DIGEST

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SB 191 Engrossed 2021 Regular Session Cloud

Proposed law prohibits a health insurance issuer, pharmacy benefit manager, or their agent from refusing to authorize, approve, or pay a participating provider for providing covered physician-administered drugs and related services to covered persons. Further prohibits a health insurance issuer, pharmacy benefit manager, or their agent from conditioning, denying, restricting, refusing to authorize or approve, or reducing payment to a participating provider for a physician-administered drug when all criteria for medical necessity are met because the participating provider obtains physician-administered drugs from a pharmacy that is not a participating provider in the health insurance issuer's network. Requires that the drug supplied meets the supply chain security controls and chain of distribution set forth by the federal Drug Supply Chain Security Act.

Proposed law provides that "participating provider" includes any clinic, hospital outpatient department or pharmacy under common ownership or control of the participating provider.

Proposed law requires payment to a participating provider to be at the rate set forth in the health insurance issuer's agreement with the provider applicable to such drugs. If no rate is included in the agreement, the payment shall be at the wholesale acquisition cost.

Proposed law prohibits a health insurance issuer, pharmacy benefit manager, or their agent from requiring a covered person pay an additional fee, or any other increased cost-sharing amount in addition to applicable cost-sharing amounts payable by the covered person as designated within the benefit plan to obtain the physician-administered drug when provided by a participating provider.

Proposed law does not prohibit a health insurance issuer or its agent from establishing differing copayments or other cost-sharing amounts within the benefit plan for covered persons who acquire physician-administered drugs from other providers nor shall it prohibit a health insurance issuer or its agent from refusing to authorize or approve or from denying coverage of a physician-administered drug based upon failure to satisfy medical necessity criteria.

Proposed law provides that the location of receiving the physician-administered drug is not to be included in the medical necessity criteria.

Proposed law does not prohibit a health insurance issuer from establishing specialty care centers of excellence based on nationally established, objective quality measures, to be utilized by covered persons focused on specific drugs or types of drugs to impact the safety, quality, affordability, and expertise of treatment.

Proposed law prohibits a pharmacy benefit manager or person acting on behalf of a pharmacy benefit manager from conditioning, denying, restricting, refusing to authorize or approve, or reducing payment to a pharmacy or pharmacist for providing covered physician-administered drugs and related services to an enrollee. Reimbursement shall be at the rate set forth in the contract between the pharmacy benefit manager or person acting on behalf of a pharmacy benefit manager with the pharmacy or pharmacist applicable to the drugs, or if no rate is included in the agreement, then at the wholesale acquisition cost.

Proposed law prohibits a pharmacy benefit manager from requiring an enrollee to pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other increased cost-sharing amount for a physician-administered drug when provided by a pharmacy, pharmacist, clinic, hospital, or hospital outpatient department.

Proposed law requires the commission of any act prohibited by proposed law to be considered an unfair method of competition and unfair practice or act which shall subject the violator to any and all actions, including investigative demands, private actions, remedies, and penalties as provided in present law.

Effective upon signature of the governor or lapse of time for gubernatorial action.

(Adds R.S. 22:1020.51-1020.53)

Summary of Amendments Adopted by Senate

Committee Amendments Proposed by Senate Committee on Insurance to the original bill

1. Moves bill from Title 40 to Title 22.

2. Adds provisions to include pharmacy benefit managers, or their agent.

3. Adds provision prohibiting a health insurance issuer from limiting or denying payment for a physician-administered drug when all criteria for medical necessity are met.

4. Adds provisions that prohibit requiring a covered person to pay an additional fee or other increased cost-sharing amount in addition to applicable cost-sharing amounts payable by the covered person as designated in the benefit.

5. Authorizes a health insurance issuer or its agent to establish differing copayments or other cost sharing amounts within the benefit plan.

6. Adds provisions that prohibit a health insurance issuer or its agent from refusing to authorize or approve or from denying coverage of a physician-administered drug based upon failure to satisfy medical necessity criteria.

7 Adds provisions that the location of receiving the physician-administered drug is not to be included in the medical necessity criteria.

Summary of Amendments Adopted by House

The Committee Amendments Proposed by House Committee on Insurance to the engrossed bill:

1. Make technical changes.

2. Provide that proposed law (R.S. 22:1020.53) does not prohibit a health insurance issuer from establishing specialty care centers of excellence based on nationally established, objective quality measures, to be utilized by covered persons focused on specific drugs or types of drugs to impact the safety, quality, affordability, and expertise of treatment.