H.611

An act relating to miscellaneous provisions affecting the Department of Vermont Health Access

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

Sec. 1. 18 V.S.A. § 4635 is amended to read:

§ 4635. PRESCRIPTION DRUG COST TRANSPARENCY

(a) As used in this section:

(1) "Health insurer" means a health insurer, as defined in section 9402 of this title, with more than 5,000 covered lives in this State for major medical health insurance, as defined in 8 V.S.A. § 4011. The term does not include Vermont Medicaid.

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

~~(2)~~(3) "Prescription drug" means a drug as defined in 21 U.S.C. § 321.

(b)(1)(A) ~~The Department of Vermont Health Access shall create annually a list of 10 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 during the previous calendar year, creating a substantial public interest in understanding the development of the drugs' pricing. The list shall include at least one generic and one brand-name drug and shall indicate each of the drugs on the list that the Department considers to be specialty drugs. The Department shall~~

~~include the percentage of the wholesale acquisition cost increase for each drug on the list; rank the drugs on the list from those with the largest increase in wholesale acquisition cost to those with the smallest increase; indicate whether each drug was included on the list based on its cost increase over the past five years or during the previous calendar year, or both; and provide the Department's total expenditure for each drug on the list during the most recent calendar year.~~

~~(B) The Department of Vermont Health Access shall create annually a list of 10 prescription drugs on which the State spends significant health care dollars and for which the cost to the Department of Vermont Health Access, net of rebates and other price concessions, has increased by 50 percent or more over the past five years or by 15 percent or more during the previous calendar year, creating a substantial public interest in understanding the development of the drugs' pricing. The list shall include at least one generic and one brand-name drug and shall indicate each of the drugs on the list that the Department considers to be specialty drugs. The Department shall rank the drugs on the list from those with the greatest increase in net cost to those with the smallest increase and indicate whether each drug was included on the list based on its cost increase over the past five years or during the previous calendar year, or both.~~

~~(C)(i)~~ Each health insurer ~~with more than 5,000 covered lives in this State for major medical health insurance~~ shall create annually a list of 10 prescription drugs on which its health insurance plans spend significant amounts of their premium dollars and for which the cost to the plans, net of rebates and other price concessions, has increased by 50 percent or more over the past five years or by 15 percent or more during the previous calendar year, or both, creating a substantial public interest in understanding the development of the drugs' pricing. The list shall include at least one generic and one brand-name drug and shall indicate each of the drugs on the list that the health insurer considers to be specialty drugs. The health insurer shall rank the drugs on the list from those with the greatest increase in net cost to those with the smallest increase and indicate whether each drug was included on the list based on its cost increase over the past five years or during the previous calendar year, or both.

~~(ii)~~(B) Each health insurer creating a list pursuant to subdivision ~~(i)~~(A) of this subdivision (b)(1)~~(C)~~ shall provide to the Office of the Attorney General the percentage by which the net cost to its plans increased over the applicable period or periods for each drug on the list, as well as the insurer's total expenditure, net of rebates and other price concessions, for each drug on the list during the most recent calendar year. Information provided to the Office of the Attorney General pursuant to this subdivision (b)(1)~~(C)(ii)~~(B) is

exempt from public inspection and copying under the Public Records Act and shall not be released.

(2) The ~~Department of Vermont Health Access and the~~ health insurers shall provide to the Office of the Attorney General and the Green Mountain Care Board the lists of prescription drugs developed pursuant to ~~subdivisions (1)(A), (B), and (C)(i)~~ subdivision (1) of this subsection annually on or before June 1. The Office of the Attorney General and the Green Mountain Care Board shall make all of the information available to the public on their respective websites.

(c)(1)(A) Of the prescription drugs listed by the ~~Department of Vermont Health Access and the~~ health insurers pursuant to ~~subdivisions (b)(1)(B) and (C)~~ subdivision (b)(1) of this section, the Office of the Attorney General shall identify 15 drugs as follows:

(i) of the drugs appearing on more than one payer's list, the Office of the Attorney General shall identify the top 15 drugs on which the greatest amount of money was spent across all payers during the previous calendar year, to the extent information is available; and

(ii) if fewer than 15 drugs appear on more than one payer's list, the Office of the Attorney General shall rank the remaining drugs based on the amount of money spent by any one payer during the previous calendar year, in

descending order, and select as many of the drugs at the top of the list as necessary to reach a total of 15 drugs.

(B) For the 15 drugs identified by the Office of the Attorney General pursuant to subdivision (A) of this subdivision (c)(1), the Office of the Attorney General shall require the manufacturer of each such drug to provide all of the following:

(i) Justification for the increase in the net cost of the drug to ~~the Department of Vermont Health Access, to~~ one or more health insurers~~, or both~~, which shall be provided to the Office of the Attorney General in a format that the Office of the Attorney General determines to be understandable and appropriate and shall be provided in accordance with a timeline specified by the Office of the Attorney General. The manufacturer shall submit to the Office of the Attorney General all relevant information and supporting documentation necessary to justify the manufacturer's net cost increase to ~~the Department of Vermont Health Access, to~~ one or more health insurers~~, or both~~ during the identified period of time, including:

(I) each factor that specifically caused the net cost increase to ~~the Department of Vermont Health Access, to~~ one or more health insurers~~, or both~~ during the specified period of time;

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Sec. 2. 18 V.S.A. § 4682 is amended to read:

§ 4682. DISCRIMINATION AGAINST 340B ENTITIES PROHIBITED

* * *

(b) A manufacturer or its agent shall not directly or indirectly require a 340B covered entity to submit any claims, utilization, encounter, purchase, or other data as a condition for allowing the acquisition of a 340B drug by or delivery of a 340B drug to a 340B contract pharmacy or a 340B covered entity unless the claims or utilization data sharing is required by the U.S. Department of Health and Human Services.

* * *

(d) ~~A manufacturer or its agent shall offer or otherwise make available 340B drug pricing to a 340B covered entity or 340B contract pharmacy in the form of a discount at the time of purchase and shall not offer or otherwise make available 340B drug pricing in the form of a rebate.~~ [Repealed.]

Sec. 3. 33 V.S.A. § 402 is amended to read:

§ 402. MEDICAID AND EXCHANGE ADVISORY COMMITTEE

(a) ~~A~~ The Medicaid and Exchange Advisory Committee is created for the purpose of advising the Commissioner of Vermont Health Access with respect to policy development and program administration for the Vermont Health Benefit Exchange, Medicaid, and Medicaid-funded programs, consistent with the requirements of federal law.

(b)(1) The Commissioner of Vermont Health Access shall appoint members of the Advisory Committee established by this section, who shall serve staggered three-year terms. The total membership of the Advisory Committee shall be at least 22 members and shall include individuals who are also members of the Beneficiary Advisory Committee, as required by 42 C.F.R. § 431.12. The Commissioner may remove members of the Committee who fail to attend three consecutive meetings and may appoint replacements. ~~The Commissioner may reappoint members to serve more than one term.~~

(2)(A) The Commissioner of Vermont Health Access shall appoint one representative of health insurers licensed to do business in Vermont to serve on the Advisory Committee. The Commissioner of Health shall also serve on the Advisory Committee.

(B) Of the remaining members of the Advisory Committee, one-quarter of the members shall be from each of the following constituencies:

(i) beneficiaries of Medicaid or Medicaid-funded programs;

(ii) representatives of those eligible for or enrolled in qualified health plans, such as individuals, self-employed individuals, health insurance brokers and agents, and ~~representatives of businesses eligible for or enrolled in the Vermont Health Benefit Exchange~~ small business owners and employees;

(iii) advocates for consumer organizations; and

(iv) health care professionals and representatives from a broad range of health care professionals.

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Sec. 4. 33 V.S.A. § 1813 is amended to read:

§ 1813. REFLECTIVE HEALTH BENEFIT PLANS

(a)(1) In the event that federal cost-sharing reduction payments to insurers are suspended or discontinued, registered carriers may offer to individuals ~~and employees of small employers~~ nonqualified reflective health benefit plans that do not include funding to offset the loss of the federal cost-sharing reduction payments. These plans shall be similar to, but contain at least one variation from, qualified health benefit plans offered through the Vermont Health Benefit Exchange that include funding to offset the loss of the federal cost-sharing reduction payments.

* * *

Sec. 5. 33 V.S.A. § 2031 is amended to read:

§ 2031. CREATION OF CLINICAL UTILIZATION REVIEW BOARD

(a) ~~No later than June 15, 2010, the~~ The Department of Vermont Health Access shall ~~create a~~ maintain the Clinical Utilization Review Board to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the

Department regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the State's Medicaid programs.

(b) The Board shall comprise a minimum of 10 members with diverse medical experience, to be appointed by the Governor upon recommendation of the Commissioner of Vermont Health Access. The Board shall solicit additional input as needed from individuals with expertise in areas of relevance to the Board's deliberations. The Chief Medical ~~Director~~ Officer of the Department of Vermont Health Access shall serve as the State's liaison to the Board. Board member terms ~~shall~~ may be staggered, ~~but in no event longer than three years from the date of appointment. The~~ and the Board shall meet at least quarterly~~, provided that the Board shall meet no less frequently than once per month for the first six months following its formation~~.

* * *

Sec. 6. 33 V.S.A. § 2072 is amended to read:

§ 2072. GENERAL ELIGIBILITY

(a) An individual shall be eligible for assistance under this subchapter if the individual:

(1) is a resident of Vermont at the time of application for benefits;

(2) is at least 65 years of age or is an individual with disabilities as defined in subdivision 2071(1) of this title; and

(3) has a household income~~, when calculated using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B), no~~ not greater than 225 percent of the federal poverty level.

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Sec. 7. INCREASE TO PREPAID BURIAL ARRANGEMENTS FOR MEDICAID ELIGIBILITY PURPOSES; RULEMAKING

(a) Subject to approval from the Centers for Medicare and Medicaid Services, the Agency of Human Services shall amend its rules and procedures allowing Medicaid applicants and recipients to preserve monies for funeral and burial expenses to increase from $10,000.00 to $15,000.00 the limit on the amount that may be preserved through an irrevocable prepaid funeral arrangement, as described in 26 V.S.A. § 1271, provided that:

(1) the written contract for the arrangement, as described in 26 V.S.A. § 1273, includes a provision specifying that Vermont Medicaid shall receive all amounts remaining after payment of the deceased individual's expenses up to an amount equal to the total Medicaid amount paid on behalf of the deceased individual; and

(2) in the event that the person responsible for making the funeral arrangements for the deceased individual fails to have funeral services provided, after the retention of assets by the funeral director as set forth in 26 V.S.A. § 1274(c), Vermont Medicaid shall receive all amounts remaining

up to an amount equal to the total Medicaid amount paid on behalf of the deceased individual.

(b) Subject to approval from the Centers for Medicare and Medicaid Services, the Agency's amended rules and procedures shall apply to prepaid funeral arrangements entered into on or after July 1, 2027.

Sec. 8. 2025 Acts and Resolves No. 50, Sec. 7 is amended to read:

Sec. 7. STATE PLAN AMENDMENT

Not later than July 1, ~~2026~~ 2027, the Department of Vermont Health Access shall seek a state plan amendment from the Centers for Medicare and Medicaid Services to allow Vermont's Medicaid program to provide coverage for doula services in accordance with 33 V.S.A. § 1901n, as added by this act.

Sec. 9. 2025 Acts and Resolves No. 50, Sec. 8 is amended to read:

Sec. 8. EFFECTIVE DATES

(a) Secs. 1–4 (establishing certification program for community-based perinatal doulas) shall take effect on July 1, ~~2026~~ 2027, provided that the Director of the Office of Professional Regulation shall commence the rulemaking process prior to that date in order to ensure that the rules will be in effect on July 1, ~~2026~~ 2027.

(b) Sec. 5 (33 V.S.A. § 1901n; Medicaid coverage for doula services) shall take effect on the later of July 1, ~~2026~~ 2027, or approval of the state plan amendment requested pursuant to Sec. 7 of this act.

(c) The remaining sections shall take effect on passage.

Sec. 10. 8 V.S.A. § 4077 is amended to read:

§ 4077. REPRODUCTIVE HEALTH CARE SERVICES

* * *

(h)(1) As used in this subsection:

(A) "HIV prevention drug" means any preexposure prophylaxis drug or postexposure prophylaxis drug, including oral and long-acting injectable formulations, that is approved by the FDA for HIV prevention or that is otherwise authorized for HIV prevention pursuant to FDA labeling or federal clinical guidelines.

(B) "Supportive health service" means any health service that is necessary to monitor a patient to ensure the safe and effective ongoing use of an HIV prevention drug and includes:

(i) an office visit;

(ii) laboratory testing;

(iii) testing for a sexually transmitted infection;

(iv) medication self-management and adherence counseling;

(v) patient education and counseling by the patient's health care provider regarding the appropriate use of the HIV prevention drug; and

(vi) any other health services that are components of comprehensive HIV prevention drug services as determined by the patient's health care provider.

(2) A health insurance plan shall provide coverage for HIV preexposure prophylaxis drugs as recommended by the U.S. Preventive Services Task Force as of August 22, 2023. This coverage shall be provided without any deductible, coinsurance, co-payment, or other cost-sharing requirement, except to the extent that such coverage would disqualify a high-deductible health plan from eligibility for a health savings account pursuant to 26 U.S.C. § 223.

(3) Medicaid and any other public health care assistance program offered or administered by the State or by any subdivision or instrumentality of the State, except for any program funded in whole or in part by federal grants that include prohibitions on coverage of HIV prevention drugs, shall provide coverage of HIV prevention drugs and supportive health services and shall:

(A) not require any cost sharing, including co-payments;

(B) provide coverage without requiring prior authorization or any other protocol that may restrict or delay dispensing for at least one FDA-approved drug in each category of preexposure and postexposure prophylaxis drugs; and

(C) not deny coverage based on the type of health care professional issuing the prescription for any HIV prevention drug for which Medicaid does

not require prior authorization, provided the health care professional is acting within the professional's authorized scope of practice and is enrolled as a participating provider in Vermont Medicaid.

Sec. 11. EFFECTIVE DATE

This act shall take effect on passage.