H.279

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

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

Sec. 1. 33 V.S.A. § 1992 is amended to read:

§ 1992. MEDICAID COVERAGE FOR ADULT DENTAL SERVICES

(a) Vermont Medicaid shall provide coverage for medically necessary dental services provided by a dentist, dental therapist, or dental hygienist working within the scope of the provider's license as follows:

(1) ~~Up to two visits per calendar year for preventive~~ Preventive services, including prophylaxis and fluoride treatment, with no co-payment. These services shall not be counted toward the annual maximum benefit amount set forth in subdivision (2) of this subsection.

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Sec. 2. 33 V.S.A. § 2001 is amended to read:

§ 2001. LEGISLATIVE OVERSIGHT

(a) ~~In connection with the Pharmacy Best Practices and Cost Control Program, the Commissioner of Vermont Health Access shall report for review by the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare prior to any modifications:~~

~~(1) the compilation that constitutes the preferred drug list or list of drugs subject to prior authorization or any other utilization review procedures;~~

~~(2) any utilization review procedures, including any prior authorization procedures; and~~

~~(3) the procedures by which drugs will be identified as preferred on the preferred drug list, and the procedures by which drugs will be selected for prior authorization or any other utilization review procedure.~~

~~(b) The Committees shall closely monitor implementation of the preferred drug list and utilization review procedures to ensure that the consumer protection standards enacted pursuant to section 1999 of this title are not diminished as a result of implementing the preferred drug list and the utilization review procedures, including any unnecessary delay in access to appropriate medications. The Committees shall ensure that all affected interests, including consumers, health care providers, pharmacists, and others with pharmaceutical expertise have an opportunity to comment on the preferred drug list and procedures reviewed under this subsection.~~

~~(c) The~~ Notwithstanding the provisions of 2 V.S.A. § 20(d), the Commissioner of Vermont Health Access shall report annually on or before October 30 to the House Committees on Appropriations, on Health Care, and on Human Services and the Senate Committees on Appropriations and on Health and Welfare concerning the Pharmacy Best Practices and Cost Control

Program and the operation of Vermont's pharmaceutical assistance programs for the most recent State fiscal year. Topics covered in the report shall include:

(1) issues related to drug cost and utilization;

(2) the effect of national trends on the pharmacy ~~program~~ programs;

(3) comparisons to other states;

(4) the Department's administration of Vermont's pharmaceutical assistance programs;

(5) the Department's use of prior authorization requirements for prescription drugs; and

(6) decisions made by the Department's Drug Utilization Review Board in relation to both drug utilization review efforts and the placement of drugs on the Department's preferred drug list.

~~(d) [Repealed.]~~

~~(e)~~(b)(1) ~~[Repealed.]~~

~~(2)~~ The Commissioner shall not enter into a contract with a pharmacy benefit manager unless the pharmacy benefit manager has agreed to disclose to the Commissioner the terms and the financial impact on Vermont and on Vermont beneficiaries of:

* * *

~~(3)~~(2) The Commissioner shall not enter into a contract with a pharmacy benefit manager who has entered into an agreement or engaged in a practice

described in subdivision ~~(2)~~(1) of this subsection, unless the Commissioner determines that the agreement or practice furthers the financial interests of Vermont and does not adversely affect the medical interests of Vermont beneficiaries.

Sec. 3. 33 V.S.A. § 2081 is amended to read:

§ 2081. ~~RULES AND LEGISLATIVE OVERSIGHT~~ RULEMAKING

~~(a)~~ The Agency of Human Services shall adopt rules necessary to implement and administer the provisions of this subchapter, including standards and schedules establishing coverage and exclusion of pharmaceuticals and maximum quantities of pharmaceuticals to be dispensed, and to comply with the requirements of the Medicare Modernization Act. ~~The Agency of Human Services shall submit the proposed rule to the Health Care Oversight Committee. The Health Care Oversight Committee shall review and advise on the Agency rules and policies developed under this subsection and shall submit for consideration any recommendations to the joint Legislative Committee on Administrative Rules.~~

~~(b) DVHA shall report on the status of the pharmaceutical assistance programs established by this subchapter to the Health Care Oversight Committee.~~

Sec. 4. SEPARATE INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE MARKETS FOR PLAN YEAR 2023 IF FEDERAL SUBSIDIES EXTENDED

(a) Purpose. The purpose of this section is to allow for separate individual and small group health insurance markets for plan year 2023 in the event that Congress extends increased opportunities for federal advanced premium tax credits to include plan year 2023 and that extension is enacted on or before September 1, 2022.

(b) Definitions. As used in this section, "health benefit plan," "registered carrier," and "small employer" have the same meanings as in 33 V.S.A. § 1811.

(c) Separate plans and community rating. Notwithstanding any provision of 33 V.S.A. § 1811 to the contrary, if the Department of Vermont Health Access, after consultation with interested stakeholders, determines on or before September 1, 2022 that Congress has extended the increased opportunities for federal premium assistance originally made available through the American Rescue Plan Act of 2021, Pub. L. No. 117-2 to eligible households purchasing qualified health benefit plans in the individual market to include plan year 2023, or has made substantially similar opportunities available, then for plan year 2023, a registered carrier shall:

(1) offer separate health benefit plans to individuals and families in the individual market and to small employers in the small group market;

(2) apply community rating in accordance with 33 V.S.A. § 1811(f) to determine the premiums for the carrier's plan year 2023 individual market plans separately from the premiums for its small group market plans; and

(3) file premium rates with the Green Mountain Care Board pursuant to 8 V.S.A. § 4062 separately for the carrier's individual market and small group market plans.

Sec. 5. EFFECTIVE DATE

This act shall take effect on passage.