TO THE HONORABLE SENATE:

The Committee on Health and Welfare to which was referred Senate Bill No. 44 entitled "An act relating to health insurance prior authorizations" 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. 18 V.S.A. § 9418(a) is amended to read:

(a) Except as otherwise specified, as used in this subchapter:

* * *

(18) ~~**"Urgent health service" or "urgent care"**~~ **"Urgent request"** means a **request for a** health service that is necessary to treat a condition or illness of an individual presenting a serious risk of harm if treatment is not provided within 24 hours or a time frame consistent with the medical exigencies of the case.

(19) "Adverse determination" means a **first-level appeal [Cigna]** decision by ~~**any organization authorized to assist**~~ **an entity engaging** in utilization review ~~**under section 9411 of this title**~~ that the health care services furnished or proposed to be furnished to a subscriber are experimental, investigational, or not medically necessary, and as a result, coverage is denied, reduced, or terminated. **[or change this definition to mirror DFR Rule H-2009-03; MVP and DFR]**

Sec. 2. 18 V.S.A. § 9418b is amended to read:

§ 9418b. PRIOR AUTHORIZATION

* * *

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

(1) a current list of services and supplies requiring prior authorization;

(2) **a general description of the [Cigna]** clinical criteria for prior authorization decisions for prescription drugs and medical services; and

(3) data regarding ~~**prior authorization approvals and denials**~~ **adverse determinations [Cigna]**, including:

(A) the ~~**numbers**~~ **total number** ~~**and frequency of prior authorization requests for drugs, diagnostic tests, and procedures;**~~ **of adverse determinations rendered during the previous calendar year; and [Cigna]**

(B) ~~**the average time between a request and a response to a request for prior authorization, including requests submitted by telephone, fax, and electronically;**~~ **the number of appeals of adverse determinations filed with an external appeals organization, the number of external appeals decisions in which the insurer's decision was upheld, and the number of external appeals decisions in which the insurer's decision was reversed. [Cigna]**

~~**(C) the numbers and frequency of denials of prior authorization requests for drugs, diagnostic tests, and procedures; and**~~

~~**(D) a summary of reasons for denials of requests for prior authorization for drugs, diagnostic tests, and procedures.**~~ **[Cigna]**

(e) All adverse determinations shall be based on written clinical criteria that are:

(1) based on nationally recognized standards, such as the Healthcare Effectiveness Data and Information Set, guidelines maintained by the National Guideline Clearinghouse, ~~**or**~~ guidelines maintained by the Center for Evidence-based Policy**, or guidelines established by a program certified by the Utilization Review Accredidation Commission or the National Committee for Quality Assurance**; **[Cigna] [or remove all examples of nationally recognized standards; BCBS and others]**

(2) evidence-based; and

(3) sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

(f) All adverse ~~**decisions**~~ **determinations** shall be made by a physician under the direction of the medical director responsible for medical services provided to the insured members, or by a panel of other appropriate health care service reviewers with at least one physician on the panel who is board certified or board eligible in the same specialty as the treatment under review.

~~(e)~~(g) In addition to any other remedy provided by law, if the ~~commissioner~~ Commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the ~~commissioner~~ Commissioner may impose an administrative penalty against the health plan of no more than $500.00 for each violation, and may order the health plan to cease and desist from further violations and order the health plan to remediate the violation. In determining the amount of penalty to be assessed, the ~~commissioner~~ Commissioner shall consider the following factors:

(1) ~~The~~ the appropriateness of the penalty with respect to the financial resources and good faith of the health plan~~.~~;

(2) ~~The~~ the gravity of the violation or practice~~.~~;

(3) ~~The~~ the history of previous violations or practices of a similar nature~~.~~;

(4) ~~The~~ the economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation~~.~~; and

(5) ~~Any~~ any other relevant factors.

~~(f)~~(h) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations,

including rules adopted by the ~~commissioner~~ Commissioner pursuant to section 9408 of this title, relating to claims administration and adjudication standards, and rules adopted by the ~~commissioner~~ Commissioner pursuant to section 9414 of this title and 8 V.S.A. § 4088h, relating to pay for performance or other payment methodology standards.

~~(g)(1)(A)~~(i)(1)(A) Notwithstanding any provision of law to the contrary, on and after March 1, 2014, when requiring prior authorization for prescription drugs, medical procedures, and medical tests, a health plan shall accept for each prior authorization request either:

(i) ~~The~~ the national standard transaction information, such as HIPAA 278 standards, for sending or receiving authorizations electronically; or

(ii) a uniform prior authorization form developed pursuant to subdivisions (2) and (3) of this subsection.

* * *

(5) A health plan shall assign each prior authorization **appeal [Cigna]** request a unique electronic ~~**identification number**~~ **identifier [BCBS]** that a provider may use to track the request during the prior authorization process, whether the request is tracked electronically, through a call center, by fax, or through other means. **[or remove subsection (5); MVP]**

Sec. 3. EFFECTIVE DATE

This act shall take effect on July 1, ~~**2013**~~ **2014**. **[BCBS and others]**

(Committee vote: _____)

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Senator [surname]

FOR THE COMMITTEE