SLS 14RS-467 **ORIGINAL**

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 prohibit the payment by an insured of a percentage of the cost of a drug; to provide with respect to limits on co-payments; 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), shall be prohibited from creating prescription drug specialty tiers that require the insured to pay a percentage of the cost of a drug rather than a co-pay. It shall also be unlawful for a health insurance issuer to charge cost-sharing for a prescription drug in excess of five hundred percent of the lowest amount of cost-sharing required by the plan for a prescription drug included in the plan's formulary as defined in R.S. 22:1060.1(2). For a health insurance issuer who charges a co-pay for a prescription drug included in the plan's formulary as defined in R.S.

22:1060.1(2), cost-sharing shall refer to such co-pays. For a health insurance issuer who charges co-insurance for a prescription drug included in the plan's formulary as defined in R.S. 22:1060.1(2), cost-sharing shall refer to the actual total dollar amount of the cost of the drug paid by the enrollee.

B. Nothing in this Section shall be construed to require a health insurance issuer of a health benefit plan to provide coverage for any additional prescription drugs not otherwise provided by law.

C. If a health care issuer of a health benefit plan provides for a limit on out-of-pocket expenses for benefits other than prescription drugs, that plan shall include from the following optional provisions the option that results in the lowest out-of-pocket prescription drug cost to the insured:

(1) Out-of-pocket expenses for prescription drugs shall be included under the health benefit plan's total limit for out-of-pocket expenses for all benefits provided under the plan.

(2) Out-of-pocket expenses for prescription drugs per health care plan year shall not exceed one thousand dollars per insured or two thousand dollars per insured family.

D. 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.

The original instrument and the following digest, which constitutes no part of the legislative instrument, were prepared by Cheryl Horne.

DIGEST

Murray (SB 165)

Proposed law prohibits a health insurance issuer of a health benefit plan that covers prescription drugs as defined in present law from creating prescription drug specialty tiers that require the insured to pay a percentage of the cost of a drug rather than a co-pay. Prohibits a health insurance issuer from charging cost-sharing for a prescription drug in excess of 500% of the lowest amount of cost-sharing required by the plan for a prescription drug included in the plan's formulary as defined in present law.

Proposed law specifies 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.

Proposed law provides that when a health care issuer of a health benefit plan provides for a limit on out-of-pocket expenses for benefits other than prescription drugs, that plan shall include one of the following options that results in the lowest out-of-pocket prescription drug cost to the insured:

(1) Out-of-pocket expenses for prescription drugs shall be included under the health benefit plan's total limit for out-of-pocket expenses for all benefits provided under the plan.

(2) Out-of-pocket expenses for prescription drugs per plan year shall not exceed one thousand dollars per insured or two thousand dollars per insured family.

Effective August 1, 2014.

(Adds R.S. 22:1060.5)