1 S.216

2 Introduced by Senator Mullin

3 Referred to Committee on

4 Date:

5 Subject: Health; health insurance; prescription drugs; formularies

6 Statement of purpose of bill as introduced: This bill proposes to require health
7 insurance plans to make information about their prescription drug formularies
8 available to enrollees, potential enrollees, and health care providers. It would
9 also require hospitals to provide prescription drug cost-sharing information to
10 hospital-affiliated physicians through the hospital's electronic prescribing
11 system.

12 An act relating to prescription drug formularies

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

14 Sec. 1. 8 V.S.A. § 4089i is amended to read:

15 § 4089i. PRESCRIPTION DRUG COVERAGE

16 (a) Prescription drugs from Canada. A health insurance or other health
17 benefit plan offered by a health insurer shall provide coverage for prescription
18 drugs purchased in Canada, and used in Canada or reimported legally or
19 purchased through the I-SaveRx program on the same benefit terms and
20 conditions as prescription drugs purchased in this country. For drugs

1 purchased by mail or through the Internet, the plan may require accreditation
2 by the Internet and Mailorder Pharmacy Accreditation Commission
3 (IMPAC/tm) or similar organization.
4 (b) No annual dollar limit. A health insurance or other health benefit plan
5 offered by a health insurer or pharmacy benefit manager shall not include an
6 annual dollar limit on prescription drug benefits.
7 (c) Out-of-pocket maximum. A health insurance or other health benefit
8 plan offered by a health insurer or pharmacy benefit manager shall limit a
9 beneficiary's out-of-pocket expenditures for prescription drugs, including
10 specialty drugs, to no more for self-only and family coverage per year than the
11 minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal
12 Revenue Code of 1986 for self-only and family coverage, respectively.
13 (d) High-deductible health plans. For prescription drug benefits offered in
14 conjunction with a high-deductible health plan (HDHP), the plan may not
15 provide prescription drug benefits until the expenditures applicable to the
16 deductible under the HDHP have met the amount of the minimum annual
17 deductibles in effect for self-only and family coverage under Section
18 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family
19 coverage, respectively, except that a plan may offer first-dollar prescription
20 drug benefits to the extent permitted under federal law. Once the foregoing
21 expenditure amount has been met under the HDHP, coverage for prescription

1 drug benefits shall begin, and the limit on out-of-pocket expenditures for
2 prescription drug benefits shall be as specified in subsection (c) of this section.
3 (e)(1) Step therapy. A health insurance or other health benefit plan offered
4 by a health insurer or by a pharmacy benefit manager on behalf of a health
5 insurer that provides coverage for prescription drugs and uses step-therapy
6 protocols shall not require failure on the same medication on more than one
7 occasion for continuously enrolled members or subscribers.
8 (2) Nothing in this subsection shall be construed to prohibit the use of
9 tiered co-payments for members or subscribers not subject to a step-therapy
10 protocol.
11 (f)(1) No off-label drug requirements. A health insurance or other health
12 benefit plan offered by a health insurer or by a pharmacy benefit manager on
13 behalf of a health insurer that provides coverage for prescription drugs shall
14 not require, as a condition of coverage, use of drugs not indicated by the
15 federal Food and Drug Administration for the condition diagnosed and being
16 treated under supervision of a health care professional.
17 (2) Nothing in this subsection shall be construed to prevent a health care
18 professional from prescribing a medication for off-label use.
19 (g) Prescription drug formularies. Each health insurance or other health
20 benefit plan offered by a health insurer or by a pharmacy benefit manager on
21 behalf of a health insurer that provides coverage for prescription drugs shall

1 provide notice to enrollees in the certificate of coverage regarding whether the
2 plan uses a prescription drug formulary. The notice shall include an
3 explanation of what a formulary is, how the plan determines which
4 prescription drugs are included or excluded, and how often the plan reviews
5 the contents of the formulary. The health insurer or pharmacy benefit manager
6 shall also do all of the following:
7 (1) Post the formulary for each health insurance or other health benefit
8 plan on the plan's website in a manner that is accessible to and searchable by
9 enrollees, potential enrollees, and providers. The formulary shall either be
10 displayed in a standard format established by the Department of Financial
11 Regulation or through a web-based search tool that allows enrollees, potential
12 enrollees, and providers to enter the name of a drug and receive plan-specific
13 information regarding whether the drug is covered and the cost-sharing range,
14 if applicable.
15 (2) Update each posted formulary within 72 hours after making any
16 changes to the formulary.
17 (3) Include all of the following on any published formulary for each
18 plan, including the formularies posted pursuant to subdivision (1) of this
19 subsection:
20 (A) any prior authorization, step therapy, or utilization management
21 requirements for each drug included in the formulary;

1 (B) if the plan uses a tier-based formulary, the specific tier the drug
2 occupies and a list of the specific co-payments for each tier; and
3 (C) for drugs subject to cost-sharing, the dollar range of coinsurance
4 typically paid by an enrollee for each specific drug included in the formulary,
5 using the following ranges and symbols:
6 (i) $100.00 or less: "$";
7 (ii) from $100.01 to $250.00: "$$";
8 (iii) from $250.01 to $500.00: "$$$";
9 (iv) from $500.01 to $1,000.00: "$$$$"; and
10 (v) over $1,000.00: "$$$$$."
11 (4) If mail order pharmacy is permitted under the plan, provide separate
12 coinsurance ranges for potential enrollees if they purchase the drug through a
13 mail order facility, using the same ranges and symbols as provided in
14 subdivision (3) of this subsection.
15 (5) For drugs covered under a plan's medical benefit and typically
16 administered by a health care professional, provide a list of all covered drugs
17 and any cost-sharing imposed on the drugs, either posted on the plan's website
18 or through a toll-free telephone number that is staffed at least during normal
19 business hours.
20 (6) Provide a description of the criteria by which medications are
21 specifically included in or excluded from the deductible.

(h) Definitions. As used in this section:

(1) “Health care professional” means an individual licensed to practice medicine under 26 V.S.A. chapter 23 or 33, an individual certified as a physician assistant under 26 V.S.A. chapter 31, or an individual licensed as an advanced practice registered nurse under 26 V.S.A. chapter 28.

(2) “Health insurer” shall have the same meaning as in 18 V.S.A. § 9402.

(3) “Out-of-pocket expenditure” means a co-payment, coinsurance, deductible, or other cost-sharing mechanism.

(4) “Pharmacy benefit manager” shall have the same meaning as in section 4089j of this title.

(5) “Step therapy” means protocols that establish the specific sequence in which prescription drugs for a specific medical condition are to be prescribed.

~~(h)~~(i) The Department of Financial Regulation shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

Sec. 2. STANDARD PRESCRIPTION DRUG FORMULARY FORMAT; RULEMAKING

The Department of Financial Regulation shall adopt rules establishing the standard format for posting online prescription drug formularies pursuant to 8 V.S.A. § 4089i(g).

1 Sec. 3. 18 V.S.A. § 9413a is added to read:

2 § 9413a. COST INFORMATION FOR ELECTRONIC PRESCRIBERS

3 (a) Each hospital providing an electronic prescribing system for use by its
4 affiliated health care providers shall indicate in the system the dollar range of
5 coinsurance typically paid by patients with commercial insurance for each drug
6 included in the electronic prescribing system, using the following ranges and
7 symbols:

8 (1) $100.00 or less: "$";
9 (2) from $100.01 to $250.00: "$$";
10 (3) from $250.01 to $500.00: "$$$";
11 (4) from $500.01 to $1,000.00: "$$$$"; and
12 (5) over $1,000.00: "$$$$$."

13 (b) Annually on or before July 1, each health insurer with more than 200
14 covered lives in this State shall provide to each hospital in this State an
15 updated copy of its formulary, including the ranges and symbols set forth in
16 subsection (a) of this section.

17 Sec. 4. EFFECTIVE DATES

18 (a) Sec. 1 (8 V.S.A. § 4089i) shall take effect on January 1, 2017.

19 (b) Sec. 2 (rulemaking) and this section shall take effect on passage.

20 (c) Sec. 3 (18 V.S.A. § 9413a) shall take effect on January 1, 2017, except
21 that health insurers shall provide a copy of their formularies to each hospital on

1 or before July 1, 2016 to enable the hospitals to update their electronic

2 prescribing systems on or before January 1, 2017.