Murray (SB 165) **Act No. 453**

New law requires a health insurance issuer of a health benefit plan that covers prescription drugs as defined in prior 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.

New law requires a health care issuer of a health benefit plan that covers prescription drugs as defined in prior 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.

New 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.

New law exempts the Office of Group Benefits from new law.

Effective January 1, 2015.

(Adds R.S. 22:1060.5)