) Applies proposed law to individual and group health coverage plans, high-deductible health plans, qualified health plans offered through a health benefit exchange, nonfederal governmental plans, and the Office of Group Benefits, to the maximum extent permitted under federal law.

(Amends R.S. 22:999.1)