HOUSE SUMMARY OF SENATE AMENDMENTS

HB 870 **2026 Regular Session** **Turner**

INSURANCE/HEALTH: Provides relative to formulary placement and cost-sharing requirements for certain generic drugs and biosimilars

Synopsis of Senate Amendments

1. Clarifies the definition of "net cost" by specifying that it represents the expense incurred by a covered individual for a drug or biological product after considering all applicable rebates and discounts.

2. Enhances transparency standards by requiring insurers to furnish a comprehensive account of portfolio-based rebates or discounts encompassing the wholesale acquisition cost and the net cost for each medication, identified by its National Drug Code (NDC).

3. Establishes continuity-of-therapy protections by prohibiting insurers from altering formulary placement, cost-sharing, or utilization management requirements for enrollees currently utilizing a reference drug during the plan year, except in specific clinical situations or through an exception process.

4. Clarifies that prescribing decisions are under the provider's discretion and introduces confidentiality provisions mandating annual reporting, while safeguarding proprietary insurer data from public disclosure.

5. Makes technical changes.

Digest of Bill as Finally Passed by Senate

Proposed law defines "biosimilar", "brand drug", "formulary", "generic drug", "net cost", "net cost calculation", "reference listed drug", "reference product", and "wholesale acquisition cost". Proposed law further defines “net cost calculation” as the cost to a covered person for a prescription drug or biological product after accounting for all applicable rebates and discounts.

Proposed law mandates that health insurance issuers providing coverage for a reference listed drug must immediately include a newly marketed generic drug on the plan formulary with more favorable cost-sharing arrangements, provided that the wholesale acquisition cost of the generic drug is lower than that of the reference listed drug at the time of the generic drug's initial marketing date.

Proposed law prohibits prior authorization, step therapy, or any other restrictions that would make accessing the generic drug more challenging than accessing the reference listed drug.

Proposed law prohibits placing any limitations on the pharmacies through which an enrollee can obtain the generic drug.

Proposed law continues to apply as long as the wholesale acquisition cost of the generic drug remains lower than that of the reference listed drug.

Proposed law further requires health insurance issuers providing coverage for a reference product to immediately include at least one biosimilar on the formulary with more favorable cost-sharing when the biosimilar’s wholesale acquisition cost is lower than that of the reference product at its initial marketing date. Similar to the provisions for generics, proposed law prohibits prior authorization, step therapy, or limitations that hinder access to

the biosimilar compared to the reference product, along with prohibiting restrictions on the pharmacies that can dispense the biosimilar. Proposed law continues to apply as long as the biosimilar's wholesale acquisition cost remains lower than that of the reference product.

Proposed law requires a notice to the commissioner of insurance if a health insurance issuer uses a net cost calculation for a branded prescription drug in a prescription drug formulary in lieu of placing a generic or biosimilar on the drug formulary. Further provides for what must be placed in the required notice. If such net cost calculations rely on portfolio-wide rebates or discounts, proposed law requires the issuer to provide a detailed accounting, including the wholesale acquisition cost and net cost for each affected drug identified by National Drug Code.

Proposed law establishes continuity-of-therapy protections by prohibiting a health insurance issuer from removing a reference listed drug or reference product from the formulary, increasing cost sharing, moving the drug or product to a less favorable tier, or imposing new utilization management requirements on an enrollee currently receiving such drug or product during a plan year, except under limited circumstances involving provider agreement or an authorized medical necessity exception.

Proposed law further clarifies that nothing shall require a prescribing provider to prescribe, or an enrollee to use, a generic drug, biosimilar, or other biological product in place of a reference listed drug or reference product.

Proposed law mandates that the commissioner of insurance submit an annual report summarizing notifications and assessing their effects on patient costs. Proposed law classifies proprietary insurer data submitted under as confidential and exempt from public records disclosure, extending these confidentiality protections to any third parties granted access to the information.

Effective August 1, 2026.

(Adds R.S. 22:1060.9)