TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 766 entitled “An act relating to prior authorization and step therapy requirements, health insurance claims, provider contracts, and collection of cost sharing amounts” respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. § 4089i(e) is amended to read:

(e)(1) A health insurance or other health benefit plan offered by a health insurer or by a pharmacy benefit manager on behalf of a health insurer that provides coverage for prescription drugs and uses step-therapy protocols shall:

(A) not require failure, including discontinuation due to lack of efficacy or effectiveness, diminished effect, or an adverse event, on the same medication on more than one occasion for ~~continuously enrolled members or subscribers~~ insureds who are continuously enrolled in a plan offered by the insurer or its pharmacy benefit manager; and

(B) grant an exception to its step-therapy protocols upon request of an insured or the insured’s treating health care professional under the same time parameters as set forth for prior authorization requests in 18 V.S.A. § 9418b(g)(4) if any one or more of the following conditions apply:

1 (i) the prescription drug required under the step-therapy protocol
2 is contraindicated or will likely cause an adverse reaction or physical or mental
3 harm to the insured;
4 (ii) the prescription drug required under the step-therapy protocol
5 is expected to be ineffective based on the insured's known clinical history,
6 condition, and prescription drug regimen;
7 (iii) the insured has already tried the prescription drugs on the
8 protocol, or other prescription drugs in the same pharmacologic class or with
9 the same mechanism of action, which have been discontinued due to lack of
10 efficacy or effectiveness, diminished effect, or an adverse event, regardless of
11 whether the insured was covered at the time on a plan offered by the current
12 insurer or its pharmacy benefit manager;
13 (iv) the insured is stable on a prescription drug selected by the
14 insured's treating health care professional for the medical condition under
15 consideration; or
16 (v) the step-therapy protocol or a prescription drug required under
17 the protocol is not in the patient's best interests because it will:
18 (I) pose a barrier to adherence;
19 (II) likely worsen a comorbid condition; or
20 (III) likely decrease the insured's ability to achieve or maintain
21 reasonable functional ability.

1 (2) Nothing in this subsection shall be construed to prohibit the use of
2 tiered co-payments for members or subscribers not subject to a step-therapy
3 protocol.
4 (3) Notwithstanding any provision of subdivision (1) of this subsection
5 to the contrary, a health insurance or other health benefit plan offered by an
6 insurer or by a pharmacy benefit manager on behalf of a health insurer that
7 provides coverage for prescription drugs shall not utilize a step-therapy, "fail
8 first," or other protocol that requires documented trials of a medication,
9 including a trial documented through a "MedWatch" (FDA Form 3500), before
10 approving a prescription for the treatment of substance use disorder.
11 Sec. 2. 18 V.S.A. § 9418a is amended to read:
12 § 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE
13 TO CODING RULES
14 (a) Health plans, contracting entities, covered entities, and payers shall
15 accept and initiate the processing of all health care claims submitted by a
16 health care provider pursuant to and consistent with the current version of the
17 American Medical Association's Current Procedural Terminology (CPT)
18 codes, reporting guidelines, and conventions; the Centers for Medicare and
19 Medicaid Services Healthcare Common Procedure Coding System (HCPCS);
20 American Society of Anesthesiologists; the National Correct Coding Initiative
21 (NCCI); the National Council for Prescription Drug Programs coding; or other

appropriate nationally recognized standards, guidelines, or conventions approved by the Commissioner.

(b)**(1)** ~~When~~ **Except as provided in subsection (c) of this section, when** editing claims, health plans, contracting entities, covered entities, and payers shall ~~adhere to~~ **require not more than** the **following** edit standards, processes, and guidelines ~~adopted by NCCI except as provided in subsection (c) of this section~~:

~~(1)~~**(A)** ~~the CPT, HCPCS, and~~ **for claims for outpatient and professional services, the** NCCI **as in effect for Medicare**;

~~(2)~~**(B)** ~~national specialty society edit standards~~ **for facility claims, the Medicare Code Editor as in effect for Medicare**; ~~or~~ **and**

~~(3)~~**(C)** **for any other claim not addressed by subdivision (1) or (2) of this subsection (b),** other appropriate nationally recognized edit standards, guidelines, or conventions approved by the Commissioner.

(2) For outpatient services, professional services, and facility claims, a health plan, contracting entity, covered entity, or payer shall apply the relevant edit standards, processes, and guidelines from NCCI or Medicare Code Editor pursuant to subdivisions (1)(A) and (B) of this subsection that were in effect for Medicare on the date of the claim submission; provided, however, that if Medicare has changed an applicable edit standard, process, or guideline within 90 days prior to the date of the claim

submission, the health plan, contracting entity, covered entity, or payer may use the version of the edit standard, process, or guideline that Medicare had applied prior to the most recent change if the health plan, contracting entity, covered entity, or payer has not yet released an updated version of its edits in accordance with subsection (d) of this section.

(c) Adherence to the edit standards in ~~subdivision (b)(1) or (2)~~ subsection (b) of this section is not required:

(1) when necessary to comply with State or federal laws, rules, regulations, or coverage mandates; or

(2) for edits that the payer determines are more favorable to providers than the edit standards in ~~subdivisions (b)(1) through (3)~~ subsection (b) of this section or to address new codes not yet incorporated by a payer's edit management software, provided the edit standards are:

(A) developed with input from the relevant Vermont provider community and national provider organizations;

(B) clearly supported by nationally recognized standards, guidelines, or conventions;

(C) approved by the Commissioner of Financial Regulation; and

(D) ~~provided the edits are~~ available to providers on the plan's websites and in ~~their~~ its newsletters **or equivalent electronic communications**.

(d) Health plans, contracting entities, covered entities, and payers shall not release edits more than ~~once per year~~ **quarterly, to take effect on January 1, April 1, July 1, or October 1, as applicable**, and the ~~annual round of~~ edits shall not be implemented without prior review and approval by the Commissioner of Financial Regulation and at least ~~90~~ **30** days' advance notice to providers. **Whenever Medicare changes an edit standard, process, or guideline that it applies to outpatient service, professional service, or facility claims, each health plan, contracting entity, covered entity, or payer shall incorporate those modifications into its next quarterly release of edits.**

(e) No health plan, contracting entity, covered entity, or payer shall subject any health care provider to prepayment **coding validation edit** review. As used in this subsection, "prepayment **coding validation edit** review" means any action by the health plan, contracting entity, covered entity, or payer, or by a contractor, assignee, agent, or other entity acting on its behalf, requiring a health care provider to provide medical record documentation in conjunction with or after submission of a claim for payment for health care services delivered, but before the claim has been adjudicated. **Nothing in this**

1 **subsection shall be construed to prohibit targeted prepayment coding**
2 **validation edit review of a specific provider, provider group, or facility**
3 **under certain circumstances, including evaluating high-dollar claims;**
4 **verifying complex financial arrangements; investigating member**
5 **questions; conducting post-audit monitoring; addressing a reasonable**
6 **belief of fraud, waste, or abuse; or other circumstances determined by the**
7 **Commissioner through a bulletin or guidance.**
8 (f) Nothing in this section shall preclude a health plan, contracting entity,
9 covered entity, or payer from determining that any such claim is not eligible
10 for payment in full or in part, based on a determination that:
11 * * *
12 ~~(e)~~(g) Nothing in this section shall be deemed to require a health plan,
13 contracting entity, covered entity, or payer to pay or reimburse a claim, in full
14 or in part, or to dictate the amount of a claim to be paid by a health plan,
15 contracting entity, covered entity, or payer to a health care provider.
16 ~~(f)~~(h) No health plan, contracting entity, covered entity, or payer shall
17 automatically reassign or reduce the code level of evaluation and management
18 codes billed for covered services (downcoding), except that a health plan,
19 contracting entity, covered entity, or payer may reassign a new patient visit
20 code to an established patient visit code based solely on CPT codes, CPT
21 guidelines, and CPT conventions.

~~(g)~~(i) Notwithstanding the provisions of subsection ~~(d)~~(f) of this section, and other than the edits contained in the conventions in subsections (a) and (b) of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for services on other bases and shall have the right to reassign or reduce the code level for selected claims for services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

~~(h)~~(j) ~~Every~~ If adding an edit pursuant to **subsection (b) or** subdivision (c)(1) or (2) of this section, a health plan, contracting entity, covered entity, ~~and~~ or payer shall publish on its provider website and in its provider newsletter ~~if applicable~~ or equivalent electronic provider communications:

(1) the name of any commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) the specific standard or standards~~, pursuant to subsection (b) of this section,~~ that the entity uses for claim edits and how those claim edits are supported by those specific standards;

(3) the payment percentages for modifiers; and

(4) ~~any significant~~ the specific edit or edits~~, as determined by the health plan, contracting entity, covered entity, or payer,~~ added to the claims software product ~~after the effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer~~.

~~(i)~~(k) Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide the information in subsection ~~(h)~~(j) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

~~(j)~~(l) For purposes of this section, "health plan" includes a workers' compensation policy of a casualty insurer licensed to do business in Vermont.

~~(k)~~(m) ~~BlueCross BlueShield of Vermont and the Vermont Medical Society are requested to continue convening a work group consisting of~~ There is established a working group comprising the health plans, contracting entities, covered entities, and payers subject to the reporting requirement in subsection 9414a(b) of this title; representatives of hospitals and health care providers~~,~~; representatives of the Department of Financial Regulation and of other relevant State agencies~~,~~; and other interested parties to study ~~the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards~~

1 ~~established by other states to determine the most appropriate way to ensure that~~
2 ~~health care providers can access information about the edit standards~~
3 ~~applicable to the health care services they provide~~ trends in coding and billing
4 that health plans, contracting entities, covered entities, or payers, or a
5 combination of them, seek to address through claim editing. The ~~work~~
6 **working** group ~~is requested to~~ **shall** provide ~~an annual~~ **a** progress report to the
7 House Committee on Health Care and the Senate Committees on Health and
8 Welfare and on Finance **upon request**.

9 ~~(l)~~(n) With respect to the ~~work~~ **working** group established under subsection
10 ~~(k)~~(m) of this section and to the extent required to avoid violations of federal
11 antitrust laws, the Department shall facilitate and supervise the participation of
12 members of the ~~work~~ **working** group.

13 Sec. 3. 18 V.S.A. § 9418b(c) and (d) are amended to read:

14 (c) ~~A health plan shall furnish, upon request from a health care provider, a~~
15 ~~current list of services and supplies requiring prior authorization.~~

16 **(1) It is the intent of the General Assembly to reduce variability in**
17 **prior authorization requirements by aligning to the greatest extent**
18 **possible with the prior authorization requirements in Vermont's Medicaid**
19 **program.**

20 **(2) A health plan shall not impose any prior authorization**
21 **requirement for any admission, item, service, treatment, or procedure that**

1 **is more restrictive than the prior authorization requirements that the**
2 **Department of Vermont Health Access would apply for the same**
3 **admission, item, service, treatment, or procedure under Vermont's**
4 **Medicaid program.**
5 **(3) Each health plan shall review the prior authorization**
6 **requirements in effect in Vermont's Medicaid program at least once every**
7 **six months to ensure that the health plan is maintaining the prior**
8 **authorization alignment required by subdivision (2) of this subsection.**
9 **(4) Nothing in this subsection shall be construed to:**
10 **(A) require prior authorization alignment with Vermont**
11 **Medicaid for prescription drugs;**
12 **(B) prohibit prior authorization requirements for any admission,**
13 **item, service, treatment, or procedure that is not covered by Vermont**
14 **Medicaid;**
15 **(C) prohibit prior authorization requirements for an admission,**
16 **item, service, treatment, or procedure that is provided out-of-network; or**
17 **(D) require a health plan to maintain the same provider network**
18 **as Vermont Medicaid.**
19 (d)**(1) A health plan shall furnish, upon request from a health care**
20 **provider, a current list of services and supplies requiring prior**
21 **authorization.**

(2) A health plan shall post a current list of services and supplies requiring prior authorization to the insurer's website.

Sec. 4. 18 V.S.A. § 9418b(g)(4) is amended to read:

(4) ~~A health plan shall respond to a completed prior authorization request from a prescribing health care provider within 48 hours after receipt for urgent requests and within two business days after receipt for nonurgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours after receipt.~~

(A)(i) For urgent prior authorization requests, a health plan shall approve, deny, or inform the insured or health care provider if any information is missing from a prior authorization request from an insured or a prescribing health care provider within 24 hours following receipt.

(ii) If a health plan informs an insured or a health care provider that more information is necessary for the health plan to make a determination on the request, the health plan shall have 24 hours to approve or deny the request upon receipt of the necessary information.

(B) For nonurgent prior authorization requests:

1 (i) A health plan shall approve or deny a completed prior
2 authorization request from an insured or a prescribing health care provider
3 within two business days following receipt.
4 (ii) A health plan shall acknowledge receipt of the prior
5 authorization request within 24 hours following receipt and shall inform the
6 insured or health care provider at that time if any information is missing that is
7 necessary for the health plan to make a determination on the request.
8 (iii) If a health plan notifies an insured or a health care provider
9 that more information is necessary pursuant to subdivision (ii) of this
10 subdivision (4)(B), the health plan shall have 24 hours to approve or deny the
11 request upon receipt of the necessary information.
12 (C) If a health plan does not, within the time limits set forth in this
13 section, respond to a completed prior authorization request, acknowledge
14 receipt of the request for prior authorization, or request missing information,
15 the prior authorization request shall be deemed to have been granted.
16 (D) Prior authorization approval for a prescribed **or ordered**
17 treatment, service, or course of medication shall be valid for the duration of ~~a~~
18 **the** prescribed or ordered ~~course of~~ treatment**, service, or course of**
19 **medication** or one year, whichever is longer**; provided, however, that for a**
20 **prescribed or ordered treatment, service, or course of medication that**
21 **continues for more than one year, a health plan shall not require renewal**

1 **of the prior authorization approval more frequently than once every five**
2 **years**.
3 (E) For an insured who is stable on a treatment, service, or course of
4 medication, as determined by a health care provider, that was approved for
5 coverage under a previous health plan, a health plan shall not restrict coverage
6 of that treatment, service, or course of medication for at least 90 days upon the
7 insured's enrollment in the new health plan.
8 Sec. 5. 18 V.S.A. § 9418c is amended to read:
9 § 9418c. FAIR CONTRACT STANDARDS
10 (a) Required information.
11 (1) Each contracting entity shall provide and each health care contract
12 shall obligate the contracting entity to provide participating health care
13 providers information sufficient for the participating provider to determine the
14 compensation or payment terms for health care services, including all of the
15 following:
16 (A) The manner of payment, such as fee-for-service, capitation, case
17 rate, or risk.
18 (B) On request, the fee-for-service dollar amount allowable for each
19 CPT code for those CPT codes that a provider in the same specialty typically
20 uses or that the requesting provider actually bills. Fee schedule information
21 may be provided ~~by CD-ROM or~~ electronically, at the election of the

1 contracting entity, but a provider may elect to receive a hard copy of the fee
2 schedule information instead of the ~~CD-ROM or~~ electronic version.
3 (C) A clearly understandable, readily available mechanism, such as a
4 specific website address, that includes the following information:
5 (i) the name of the commercially available claims editing software
6 product that the health plan, contracting entity, covered entity, or payer uses;
7 (ii) the specific standard or standards from subsection 9418a(c) of
8 this title that the entity uses for claim edits and how those claim edits are
9 supported by those specific standards;
10 (iii) payment percentages for modifiers; and
11 (iv) any significant edits, as determined by the health plan,
12 contracting entity, covered entity, or payer, added to the claims software
13 product, which are made at the request of the health plan, contracting entity,
14 covered entity, or payer, and which have been approved by the Commissioner
15 pursuant to subsection 9418a(b) or (c) of this title.
16 (D) Any policies for prepayment or postpayment audits, or both,
17 including whether the policies include limits on the number of medical records
18 a contracting entity may request for audit in any calendar year.
19 * * *
20 (5)**(A)** If a contracting entity uses policies or manuals to augment the
21 content of the contract with a health care provider, the contracting entity shall

ensure that those policies or manuals contain sufficient information to allow providers to understand and comply with the content. ~~The contracting entity shall treat~~

(B) **For** any new policy or manual, ~~and~~ **or** any change to an existing policy or manual, ~~as a contract amendment and shall comply with the requirements for contract amendments set forth in section 9418d of this title~~ **the contracting entity shall do all of the following:**

(i) Provide notice of the new policy, manual, or change to each participating provider in writing not fewer than 60 days prior to the effective date of the policy, manual, or change, which notice shall be conspicuously entitled "Notice of Policy Change" and shall include:

(I) a summary of the new policy, manual, or change;

(II) an explanation of the policy, manual, or change;

(III) the effective date of the policy, manual, or change; and

(IV) a notice of the right to object in writing to the policy, manual, or change, along with a timeframe for objection and where and how to send the objection.

(ii) Provide the participating provider 60 days after receiving the notice and summary to object in writing to the new policy, manual, or change. If the participating provider objects to the new policy, manual, or change, the contracting entity shall provide an initial substantive response

1 **to the objection within 30 days following the contracting entity's receipt of**
2 **the written objection, and the contracting entity shall work together with**
3 **the provider to achieve a reasonable resolution to the objection within 60**
4 **days following the provider's receipt of contracting entity's initial**
5 **substantive response. If the provider is not satisfied with the proposed**
6 **resolution, the provider may pursue any remedy available to the provider**
7 **under the health care contract or under applicable law.**
8 * * *
9 **Sec. 6. REDUCING ADMINISTRATIVE BURDENS; WORKING**
10 **GROUP; REPORT**
11 **The Director of Health Care Reform in the Agency of Human Services**
12 **shall convene a working group comprising representatives of health**
13 **insurers; health care providers, including pharmacists; the Office of the**
14 **Health Care Advocate; the Department of Vermont Health Access; the**
15 **Green Mountain Care Board; and the Department of Financial**
16 **Regulation to consider ways in which health benefit plan designs and**
17 **methods of collecting patient cost sharing may be developed in a manner**
18 **that reduces the administrative burdens on patients, health care**
19 **providers, and payers, including a consideration of payers billing patients**
20 **directly for their cost sharing amounts. On or before January 15, 2025,**
21 **the Director of Health Care Reform shall provide the working group's**

1 **findings and recommendations to the House Committee on Health Care**
2 **and the Senate Committees on Health and Welfare and on Finance.**
3 **Sec. 7. PRIOR AUTHORIZATION; IMPACT REPORTS**
4 **On or before January 15, 2027, each health insurer with at least 2,000**
5 **covered lives in Vermont shall report to the House Committee on Health**
6 **Care and the Senate Committees on Health and Welfare and on Finance**
7 **regarding the impact of the prior authorization provisions of this act on**
8 **the following during plan years 2025 and 2026:**
9 **(1) utilization of health care services covered by the insurer's plans;**
10 **(2) development of the insurer's premium rates for future plan**
11 **years; and**
12 **(3) the insurer's estimated avoided costs, including:**
13 **(A) the specific methodologies that the insurer uses to**
14 **determine the amount of "savings" from avoided costs;**
15 **(B) the costs of the alternative tests, procedures, medications,**
16 **and other items or services ordered for insureds as a result of the**
17 **insurer's denials of requests for prior authorizations; and**
18 **(C) the costs of emergency department visits and inpatient**
19 **stays, including stays in intensive care units, as a result of the**
20 **insurer's denials of requests for prior authorizations.**

1 **Sec. 8. REPEAL**

2 **18 V.S.A. § 9418(m) and (n) (claims edit working group) are repealed**
3 **on January 1, 2028.**

4 Sec. 9. EFFECTIVE DATES

5 **(a) Secs. 6 (administrative burdens working group) and 7 (prior**
6 **authorization; impact reports) and this section shall take effect on**
7 **passage.**

8 (b) **Sec. 3 (18 V.S.A. § 9418b(g)(4); prior authorization time frames)**
9 **shall take effect on January 1, 2025, except that a health plan that must**
10 **modify its technology in order to continue administering its own internal**
11 **utilization review process for certain services shall have until not later**
12 **than January 1, 2026 to come into compliance with the provisions of Sec. 3**
13 **as to those services.**

14 (c) The remaining sections shall take effect on January 1, 2025 and shall
15 apply to all health plans issued on and after that date, to all health care provider
16 contracts entered into or renewed on and after that date, and to all claims
17 processed on and after that date.

18 **and that after passage the title of the bill be amended to read: "An act**
19 **relating to prior authorization and step therapy requirements, health**
20 **insurance claims, and provider contracts"**

21

1
2
3
4
5
6 (Committee vote: ___________)
7 _______________________
8 Representative ___________
9 FOR THE COMMITTEE