

1 H.220

2 Introduced by Representatives Black of Essex, Brumsted of Shelburne, Cina
3 of Burlington, Farlice-Rubio of Barnet, Garofano of Essex,
4 Goldman of Rockingham, Houghton of Essex Junction, and
5 Small of Winooski

6 Referred to Committee on

7 Date:

8 Subject: Health; health care; preventive services; health insurance; sexually
9 transmitted infections; colorectal cancer screenings; Green Mountain
10 Care Board; health insurers; health care providers; pay parity

11 Statement of purpose of bill as introduced: This bill proposes to adjust the age
12 at which an individual's colorectal cancer screenings are covered by health
13 insurance. This bill would also increase primary care payments and spending.

14 An act relating to primary care and preventive services

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

16 * * * Preventive Services * * *

17 Sec. 1. 8 V.S.A. § 4100g is amended to read:

18 § 4100g. COLORECTAL CANCER SCREENING; COVERAGE

19 REQUIRED

20 * * *

1 (b) Insurers shall provide coverage for colorectal cancer screening at a
2 minimum in accordance with U.S. Preventive Services Task Force guidelines,
3 including:

4 (1) Providing an insured ~~50 years of age or older~~ with the option of:

5 (A) annual fecal occult blood testing plus one flexible sigmoidoscopy
6 every five years; or

7 (B) one colonoscopy every 10 years.

8 (2) For an insured who is at high risk for colorectal cancer, colorectal
9 cancer screening examinations and laboratory tests as recommended by the
10 treating physician.

11 * * *

12 * * * Blueprint for Health * * *

13 Sec. 2. BLUEPRINT FOR HEALTH; PATIENT CENTERED MEDICAL
14 HOMES; REPORT

15 On or before January 15, 2024, the Director of Health Care Reform in the
16 Agency of Human Services shall recommend to the House Committees on
17 Health Care and on Appropriations and the Senate Committees on Health and
18 Welfare, on Appropriations, and on Finance the amounts by which health
19 insurers and Vermont Medicaid should increase the amount of the per-person,
20 per-month payments they make to Patient Centered Medical Homes
21 participating in Blueprint for Health, in furtherance of the goal of providing

1 additional resources necessary for delivery of comprehensive primary care
2 services to Vermonters and to sustain access to primary care services in
3 Vermont. The Agency shall also provide an estimate of the State funding that
4 would be needed to support the increase for Medicaid, both with and without
5 federal financial participation.

6 * * * Primary Care Providers; Medicaid Reimbursement Rates * * *

7 Sec. 3. 33 V.S.A. § 1901a is amended to read:

8 § 1901a. MEDICAID BUDGET

9 (a) Financial plan. The General Assembly shall approve each year a
10 Medicaid budget. The annual Medicaid budget shall include an annual
11 financial plan, and a five-year financial plan accounting for expenditures and
12 revenues relating to Medicaid and any other health care assistance program
13 administered by the Agency of Human Services.

14 (b) Quarterly information and analysis. The Secretary of Human Services
15 or ~~his or her~~ the Secretary's designee and the Commissioner of Finance and
16 Management shall provide quarterly to the Joint Fiscal Committee such
17 information and analysis as the Committee reasonably determines is necessary
18 to assist the General Assembly in the preparation of the Medicaid budget.

19 (c) Medicaid provider rates; primary care. It is the intent of the General
20 Assembly that Vermont's health care system should reimburse all Medicaid
21 participating providers at rates that are equal to 100 percent of the Medicare

1 rates for the services provided, with first priority for primary care providers. In
2 support of this goal, in its annual budget proposal, the Department of Vermont
3 Health Access shall either provide reimbursement rates for Medicaid
4 participating providers for primary care services at rates that are equal to 100
5 percent of the Medicare rates for the services in effect in calendar year 2022,
6 with positive medical inflation adjustment rates in subsequent years, or, in
7 accordance with 32 V.S.A. § 307(d)(6), provide information on the additional
8 amounts that would be necessary to achieve full reimbursement parity for
9 primary care services with the Medicare rates.

10 Sec. 4. 18 V.S.A. § 9414b is added to read:

11 § 9414b. INCREASING PRIMARY CARE SPENDING ALLOCATIONS

12 (a)(1) Each of the following entities shall increase the percentage of total
13 health care spending it allocates to primary care, using the baseline percentages
14 determined by the Green Mountain Care Board in accordance with 2020 Acts
15 and Resolves No. 17, by at least one percentage point per year until primary
16 care comprises at least 12 percent of the plan's or payer's overall annual health
17 care spending:

18 (A) each health insurer with 500 or more covered lives for
19 comprehensive, major medical health insurance in this State;

20 (B) the State Employees' Health Benefit Plan; and

1 (C) health benefit plans offered pursuant to 24 V.S.A. § 4947 to
2 entities providing educational services.

3 (2) Upon achieving the 12 percent primary care spending allocation
4 required by subdivision (1) of this subsection, each plan or payer shall
5 maintain or increase the percentage of total health care spending it allocates to
6 primary care at or above 12 percent.

7 (3) A plan's or payer's increased proportional spending on primary care
8 shall not:

9 (A) result in higher health insurance premiums;

10 (B) be achieved through increased fee-for-service payments to
11 providers; or

12 (C) increase the plan's or payer's overall health care expenditures.

13 (b)(1) On or before June 1 of each year, each entity listed in subdivisions
14 (a)(1)(A)–(C) of this section shall report to the Green Mountain Care Board the
15 percentage of its total health care spending that was allocated to primary care
16 during the previous plan year.

17 (2) On or before December 1 of each year from 2024 to 2029, the Green
18 Mountain Care Board shall report to the House Committee on Health Care and
19 the Senate Committees on Health and Welfare and on Finance on progress
20 toward increasing the percentage of health care spending systemwide that is
21 allocated to primary care.

1 Sec. 5. 21 V.S.A. § 640 is amended to read:

2 § 640. MEDICAL BENEFITS; ASSISTIVE DEVICES; HOME AND
3 AUTOMOBILE MODIFICATIONS

4 * * *

5 (d) The liability of the employer to pay for medical, surgical, hospital, and
6 nursing services and supplies, prescription drugs, and durable medical
7 equipment provided to the injured employee under this section shall not exceed
8 the maximum fee for a particular service, prescription drug, or durable medical
9 equipment as provided by a schedule of fees and rates prepared by the
10 Commissioner. The Commissioner shall update the schedule of fees and rates
11 on a consistent basis and not less than biennially. The reimbursement rate for
12 services and supplies in the fee schedule shall include consideration of medical
13 necessity, clinical efficacy, cost-effectiveness, and safety, and those services
14 and supplies shall be provided on a nondiscriminatory basis consistent with
15 workers' compensation and health care law. The Commissioner shall
16 authorize reimbursement at a rate higher than the scheduled rate if the
17 employee demonstrates to the Commissioner's satisfaction that reasonable and
18 necessary treatment, prescription drugs, or durable medical equipment is not
19 available at the scheduled rate. An employer shall establish direct billing and
20 payment procedures and notification procedures as necessary for coverage of
21 ~~medically necessary~~ medically necessary prescription medications for chronic

1 conditions of injured employees, in accordance with rules adopted by the
2 Commissioner.

3 * * *

4 Sec. 6. 8 V.S.A. § 4062g is added to read:

5 § 4062g. EXEMPTION FROM PRIOR AUTHORIZATION

6 REQUIREMENTS

7 (a) Definitions. As used in this section:

8 (1) “Health care services” has the same meaning as in section 5101 of
9 this title.

10 (2) “Health insurance plan” means Medicaid and a group health
11 insurance policy or health benefit plan offered by a health insurance company,
12 nonprofit hospital or medical service corporation, or health maintenance
13 organization but does not include policies or plans providing coverage for a
14 specified disease or other limited benefit coverage.

15 (3) “Health insurer” and “health care provider” have the same meanings
16 as in 18 V.S.A. § 9402.

17 (4) “Prior authorization” means a determination by a health insurer that
18 health care services proposed to be provided to a patient are medically
19 necessary and appropriate.

20 (b) Exemption from prior authorization requirements for health care
21 providers providing certain health care services.

1 (1) A health insurer that uses a prior authorization process for health
2 care services may not require a health care provider to obtain prior
3 authorization for any health care service if, in the most recent six-month
4 evaluation period, as described in subdivision (2) of this subsection, the health
5 insurer has approved or would have approved not less than 90 percent of the
6 prior authorization requests submitted by the health care provider for the
7 particular health care service.

8 (2) Except as provided in subdivision (3) of this subsection, a health
9 insurer shall evaluate whether a health care provider qualifies for an exemption
10 from prior authorization requirements under subdivision (1) of this subsection
11 once every six months.

12 (3) A health insurer may continue an exemption under subdivision (1) of
13 this subsection without evaluating whether the health care provider qualifies
14 for the exemption for a particular evaluation period.

15 (4) A health care provider is not required to request an exemption under
16 subdivision (1) of this subsection to qualify for the exemption.

17 (c) Duration of prior authorization exemption.

18 (1) A health care provider's exemption from prior authorization
19 requirements under this section remains in effect until:

20 (A) the 30th day after the date the health insurer notifies the health
21 care provider of the health insurer's determination to rescind the exemption

1 under this section if the health care provider does not appeal the health
2 insurer's determination; or

3 (B) if the health care provider appeals the determination, the fifth day
4 after the date the independent review organization affirms the health insurer's
5 determination to rescind the exemption.

6 (2) If a health insurer does not finalize a rescission determination as
7 specified in subdivision (1) of this subsection, then the health care provider is
8 considered to have met the criteria under this section to continue to qualify for
9 the exemption.

10 (d) Denial or rescission of prior authorization exemption.

11 (1) A health insurer may rescind an exemption from prior authorization
12 requirements under this section only:

13 (A) During January or June of each year:

14 (B) If the health insurer makes a determination, on the basis of
15 retrospective review of a random sample of not fewer than five and not more
16 than 20 claims submitted by the health care provider during the most recent
17 evaluation period prescribed in this section, that less than 90 percent of the
18 claims for the particular health care service met the medical necessity criteria
19 that would have been used by the health insurer when conducting prior
20 authorization review for the particular health care service during the relevant
21 evaluation period.

1 (C) If the health insurer complies with other applicable requirements
2 specified in this section, including notifying the health care provider not less
3 than 25 days before the proposed rescission is to take effect. The notice shall
4 include the sample information used to make the determination under
5 subdivision (B) of this subdivision (d)(1) and a plain language explanation of
6 how the health care provider may appeal and seek an independent review of
7 the determination.

8 (2) A determination made under subdivision (1)(B) of this subsection
9 shall be made by an individual licensed to practice medicine in this State. For
10 a determination made under subdivision (1)(B) of this subsection with respect
11 to a physician, the determination shall be made by an individual licensed to
12 practice medicine in this State who has the same or similar specialty as that
13 physician.

14 (3) A health insurer may deny an exemption from prior authorization
15 requirements under this section only if:

16 (A) the health care provider does not have the exemption at the time
17 of the relevant evaluation period; and

18 (B) the health insurer provides the health care provider with actual
19 statistics and data for the relevant prior authorization request evaluation period
20 and detailed information sufficient to demonstrate that the health care provider

1 does not meet the criteria for an exemption from prior authorization
2 requirements for the particular health care service under this section.

3 (e) Independent review of exemption determination.

4 (1) A health care provider has a right to a review of an adverse
5 determination regarding a prior authorization exemption conducted by an
6 independent review organization. A health insurer may not require a health
7 care provider to engage in an internal appeal process before requesting review
8 by an independent review organization under this section.

9 (2) A health insurer shall pay:

10 (A) for any appeal or independent review of an adverse determination
11 regarding a prior authorization exemption requested under this section; and

12 (B) a reasonable fee determined by the Board of Medical Practice for
13 any copies of medical records or other documents requested from a health care
14 provider during an exemption rescission review requested under this section.

15 (3) An independent review organization shall complete an expedited
16 review of an adverse determination regarding a prior authorization exemption
17 not later than the 30th day after the date a health care provider files the request
18 for review under this section.

19 (4) A health care provider may request that the independent review
20 organization consider another random sample of not less than five and not
21 more than 20 claims submitted to the health insurer by the health care provider

1 during the relevant evaluation period for the relevant health care service as part
2 of its review. If the health care provider makes such a request under this
3 subdivision, the independent review organization shall base its determination
4 on the medical necessity of claims reviewed by the health insurer under
5 subdivision (d)(1)(B) of this section and those reviewed under this subdivision.

6 (f) Effect of appeal or independent review determination.

7 (1) A health insurer is bound by an appeal or independent review
8 determination that does not affirm the determination made by the health insurer
9 to rescind a prior authorization exemption.

10 (2) A health insurer may not retroactively deny a health care service on
11 the basis of a rescission of an exemption, even if the health insurer's
12 determination to rescind the prior authorization exemption is affirmed by an
13 independent review organization.

14 (3) If a determination of a prior authorization exemption made by the
15 health insurer is overturned on review by an independent review organization,
16 the health insurer:

17 (A) may not attempt to rescind the exemption before the end of the
18 next evaluation period that occurs; and

19 (B) may only rescind the exemption after the health insurer complies
20 with subsections (c)–(e) of this section.

1 (g) Eligibility for prior authorization exemption following finalized
2 exemption rescission or denial. After a final determination or review affirming
3 the rescission or denial of an exemption for a specific health care service under
4 this section, a health care provider is eligible for consideration of an exemption
5 for the same health care service after the six-month evaluation period that
6 follows the evaluation period that formed the basis of the rescission or denial
7 of an exemption.

8 (h) Effect of prior authorization exemption.

9 (1) A health insurer may not deny or reduce payment to a health care
10 provider for a health care service for which the health care provider has
11 qualified for an exemption from prior authorization requirements under this
12 section based on medical necessity or appropriateness of care unless the health
13 care provider:

14 (A) knowingly and materially misrepresented the health care service
15 in a request for payment submitted to the health insurer with the specific intent
16 to deceive and obtain an unlawful payment from the health insurer; or

17 (B) failed to substantially perform the health care service.

18 (2) A health insurer may not conduct a retrospective review of a health
19 care service subject to an exemption except:

20 (A) to determine if the health care provider still qualifies for an
21 exemption under this section; or

1 (B) if the health insurer has a reasonable cause to suspect a basis for
2 denial exists under subdivision (1) of this subsection (h).

3 (3) For a retrospective review described by subdivision (2) of this
4 subsection, nothing in this section may be construed to modify or otherwise
5 affect any other applicable law, except to prescribe the only circumstances
6 under which:

7 (A) a retrospective utilization review may occur as specified in
8 subdivision (2)(B) of this subsection (h); or

9 (B) payment may be denied or reduced as specified by subdivision
10 (1) of this subsection.

11 (4) Not later than five days after qualifying for an exemption from prior
12 authorization requirements under this section, a health insurer shall provide to
13 a health care provider notice that includes:

14 (A) a statement that the health care provider qualifies for an
15 exemption from prior authorization requirements under subsection (b) of this
16 section;

17 (B) a list of the health care services and health benefit plans to which
18 the exemption applies; and

19 (C) a statement of the duration of the exemption.

20 (5) If a health care provider submits a prior authorization request for a
21 health care service for which the health care provider qualifies for an

1 exemption from prior authorization requirements under subsection (b) of this
2 section, the health insurer shall promptly provide a notice to the health care
3 provider that includes:

4 (A) the information described by subdivision (4) of this subsection
5 (h); and

6 (B) a notification of the health insurer's payment requirements.

7 (6) Nothing in this section may be construed to:

8 (A) authorize a health care provider to provide a health care service
9 outside the scope of the health care provider's applicable license issued under
10 Title 26; or

11 (B) require a health insurer to pay for a health care service that is in
12 violation of the laws of this State.

13 * * * Effective Date * * *

14 Sec. 7. EFFECTIVE DATE

15 This act shall take effect on passage, except Sec. 6 applies only to a request
16 for prior authorization of health care services made on or after January 1, 2024.