DIGEST

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HB 766 Reengrossed 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 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 for certain high-deductible plan policies.

(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.

(8) Revises applicability provisions to clarify that the proposed law does not apply to limited benefit health insurance policies or contracts.

(9) Clarifies that nothing in the proposed law will 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.

(Amends R.S. 22:999.1)

Summary of Amendments Adopted by House

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

1. Clarify the scope of applicability by specifying that it does not apply to limited-benefit health insurance policies or contracts.

2. Establish an exemption for self-funded employee benefit plans governed by the Employee Retirement Income Security Act of 1974 (ERISA). It stipulates that proposed law shall not be interpreted as regulating these plans, except to the extent permitted by federal law.

3. Make technical changes.

The Committee Amendments Proposed by House Committee on Appropriations to the engrossed bill:

1. Reinstate present law regarding cost-sharing requirements.

2. Limit application of proposed law regarding copayment adjustment programs to certain high-deductible plans.