SLS 14RS-467 **REENGROSSED**

Regular Session, 2014

SENATE BILL NO. 165

BY SENATOR MURRAY

HEALTH/ACC INSURANCE. Provides relative to prescription drug specialty tiers. (8/1/14)

AN ACT

To enact R.S. 22:1060.5, relative to prescription drug specialty tiers; to provide with respect to limits on coinsurance; to provide for limits on out-of-pocket expenses for prescription drugs; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1060.5 is hereby enacted to read as follows:

§1060.5. Specialty drug tiers; prohibitions; limits on co-payments

A. A health insurance issuer of a health benefit plan that covers prescription drugs, as defined in R.S. 22:1060.1(8), and utilizes a formulary tier that is higher than a preferred or non-preferred brand drug tier, sometimes known as a specialty drug tier, shall limit any required co-payment or coinsurance applicable to drugs on such tier to an amount not to exceed one hundred and fifty dollars per month for each drug up to a thirty-day supply of any single drug. This limit shall be inclusive of any co-payment or coinsurance. This limit shall be applicable after any deductible is reached and until the individual's maximum out-of-pocket limit has been reached.

B. A health care issuer of a health benefit plan that covers prescription

drugs, as defined in R.S. 22:1060.1(8), and utilizes specialty tiers shall be required to implement an exceptions process that allows enrollees to request an exception to the formulary. Under such an exception, a non-formulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both. In the event an enrollee is denied an exception, such denial shall be considered an adverse event and shall be subject to the health plan internal review process and the state external review process.

C. The provisions of this Section shall not apply to the Office of Group Benefits or to the claims of the Office of Group Benefits enrollees administered by health insurance issuers.

Section 2. The provisions of this Section shall become effective on January 1, 2015.

The original instrument was prepared by Cheryl Horne. The following digest, which does not constitute a part of the legislative instrument, was prepared by Nancy Vicknair.

DIGEST

Murray (SB 165)

Proposed law requires a health insurance issuer of a health benefit plan that covers prescription drugs as defined in present law and utilizes a formulary tier that is higher than a preferred or non-preferred brand drug tier, sometimes known as a specialty drug tier, to limit any required co-payment or coinsurance applicable to drugs on such tier to an amount not to exceed $150 per month for each drug up to a 30-day supply of any single drug. Requires such limit to be inclusive of any co-payment or coinsurance and be applicable after any deductible is reached and until the individual's maximum out-of-pocket limit has been reached.

Proposed law requires a health care issuer of a health benefit plan that covers prescription drugs as defined in present law and utilizes specialty tiers to implement an exceptions process allowing enrollees to request an exception to the formulary. Further provides that under such an exception, a non-formulary specialty drug could be deemed covered under the formulary if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual, would have adverse effects for the individual, or both.

Proposed law provides that in the event an enrollee is denied an exception, such denial shall be considered an adverse event and shall be subject to the health plan internal review process and the state external review process.

Proposed law exempts the Office of Group Benefits from proposed law.

Effective January 1, 2015.

(Adds R.S. 22:1060.5)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Removes the prohibition on payments by an insured of a percentage of the cost of a drug.

2. Removes the prohibition by an insurance issuer to charge a cost-sharing for a prescription drug in excess of 500% of the lowest amount of cost-sharing required by a prescription drug plan.

3. Removes the limits on out-of-pocket expenses.

4. Requires a health insurance issuer of a health benefit plan that covers prescription drugs and utilizes a speciality drug tier to limit any required co-payment or coinsurance applicable to speciality drugs on a speciality tier to an amount not to exceed $150 per month for each specialty drug up to a 30-day supply of any single drug.

5. Exempts 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 and the Office of Group Benefits from proposed law.

6. Adds an effective date of January 1, 2015.

Senate Floor Amendments to engrossed bill

1. Remove provision specifying that nothing in proposed law requires a health insurance issuer of a health benefit plan to provide coverage for any additional prescription drugs not otherwise provided by law.

2. Removes provision exempting 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.

3. Requires that the co-payment and coinsurance amounts paid for specialty tier drugs be inclusive of such co-payment or coinsurance and be applicable after any deductible is reached and until the individual's maximum out-of-pocket limit has been reached.

4. Technical amendments.