SENATE FLOOR AMENDMENTS

2026 Regular Session

Amendments proposed by Senator Bass to Reengrossed House Bill No. 870 by Representative Turner

AMENDMENT NO. 1

In Amendment No. 2 proposed by the Senate Committee on Insurance and adopted by the Senate on May 7, 2026, on page 1, delete lines 5 and 6 and insert "(5)" Net cost calculation" means the cost to a covered person under the health benefit plan of a brand-name or generic prescription drug or a biological product or biosimilar, net of all applicable rebates and discounts."

AMENDMENT NO. 2

In Amendment No 10 proposed by the Senate Committee on Insurance and adopted by the Senate on May 7, 2026, on page 1, between lines 31 and 32 insert the following:

"(3) If the net cost is based on rebates or discounts including more than one drug product from the brand manufacturers portfolio, then the health insurance issuer shall provide a detailed accounting of the total portfolio rebate or discount, including for each NDC the following:

(a) Wholesale acquisitions cost.

(b) Net cost."

AMENDMENT NO. 3

In Amendment No. 10 proposed by the Senate Committee on Insurance and adopted by the Senate on May 7, 2026, on page 1, at the beginning of line 32 change "(3)" to "(4)"

AMENDMENT NO. 4

In Amendment No. 10 proposed by the Senate Committee on Insurance and adopted by the Senate on May 7, 2026, on page 2, at the beginning of line 1 change "(4)" to "(5)"

AMENDMENT NO. 5

In Amendment No. 10 proposed by the Senate Committee on Insurance and adopted by the Senate on May 7, 2026, on page 2, after line 7 insert the following:

"E. Continuity of therapy for current users.

(1) A health insurance issuer shall not, during the plan year, use compliance with this Section as the basis to remove a reference listed drug or reference product from a plan formulary, increase cost sharing, move the drug or product to a less favorable tier, or impose new authorization, step therapy, quantity limits, or other utilization management requirements for an enrollee who is currently receiving the reference listed drug or reference product, unless one of the following applies:

(a) The prescribing provider, after consultation with the enrollee, agrees that a switch is medically appropriate.

(b) The issuer provides a clear, readily accessible medical-necessity exception process and grants an exception for continued coverage of the reference listed drug or reference listed product.

(2) Nothing in this Section shall be construed to require a prescribing provider to prescribe a generic drug or any biological product, or to require an enrollee to switch from a reference listed drug or reference product to a generic drug or any biological product.

F. Confidentiality.

(1) To ensure transparency regarding formulary decisions, the commissioner shall provide an annual report, providing a summary of the notifications under this Section, including an analysis of the overall impact on patient costs.

(2) All information and data obtained by the department pursuant to this Subpart that is not otherwise publicly available is considered to be a trade secret, confidential, and proprietary, is not subject to disclosure pursuant to the Public Records Law, R.S. 44:1 et seq., and shall not be disclosed directly or indirectly.

(3) The Department of Insurance shall impose the confidentiality protections of this Section on any third party that may receive or otherwise have access to this information."