TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 216 entitled "An act relating to prescription drug formularies" respectfully reports that it has considered the same and recommends that the House propose to the Senate 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) The Green Mountain Care Board, in collaboration with the Department of Vermont Health Access, shall identify annually up to 15 prescription drugs 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, with some of the drugs being generic drugs, some brand-name drugs, and some specialty drugs. The Board shall provide the list of prescription drugs to the Office of the Attorney General.

(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, including:

(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.

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 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

(3) identify the benefits 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. 5. 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) one 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 one standard bronze-level 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) 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. 6. EFFECTIVE DATE

(a) 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 vote: _____)

_____

Representative _____

FOR THE COMMITTEE