Senate conferees' proposal #2

Report of Committee of Conference

S.216

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

The Committee of Conference, to which were referred the disagreeing votes of the two Houses upon Senate Bill, entitled:

S.216. An act relating to prescription drug formularies.

Respectfully reports that it has met and considered the same and recommends that the House recede from its proposal of amendment and that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The General Assembly finds that:

(1) The costs of prescription drugs have been increasing dramatically without any apparent reason.

(2) Containing health care costs requires containing prescription drug costs.

(3) In order to contain prescription drug costs, it is essential to understand the drivers of those costs, as transparency is typically the first step toward cost containment.

Sec. 2. 18 V.S.A. § 4635 is added to read:

§ 4635. PHARMACEUTICAL COST TRANSPARENCY

(a) As used in this section:

(1) "Manufacturer" shall have the same meaning as "pharmaceutical manufacturer" in section 4631a of this title.

(2) "Prescription drug" means a drug as defined in 21 U.S.C. § 321.

(b)(1) The Green Mountain Care Board, in collaboration with the Department of Vermont Health Access, shall identify annually up to 15 prescription drugs ~~**with a wholesale acquisition cost of $500.00 or more monthly or per course of treatment,**~~ on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased by **50** percent or more over the past five years or by **15** percent or more over the past 12 months, creating a substantial public interest in understanding the development of the drugs' pricing. The drugs identified shall represent different drug classes.

(2) The Board shall provide to the Office of the Attorney General the list of prescription drugs developed pursuant to this subsection and the percentage of the wholesale acquisition cost increase for each drug and shall make the information available to the public on the Board's website.

(c)(1) For each prescription drug identified pursuant to subsection (b) of this section, the Office of the Attorney General shall require the drug's

manufacturer to provide a justification for the increase in the wholesale acquisition cost of the drug in a format that the Attorney General determines to be understandable and appropriate. The manufacturer shall submit to the Office of the Attorney General all relevant information and supporting documentation necessary to justify the manufacturer's wholesale acquisition cost increase, which may include:

(A) all factors that have contributed to the wholesale acquisition cost increase;

(B) the percentage of the total wholesale acquisition cost increase attributable to each factor; and

(C) an explanation of the role of each factor in contributing to the wholesale acquisition cost increase.

(2) Nothing in this section shall be construed to restrict the legal ability of a prescription drug manufacturer to changes prices to the extent permitted under federal law.

(d) The Attorney General, in consultation with the Department of Vermont Health Access, shall provide a report to the General Assembly on or before December 1 of each year based on the information received from manufacturers pursuant to this section. The Attorney General shall also post the report on the Office of the Attorney General's website.

(e) Information provided to the Office of the Attorney General pursuant to this section is exempt from public inspection and copying under the Public Records Act and shall not be released in a manner that allows for the identification of an individual drug or manufacturer or that is likely to compromise the financial, competitive, or proprietary nature of the information.

(f) The Attorney General may bring an action in the Civil Division of the Superior Court, Washington County for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer that fails to provide the information required by subsection (c) of this section a civil penalty of no more than $10,000.00 per violation. Each unlawful failure to provide information shall constitute a separate violation. In any action brought pursuant to this section, the Attorney General shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Protection Act, 9 V.S.A. chapter 63.

Sec. 3. PRESCRIPTION DRUG FORMULARIES; RULEMAKING

On or before January 1, 2017, the Commissioner of Financial Regulation shall adopt rules pursuant to 3 V.S.A. chapter 25 to require all health insurers that offer health benefit plans to Vermont residents through the Vermont Health Benefit Exchange to provide information to enrollees, potential enrollees, and health care providers about the Exchange plans' prescription

drug formularies. The rules shall ensure that the formulary is posted online in a standard format established by the Department of Financial Regulation; that the formulary is updated frequently and is searchable by enrollees, potential enrollees, and health care providers; and that it includes information about the prescription drugs covered, applicable cost-sharing amounts, drug tiers, prior authorization, step therapy, and utilization management requirements.

Sec. 4. 340B DRUG DISPENSING FEES

(a) The Department of Vermont Health Access shall use the same dispensing fee in its reimbursement formula for 340B prescription drugs as the Department uses to pay for non-340B prescription drugs under the Medicaid program.

(b) Notwithstanding the provisions of subsection (a) of this section, the Department is authorized to modify the dispensing fee or reimbursement formula provided to federally qualified health centers **and Title X family planning clinics** for dispensing 340B prescription drugs to Medicaid beneficiaries.

Sec. 5. 340B DRUG REIMBURSEMENT; REPORT

(a) The Department of Vermont Health Access shall:

(1) determine the formula used by other states' Medicaid programs to reimburse covered entities that use 340B pricing for dispensing prescription drugs to Medicaid beneficiaries;

~~(2) evaluate the advantages and disadvantages of using the same dispensing fee in its reimbursement formula for 340B prescription drugs as the Department uses to pay for non-340B prescription drugs under the Medicaid program;~~ and

(**2**) identify the benefits**, if any,** of 340B drug pricing to consumers, other payers, and the overall health care system.

(b) On or before March 15, 2017, the Department shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding its findings and recommendations, including recommended modifications to Vermont's 340B reimbursement formula, if any, and the financial implications of implementing any recommended modifications.

Sec. 6. OUT-OF-POCKET PRESCRIPTION DRUG LIMITS; 2018 PILOT; REPORTS

(a) The Department of Vermont Health Access shall convene an advisory group to develop options for bronze-level qualified health benefit plans to be offered on the Vermont Health Benefit Exchange for the 2018 plan year, including:

(1) one or more plans with a higher out-of-pocket limit on prescription drug coverage than the limit established in 8 V.S.A. § 4089i; and

(2) two or more plans with an out-of-pocket limit at or below the limit established in 8 V.S.A. § 4089i.

(b) The advisory group shall include at least the following members:

(1) the Commissioner of Vermont Health Access or designee;

(2) a representative of each of the commercial health insurers offering plans on the Vermont Health Benefit Exchange;

(3) a representative of the Office of the Vermont Health Advocate;

(4) a member of the Medicaid and Exchange Advisory Board, appointed by the Commissioner;

(5) a representative of Vermont's AIDS services organizations;

(6) a consumer appointed by Vermont's AIDS services organizations;

(7) a representative of the American Cancer Society;

(8) a consumer appointed by the American Cancer Society; and

(9) a Vermont Health Connect navigator.

(c)(1) The advisory group shall meet at least six times prior to the Department submitting plan designs to the Green Mountain Care Board for approval.

(2) In developing the standard qualified health benefit plan designs for the 2018 plan year, the Department of Vermont Health Access shall present the recommendations of the advisory committee established pursuant to subsection (a) of this section to the Green Mountain Care Board.

(d)(1) Prior to the date on which qualified health plan forms must be filed with the Department of Financial Regulation pursuant to 8 V.S.A. § 4062, a health insurer offering qualified health benefit plans on the Vermont Health Benefit Exchange shall seek approval from the Green Mountain Care Board to modify the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more nonstandard bronze-level plans. In considering an insurer's request, the Green Mountain Care Board shall provide an opportunity for the advisory group established in subsection (a) of this section, and any other interested party, to comment on the recommended modifications.

(2)(A) Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the Green Mountain Care Board may approve modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for one or more bronze-level plans for the 2018 plan year only.

(B) For the 2018 plan year, the Department of Vermont Health Access shall certify at least two standard bronze-levels plan that includes the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, as long as the plan complies with federal requirements. Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, the Department may certify one or more bronze-level qualified health benefit plans with modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i for the 2018 plan year only.

(e)(1) For each individual enrolled in a bronze-level qualified health benefit plan for plan years 2016 and 2017 who had out-of-pocket prescription drug expenditures during the 2016 plan year that met the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i, the health insurer shall, absent an alternative plan selection or plan cancellation by the individual, automatically reenroll the individual in a bronze-level qualified health benefit plan for plan year 2018 with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i.

(2) Prior to reenrolling the individual in a plan pursuant to subdivision (1) of this subsection, the health insurer shall notify the individual of the insurer's intent to reenroll automatically the individual in a bronze-level plan for plan year 2018 with an out-of-pocket prescription drug limit at or below the limit established in 8 V.S.A. § 4089i and of the availability of bronze-level plans with higher out-of-pocket prescription drug limits.

(f)**(1)** The ~~**Commissioner of Vermont Health Access, with assistance from the**~~ Director of Health Care Reform in the Agency of Administration**, in consultation with the Department of Vermont Health Access and the Office of Legislative Council,** shall determine whether the Secretary of the U.S. Department of Health and Human Services has the authority under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the federal Health Care and Education Reconciliation Act of 2010, Pub. L.

No. 111-152 (ACA), to waive annual limitations on out-of-pocket expenses or actuarial value requirements for bronze-level plans, or both. On or before October 1, 2016, the ~~Commissioner~~ **Director** shall present information to the Health Reform Oversight Committee regarding the authority of the Secretary of the U.S. Department of Health and Human Services to waive out-of-pocket limits and actuarial value requirements ~~and the status of the State's waiver application, if any~~**, the estimated costs of applying for a waiver, and alternatives to a waiver for preserving the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i**.

(2) If the ~~Commissioner and the~~ Director **of Health Care Reform determines** that the Secretary has the necessary authority, then **on or before March 1, 2017,** the Commissioner **of Vermont Health Access**, with the Director's assistance, shall apply for a waiver of the cost-sharing or actuarial value limitations, or both, in order to preserve the availability of bronze-level qualified health benefit plans that meet Vermont's out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

(g) On or before February 15, 2017, the Department of Vermont Health Access shall provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) an overview of the cost-share increase trend for bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange

for the 2014 through 2017 plan years that were subject to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i;

(2) detailed information regarding lower cost-sharing amounts for selected services that will be available in bronze-level qualified health benefit plans in the 2018 plan year due to the flexibility to increase the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i pursuant to subdivision (d)(2) of this section;

(3) a comparison of the bronze-level qualified health benefit plans offered in the 2018 plan year in which there will be flexibility in the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i with the plans in which there will not be flexibility;

(4) information about the process engaged in by the advisory group established in subsection (a) of this section and the information considered to determine modifications to the cost-sharing amounts in all bronze-level qualified health benefit plans for the 2018 plan year, including prior year utilization trends, feedback from consumers and health insurers, Health Benefit Exchange outreach and education efforts, and relevant national studies;

(5) cost-sharing information for standard bronze-level qualified health benefit plans from states with federally facilitated exchanges compared to those on the Vermont Health Benefit Exchange; and

(6) an overview of the outreach and education plan for enrollees in bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange.

(f) On or before February 1, 2018, the Department of Vermont Health Access shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance:

(1) enrollment trends in bronze-level qualified health benefit plans offered on the Vermont Health Benefit Exchange; and

(2) recommendations from the advisory group established pursuant to subsection (a) of this section regarding continuation of the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

Sec. 7. EFFECTIVE DATE

This bill shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to prescription drugs"

COMMITTEE ON THE PART OF THE SENATE	COMMITTEE ON THE PART OF THE HOUSE
_____	_____
SEN. KEVIN J. MULLIN	REP. WILLIAM J. LIPPERT
_____	_____
SEN. MICHAEL D. SIROTKIN	REP. CHRISTOPHER A. PEARSON
_____	_____
SEN. TIMOTHY R. ASHE	REP. ROBERT L. BANCROFT