Regular Session, 2011

HOUSE BILL NO. 345

BY REPRESENTATIVE LAFONTA

Prefiled pursuant to Article III, Section 2(A)(4)(b)(i) of the Constitution of Louisiana.

INSURANCE/HEALTH: Provides relative to coverage of prescription drugs by health benefit plans, including through a drug formulary

AN ACT

To amend and reenact R.S. 22:1068(D) and 1074(D) and to enact R.S. 22:1061(5)(y) and Subpart B-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, to be comprised of R.S. 22:1060.1 through 1060.4, relative to health insurance; to provide with respect to coverage by a health benefit plan of prescription drugs, including through the use of a drug formulary; to provide relative to guaranteed renewability of coverage in the group and individual market with regard to modifications affecting drug coverage; to provide for applicability; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:1068(D) and 1074(D) are hereby amended and reenacted and R.S. 22:1061(5)(y) and Subpart B-1 of Part III of Chapter 4 of Title 22 of the Louisiana Revised Statutes of 1950, comprised of R.S. 22:1060.1 through 1060.4, are hereby enacted to read as follows:

SUBPART B-1. COVERAGE OF PRESCRIPTION DRUGS

THROUGH A DRUG FORMULARY

§1060.1. Definitions

As used in this Subpart, the following definitions shall apply:

(1) "Authorized prescriber" means a person licensed, registered, or otherwise authorized by the appropriate licensing board to prescribe prescription drugs in the course of professional practice.

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(2) "Drug formulary" or "formulary" means a list of prescription drugs which meets any of the following criteria:

(a) For which a health benefit plan provides coverage.

(b) For which a health benefit plan approves payment.

(c) That a health insurance issuer encourages or offers incentives for physicians or other authorized prescribers to prescribe.

(3) "Enrollee" or "insured" means an individual who is enrolled or insured by a health insurance issuer under a health benefit plan.

(4) "Health benefit plan" or "plan" means an entity which provides benefits through or by a health insurance issuer consisting of health care services provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care services under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract; however, "health benefit plan" shall not include benefits due under Chapter 10 of Title 23 of the Louisiana Revised Statutes of 1950 or limited benefit and supplemental health insurance policies, benefits provided under a separate policy, certificate, or contract of insurance for accidents, disability income, limited scope dental or vision benefits, benefits for long-term care, nursing home care, home health care, or specific diseases or illnesses, or any other limited benefit policy or contract as defined in R.S. 22:47(2)(c).

(5) "Health care services" means services, items, supplies, or prescription drugs for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.

(6) "Health insurance issuer" or "issuer" means any entity that offers a health benefit plan through a policy, contract, or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Subpart, a "health insurance issuer" or "issuer" shall include but not be limited to a health maintenance organization as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of

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this Title. A "health insurance issuer" or "issuer" shall not include any entity preempted as an employee benefit plan under the Employee Retirement Income Security Act of 1974 or the Office of Group Benefits.

(7) "Physician" means a person licensed by the Louisiana State Board of Medical Examiners.

(8) "Prescription drug" or "drug" means any of the following:

(a) A substance for which federal or state law requires a prescription before the substance may be legally dispensed to the public.

(b) A drug or device that under federal law is required, before being dispensed or delivered, to be labeled with the statement: "Caution: Federal law prohibits dispensing without prescription" or "Rx only" or another legend that complies with federal law.

(c) A drug or device that is required by federal or state statute or regulation to be dispensed on prescriptions or that is restricted to use by a physician or other authorized prescriber.

§1060.2. Notice and disclosure of certain information required

A health insurance issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan shall:

(1) Provide in plain language in the coverage documentation provided to each enrollee each of the following:

(a) Notice that the plan uses one or more drug formularies.

(b) An explanation of what a drug formulary is.

(c) A statement regarding the method the health insurance issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary.

(d) A statement of how often the health insurance issuer reviews the contents of each drug formulary.

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(e) Notice, on a form approved by the Department of Insurance, that an enrollee may contact the health insurance issuer to determine whether a specific drug is included in a particular drug formulary.

(2) Disclose to an individual upon request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary.

(3) Notify an enrollee and any other individual who requests information pursuant to this Section that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness.

§1060.3. Continuation of coverage required; other drugs not precluded

A. A health insurance issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or medical illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date.

B. This Section shall not prohibit a physician or other authorized prescriber from prescribing a drug that is an alternative to a drug for which continuation of coverage is required by Subsection A of this Section if the alternative drug meets each of the following conditions:

(1) The drug is covered under the health benefit plan.

(2) The drug is medically appropriate for the enrollee.

§1060.4. Adverse determination

A. The refusal of a health insurance issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for the purposes of Subpart F of this Part, R.S. 22:1121 et seq., relative to medical necessity review organizations, if each of the following conditions is met:

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(1) The drug is not included in a drug formulary used by the health benefit plan.

(2) The enrollee's physician or other authorized prescriber has determined the drug is medically necessary.

B. The enrollee may appeal the adverse determination pursuant to Subpart F of this Part, R.S. 22:1121 et seq., relative to medical necessity review organizations.

§1061. Definitions

As used in R.S. 22:984 and 1061 through 1079, the following terms shall have the following meanings:

* * *

(5) Other definitions are:

* * *

(y) "Modification affecting drug coverage" means any of the following:

(i) Removing a drug from a formulary.

(ii) Adding a requirement that an enrollee receive prior authorization for a drug.

(iii) Imposing or altering a quantity limit for a drug.

(iv) Imposing a step-therapy restriction for a drug.

(v) Moving a drug to a higher cost-sharing tier, unless a generic alternative is available.

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§1068. Guaranteed renewability of coverage for employers in the group market

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D. ~~At the time of coverage renewal, a~~ A health insurance issuer may modify ~~the~~ health insurance coverage ~~for a product~~ offered to a group health plan~~:~~ if each of the following conditions is met:

(1) ~~In the large group market.~~ The modification occurs at the time of coverage renewal.

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(2) ~~In the small group market if, for coverage that is available in such market other than only through one or more bona fide associations, such~~ The modification is approved by the commissioner and is effective on a uniform basis among all small or large employers covered by that group health ~~plans with that product.~~ plan.

(3) The issuer notifies, on a form approved by the Department of Insurance, each affected covered small or large employer and enrollee of the modification, including modification of coverage of a particular product or modification of drug coverage, not later than the sixtieth day before the date the modification is effective.

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§1074. Guaranteed renewability of individual health insurance coverage

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D. ~~At the time of coverage renewal, a~~ A health insurance issuer may modify the health insurance coverage for a policy form offered to individuals in the individual market ~~so long as~~ if each of the following conditions is met:

(1) The modification occurs at the time of coverage renewal.

(2) ~~such~~ The modification is approved by the commissioner, is consistent with state law, and is effective on a uniform basis among all individuals with that policy form.

(3) The issuer notifies, on a form approved by the Department of Insurance, each affected individual of the modification, including modification of coverage of a particular product or modification of drug coverage, not later than the sixtieth day before the date the modification is effective.

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Section 2. This Act shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after January 1, 2012.

Section 3. This Act shall become effective on January 1, 2012.

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DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

LaFonta HB No. 345

Abstract: Requires notification and disclosure by a health benefit plan of covered prescription drugs, including through the use of a drug formulary. Limits modification of such a formulary during a plan year.

Proposed law provides relative to coverage of prescription drugs by health benefit plans, including through the use of a drug formulary, as follows:

(1) Defines certain terms, including "drug formulary", "health insurance issuer","health benefit plan", and "prescription drug".

(2) Requires a health insurance issuer of a health benefit plan that covers prescription drugs and uses one or more drug formularies to specify the prescription drugs covered under the plan to provide in plain language in the coverage documentation provided to each enrollee each of the following:

(a) Notice that the plan uses one or more drug formularies.

(b) An explanation of what a drug formulary is.

(c) A statement regarding the method the health insurance issuer uses to determine the prescription drugs to be included in or excluded from a drug formulary.

(d) A statement of how often the health insurance issuer reviews the contents of each drug formulary.

(e) Notice on a form approved by the Dept. of Insurance (DOI) that an enrollee may contact the health insurance issuer to determine whether a specific drug is included in a particular drug formulary.

(3) Further requires such a health insurance issuer to disclose to an individual upon request, not later than the third business day after the date of the request, whether a specific drug is included in a particular drug formulary. Additionally requires such a health insurance issuer to notify an enrollee and any other individual who requests information under proposed law that the inclusion of a drug in a drug formulary does not guarantee that an enrollee's physician or other authorized prescriber will prescribe the drug for a particular medical condition or mental illness.

(4) A health insurance issuer of a health benefit plan that covers prescription drugs shall offer to each enrollee at the contracted benefit level and until the enrollee's plan renewal date any prescription drug that was approved or covered under the plan for a medical condition or medical illness, regardless of whether the drug has been removed from the health benefit plan's drug formulary before the plan renewal date. Specifies that proposed law shall not prohibit a physician or other authorized prescriber from prescribing a drug that is an alternative to a drug for which such continuation of coverage is required if the alternative drug is covered under the health benefit plan and is medically appropriate for the enrollee.

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(5) Present law, the Medical Necessity Review Organization Act, which establishes the minimum standards required for any entity to determine what medical services or procedures will be covered under a health plan based on medical necessity. Provides for an internal and external appeal and review of an adverse determination, meaning that a covered benefit has been reviewed and denied, reduced, or terminated.

Proposed law provides that refusal of a health insurance issuer to provide benefits to an enrollee for a prescription drug is an adverse determination for the purposes of present law if the drug is not included in a drug formulary used by the health benefit plan and the enrollee's physician or other authorized prescriber has determined the drug is medically necessary. Specifically authorizes the enrollee to appeal such adverse determination pursuant to present law.

(6) Present law relative to portability, availability, and renewability of health insurance coverage provides for numerous definitions.

Proposed law adds the definition of "modification affecting drug coverage" as meaning any of the following:

(a) Removing a drug from a formulary.

(b) Adding a requirement that an enrollee receive prior authorization for a drug.

(c) Imposing or altering a quantity limit for a drug.

(d) Imposing a step-therapy restriction for a drug.

(e) Moving a drug to a higher cost-sharing tier, unless a generic alternative is available.

(7) Present law, relative to guaranteed renewability of coverage for employers in the group market, allows a health insurance issuer, at the time of coverage renewal, to modify coverage for a product offered to a group health plan in the large group market. Provides that such a modification is allowed in the small group market if it is approved by the commissioner and is effective on a uniform basis among group health plans with that product.

Proposed law instead allows a health insurance issuer to modify health insurance coverage offered to a group health plan at the time of coverage renewal if the modification is approved by the commissioner and is effective among all small or large employers covered by a group health plan. Additionally requires the issuer to notify on a form approved by DOI each affected covered small or large employer and enrollee of the modification, including modification of coverage of a particular product or modification of drug coverage, not later than the 60th day before the date the modification is effective.

(8) Present law, relative to guaranteed renewability of individual health insurance coverage, allows a health insurance issuer, at the time of coverage renewal, to modify the health insurance coverage for a policy form offered to individuals in the individual market so long as such modification is consistent with state law and effective on a uniform basis among all individuals with that policy form.

Proposed law allows a health insurance issuer to modify the health insurance coverage for a policy form offered to individuals in the individual market at the time of coverage renewal if the modification is approved by the commissioner, is consistent with state law, and is effective on a uniform basis among all individuals with that policy form. Additionally requires the issuer to notify on a form approved by DOI each affected individual of the modification, including modification of

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coverage of a particular product or modification of drug coverage, not later than the 60th day before the date the modification is effective.

(9) Provides that proposed law shall apply only to a health benefit plan, group health plan, or individual health insurance policy delivered, issued for delivery, or renewed on or after Jan. 1, 2012.

Effective January 1, 2012.

(Amends R.S. 22:1068(D) and 1074(D); Adds R.S. 22:1061(5)(y) and 1060.1-1060.4)

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Insurance to the original bill.

1. Added requirement that the commissioner of insurance approve modifications to individual health plans at the time of coverage renewal.

House Floor Amendments to the engrossed bill.

1. Modified the definition of "drug formulary".

2. Required that certain notifications provided by health insurance issuers to employers and enrollees be on forms approved by the Department of Insurance.

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