New 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 new 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 new 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.

(5) Existing 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.

New 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 existing 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 existing law.

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

New 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) Prior law, relative to guaranteed renewability of coverage for employers in the group market, allowed 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. Provided that such a modification was allowed in the small group market if it is approved by the commissioner and was effective on a uniform basis among group health plans with that product.

New 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) Prior law, relative to guaranteed renewability of individual health insurance coverage, allowed 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 was consistent with state law and was effective on a uniform basis among all individuals with that policy form.

New 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 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 new 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)