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. 18 V.S.A. § 4635 is added to read:

§ 4635. PRESCRIPTION DRUG PRICING INCREASE DISCLOSURES

(a) As used in this section:

(1) "Health insurer" shall have the same meaning as in section 9402 of this title.

(2) "State purchaser" means the Department of Vermont Health Access, the Department of Corrections, or the Vermont State Employees Health Benefit Plan.

(b) A manufacturer of a brand name prescription drug that is purchased or reimbursed by any State purchaser and health insurer shall notify each State purchaser and health insurer if it is increasing the wholesale acquisition cost of a prescription drug by more than 10 percent during any 12-month period or if intends to introduce to market a prescription drug with a wholesale acquisition cost of $10,000.00 or more per year or per course of treatment. The notice shall be provided in writing at least 60 days prior to the planned effective date

of the increase or introduction to market. A copy of the notice shall be provided concurrently to the House Committees on Appropriations and on Health Care and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

(c) A manufacturer of a generic prescription drug with a price of $100.00 or more per 30-day supply shall notify each State purchaser and health insurer if it is increasing the wholesale acquisition cost of the prescription drug by more than 10 percent during a 12-month period. The notice shall be provided in writing at least 60 days prior to the planned effective date of the increase. A copy of the notice shall be provided concurrently to the House Committees on Appropriations and on Health Care and the Senate Committees on Appropriations, on Health and Welfare, and on Finance.

(d)(1) Within 30 days of notification of a price increase, or of the introduction to market of a prescription drug with a wholesale acquisition cost of $10,000.00 or more annually or per course of treatment, a manufacturer shall report all of the following information to each State purchaser and health insurer:

(A) a justification for the proposed increase in the price of the drug, including all information and supporting documentation as to why the increase is justified;

(B) the expected marketing budget for the drug;

(C) the date the drug was purchased, if it was not developed by the manufacturer; and

(D) a schedule of past price increases for the drug.

(2) Failure to report the information to State purchase or health insurers, or both, shall result in a civil penalty of $1,000.00 per day for each day after the 30-day notification period.

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

Sec. 2. 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. 3. 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. 4. OUT-OF-POCKET PRESCRIPTION DRUG LIMITS; 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 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.

(B) Notwithstanding any provision of 8 V.S.A. § 4089i to the contrary, 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 for the 2018 plan year, as long as the plan

complies with federal requirements. The Department may certify one or more standard 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.

(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. 5. EFFECTIVE DATES

(a) Sec. 1 shall take effect on July 1, 2016.

(b) The remaining section 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