

1 H.659

2 Introduced by Representative Baker of West Rutland

3 Referred to Committee on

4 Date:

5 Subject: Health; insurance; prescription drug coverage; cost-sharing; preferred  
6 drug lists

7 Statement of purpose: This bill proposes to establish criteria for prescription  
8 drug coverage provided by a health insurer in Vermont.

9 An act relating to prescription drug coverage by health insurers

10 It is hereby enacted by the General Assembly of the State of Vermont:

11 Sec. 1. 8 V.S.A. § 4089j is amended to read:

12 § 4089J. ~~RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS~~

13 PRESCRIPTION DRUG COVERAGE; COST-SHARING;

14 FORMULARIES

15 (a) A health insurer and pharmacy benefit manager doing business in

16 Vermont shall permit a retail pharmacist licensed under chapter 36 of Title 26

17 to fill prescriptions in the same manner and at the same level of reimbursement

18 as they are filled by mail order pharmacies with respect to the quantity of drugs

19 or days' supply of drugs dispensed under each prescription.

1        (b) Unless otherwise prohibited by law, a health insurer and pharmacy  
2        benefit manager that provides prescription drug coverage through a health plan  
3        in Vermont shall:

4            (1) limit the co-payment and coinsurance amounts with respect to any  
5            covered drug so that they shall not exceed the cost of the drug to the health  
6            plan;

7            (2) limit the maximum co-payment and coinsurance amounts so the total  
8            does not exceed five times the dollar value of the lowest co-payment and  
9            coinsurance amount whose cost is above zero dollars.

10        (c) Every health insurer offering a health plan with an overall out-of-pocket  
11        limit on benefits shall include out-of-pocket expenses for prescription drugs in  
12        the overall cap, except that out-of-pocket expenses for prescription drugs shall  
13        not exceed \$1,000.00 per covered individual or \$2,000.00 per covered family  
14        per contract year. This amount shall be adjusted annually in the same  
15        percentage as the change in the consumer price index.

16        (d) Every health insurer and pharmacy benefit manager that provides  
17        prescription drug coverage through a health plan with a formulary or preferred  
18        drug list shall:

19            (1) provide an override process for any protocols requiring that a health  
20            care professional prescribe a preferred drug prior to prescribing a different  
21            drug, which shall allow an override when:

1           (A) the preferred drug has been ineffective in treating the patient's  
2           condition in the past;

3           (B) in the health care professional's clinical assessment based on  
4           medical or scientific evidence, the preferred drug is expected to be ineffective  
5           based on the known, relevant medical or mental characteristics of the patient;  
6           or

7           (C) in the health care professional's clinical assessment based on  
8           medical or scientific evidence, the preferred treatment is expected to cause an  
9           adverse reaction or other harm to the patient.

10           (2) limit any durational requirement for prescribing a preferred drug to  
11           14 days if the health care professional deems the treatment clinically  
12           ineffective.

13           ~~(b)~~(c) As used in this section:

14           (1) "Health insurer" ~~is defined by~~ shall have the same meaning as in  
15           section 9402 of Title 18.

16           (2) "Health care professional" means an individual who is authorized by  
17           law to prescribe or to recommend prescription drugs and who either is licensed  
18           by the state or is otherwise lawfully providing health care in this state.

19           (3) "Health plan" means any health insurance policy or health benefit  
20           plan offered by a health insurer or Medicaid, or a public health benefits plan

1 funded through a Medicaid waiver, or any other public health benefit plan  
2 administered by the state or any subdivision or instrumentality of the state.

3 ~~(2)~~(4) “Pharmacy benefit manager” means an entity that performs  
4 pharmacy benefit management and includes a person that performs in a  
5 contractual or employment relationship with an entity performing pharmacy  
6 benefit management for a health plan. “Pharmacy benefit management” means  
7 an arrangement for the procurement of prescription drugs at negotiated  
8 ~~dispensing rates~~ rates for dispensation with this state to beneficiaries, the  
9 administration or management of prescription drug benefits provided by a  
10 health insurance plan for the benefit of beneficiaries, or any of the following  
11 services provided with regard to the administration of pharmacy benefits:

12 (A) mail service pharmacy;

13 (B) claims processing, retail network management, and payment of  
14 claims to pharmacies for prescription drugs dispensed to beneficiaries;

15 (C) clinical formulary development and management services;

16 (D) rebate contracting and administration;

17 (E) certain patient compliance, therapeutic intervention, and generic  
18 substitution programs; and

19 (F) disease or chronic care management programs.

1       ~~(e) This section shall apply to Medicaid, the Vermont health access plan,~~  
2       ~~the VScript pharmaceutical assistance program, and any other public health~~  
3       ~~care assistance program.~~

4       Sec. 2. 18 V.S.A. § 4601(4) is amended to read:

5           (4) “Generic drug” means a drug listed by generic name and considered  
6       to be ~~chemically and~~ an A-rated generic, which is a therapeutically equivalent  
7       to a drug listed by brand name, ~~as both names are identified in the most recent~~  
8       ~~edition of the federal Food and Drug Administration’s “Orange Book” of~~  
9       ~~approved drug products~~ drug, as defined by the federal Food and Drug  
10       Administration, to the prescribed drug;

11       Sec. 3. 18 V.S.A. § 4605(a) is amended to read:

12           (a) When a pharmacist receives a prescription for a drug which is listed  
13       either by generic name or brand name in the most recent edition of the U.S.  
14       Department of Health and Human Services’ publication Approved Drug  
15       Products With Therapeutic Equivalence (the “Orange Book”) of approved drug  
16       products, the pharmacist shall select the lowest priced generic drug ~~from the~~  
17       ~~list which is equivalent as defined by the “Orange Book”, unless otherwise.~~ If  
18       specifically instructed in writing by the prescriber, ~~or by~~ and the purchaser if  
19       ~~the purchaser agrees to pay any additional cost in excess of the benefits~~  
20       ~~provided by the purchaser’s health benefit plan if allowed under the legal~~

1 ~~requirements applicable to the plan, otherwise to pay the full cost for the~~  
2 ~~higher priced drug, the pharmacist may substitute an alternative drug.~~

3 Sec. 4. 18 V.S.A. § 9422 is added to read:

4 § 9422. PRESCRIPTION DRUG INCENTIVES

5 (a) A health insurer as defined in section 4089j of Title 8 and a pharmacy  
6 benefits manager as defined in section 4089j of Title 8 shall not:

7 (1) provide any form of financial incentive to health care providers to  
8 prescribe a specific drug or type of drug;

9 (2) pay a health care professional as defined in section 4089j of Title 8,  
10 a health care provider, or a pharmacist to change a stable patient or request a  
11 stable patient to change from one drug to another specific drug; or

12 (3) provide any financial benefits, including payments of bonuses, for  
13 prescribing a specific drug or type of drug.

14 (b) Annually beginning January 1, 2011, a health insurer as defined in  
15 section 4089j of Title 8 and a pharmacy benefits manager as defined in section  
16 4089j of Title 8 shall disclose any financial incentive used to influence or  
17 impact the clinical decision-making of health care professionals, including the  
18 choice of a prescription drug, to the commissioner of banking, insurance,  
19 securities, and health care administration in the form and manner prescribed by  
20 the commissioner. The commissioner shall make this information publicly  
21 available on a searchable website.