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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~~

1 list that the Department considers to be specialty drugs. The Department shall
2 include the percentage of the wholesale acquisition cost increase for each drug
3 on the list; rank the drugs on the list from those with the largest increase in
4 wholesale acquisition cost to those with the smallest increase; indicate whether
5 each drug was included on the list based on its cost increase over the past five
6 years or during the previous calendar year, or both; and provide the
7 Department's total expenditure for each drug on the list during the most recent
8 calendar year.

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

showing markup from Senate Proposal of Amendment

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

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

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

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

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

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

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

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

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

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

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

20 * * *

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

2 § 4682. DISCRIMINATION AGAINST 340B ENTITIES PROHIBITED

3 * * *

4 (b) A manufacturer or its agent shall not directly or indirectly require a
5 340B covered entity to submit any claims, utilization, encounter, purchase, or
6 other data as a condition for allowing the acquisition of a 340B drug by or
7 delivery of a 340B drug to a 340B contract pharmacy **or a 340B covered**
8 **entity** unless the claims or utilization data sharing is required by the U.S.
9 Department of Health and Human Services.

10 * * *

11 ~~(d) A manufacturer or its agent shall offer or otherwise make available~~
12 ~~340B drug pricing to a 340B covered entity or 340B contract pharmacy in the~~
13 ~~form of a discount at the time of purchase and shall not offer or otherwise~~
14 ~~make available 340B drug pricing in the form of a rebate. [Repealed.]~~

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

16 § 402. MEDICAID AND EXCHANGE ADVISORY COMMITTEE

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

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

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

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

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

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

20 (iii) advocates for consumer organizations; and

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

3 * * *

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

5 § 1813. REFLECTIVE HEALTH BENEFIT PLANS

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

14 * * *

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

16 § 2031. CREATION OF CLINICAL UTILIZATION REVIEW BOARD

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

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

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

13 * * *

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

15 § 2072. GENERAL ELIGIBILITY

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

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

19 (2) is at least 65 years of age or is an individual with disabilities as

20 defined in subdivision 2071(1) of this title; and

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

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

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

7 Sec. 7. STATE PLAN AMENDMENT

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

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

13 Sec. 8. EFFECTIVE DATES

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

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

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

2 Sec. 10. 8 V.S.A. § 4077 is amended to read: **(NEW)**

3 § 4077. REPRODUCTIVE HEALTH CARE SERVICES

4 * * *

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

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

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

14 **(i) an office visit;**

15 **(ii) laboratory testing;**

16 **(iii) testing for a sexually transmitted infection;**

17 **(iv) medication self-management and adherence counseling;**

18 **(v) patient education and counseling by the patient’s health**

19 **care provider regarding the appropriate use of the HIV prevention drug;**

20 **and**

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

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

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

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

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

1 (C) not deny coverage based on the type of health care
2 professional issuing the prescription for any HIV prevention drug for
3 which Medicaid does not require prior authorization, provided the health
4 care professional is acting within the professional's authorized scope of
5 practice and is enrolled as a participating provider in Vermont Medicaid.

6 Sec. 11. EFFECTIVE DATE

7 This act shall take effect on July 1, 2026 passage.