

ACT No. 833

2026 Regular Session

HOUSE BILL NO. 766

BY REPRESENTATIVES FREEMAN AND CHASSION

1 AN ACT

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

8 Be it enacted by the Legislature of Louisiana:

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

10 §999.1. Parity for orally administered anti-cancer medications with intravenously
11 administered or injected anti-cancer medications

12 A. It is hereby declared that the public policy of this state is that every
13 person within this state with a health insurance coverage plan that provides coverage
14 for cancer treatment shall have access to the type of covered medication used to treat
15 ~~his~~ the insured's cancer, as such a decision affects the person's overall, long-term
16 health and quality of life. It is also declared that orally administered anti-cancer
17 medications, although very effective in killing or slowing the growth of cancerous
18 cells, have high out-of-pocket costs to the covered person, impacting the decision of
19 physicians to prescribe such medications, thus restricting patient access to life-saving
20 oral anti-cancer medications. It is further declared that physicians must be able to
21 make the best choice for their patients, considering the unique aspects of each patient
22 and the progress of the disease.

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

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

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

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

25 ~~(4)~~ (5) A health insurance issuer that limits the total amount paid by a
26 covered person through all cost-sharing requirements to no more than ~~one hundred~~
27 eighty dollars per filled prescription for any orally administered anti-cancer
28 medication shall be considered in compliance with this Section. For purposes of this
29 Paragraph, "cost-sharing requirements" shall include copayments, coinsurance,
30 deductibles, and any other amounts paid by the covered person for that prescription.

1 (6) A health insurance issuer shall not implement or utilize a copayment
2 adjustment program, including but not limited to an accumulator adjustment
3 program, maximizer program, or similar benefit design that adjusts, reduces,
4 excludes, or otherwise fails to credit the value of any manufacturer-sponsored or
5 third-party payment, discount, voucher, coupon, or financial assistance toward an
6 enrollee's deductible, cost-sharing obligation, or annual out-of-pocket maximum
7 under the health coverage plan for anti-cancer medications as part of high-deductible
8 health plan policies that are eligible for use in conjunction with health savings
9 accounts (HSAs), medical savings accounts (MSAs), or other similar programs
10 authorized under 26 U.S.C. 220 et seq.

11 C. As used in this Section:

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

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

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

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

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

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

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

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

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

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

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

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

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

28 (2) The provisions of this Section do not apply to limited benefit health
 29 insurance policies or contracts.

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

SPEAKER OF THE HOUSE OF REPRESENTATIVES

PRESIDENT OF THE SENATE

GOVERNOR OF THE STATE OF LOUISIANA

APPROVED: _____