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H.766

An act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts

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

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:

(i) the prescription drug required under the step-therapy protocol is contraindicated or will likely cause an adverse reaction or physical or mental harm to the insured;

1                   (ii) the prescription drug required under the step-therapy protocol  
2                   is expected to be ineffective based on the insured's known clinical history,  
3                   condition, and prescription drug regimen;

4                   (iii) the insured has already tried the prescription drugs on the  
5                   protocol, or other prescription drugs in the same pharmacologic class or with  
6                   the same mechanism of action, which have been discontinued due to lack of  
7                   efficacy or effectiveness, diminished effect, or an adverse event, regardless of  
8                   whether the insured was covered at the time on a plan offered by the current  
9                   insurer or its pharmacy benefit manager;

10                  (iv) the insured is stable on a prescription drug selected by the  
11                  insured's treating health care professional for the medical condition under  
12                  consideration; or

13                  (v) the step-therapy protocol or a prescription drug required under  
14                  the protocol is not in the patient's best interests because it will:

15                           (I) pose a barrier to adherence;

16                           (II) likely worsen a comorbid condition; or

17                           (III) likely decrease the insured's ability to achieve or maintain  
18                   reasonable functional ability.

19                  (2) Nothing in this subsection shall be construed to prohibit the use of  
20                  tiered co-payments for members or subscribers not subject to a step-therapy  
21                  protocol.

1           (3) Notwithstanding any provision of subdivision (1) of this subsection  
2 to the contrary, a health insurance or other health benefit plan offered by an  
3 insurer or by a pharmacy benefit manager on behalf of a health insurer that  
4 provides coverage for prescription drugs shall not utilize a step-therapy, “fail  
5 first,” or other protocol that requires documented trials of a medication,  
6 including a trial documented through a “MedWatch” (FDA Form 3500), before  
7 approving a prescription for the treatment of substance use disorder.

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

9       § 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE

10                               TO CODING RULES

11       (a) Health plans, contracting entities, covered entities, and payers shall  
12 accept and initiate the processing of all health care claims submitted by a  
13 health care provider pursuant to and consistent with the current version of the  
14 American Medical Association’s Current Procedural Terminology (CPT)  
15 codes, reporting guidelines, and conventions; the Centers for Medicare and  
16 Medicaid Services Healthcare Common Procedure Coding System (HCPCS);  
17 American Society of Anesthesiologists; the National Correct Coding Initiative  
18 (NCCI); the National Council for Prescription Drug Programs coding; or other  
19 appropriate nationally recognized standards, guidelines, or conventions  
20 approved by the Commissioner.

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

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

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

9           ~~(3)(C)~~ for pharmacy claims, appropriate nationally recognized edit  
10 standards, guidelines, or conventions; and

11           (D) for any other claim not addressed by subdivision (A), (B), or (C)  
12 of this subdivision (1), other appropriate nationally recognized edit standards,  
13 guidelines, or conventions approved by the Commissioner.

14           (2) For outpatient services, professional services, and facility claims, a  
15 health plan, contracting entity, covered entity, or payer shall apply the relevant  
16 edit standards, processes, and guidelines from NCCI or Medicare Code Editor  
17 pursuant to subdivisions (1)(A) and (B) of this subsection that were in effect  
18 for Medicare on the date of the claim submission; provided, however, that if  
19 Medicare has changed an applicable edit standard, process, or guideline within  
20 90 days prior to the date of the claim submission, the health plan, contracting  
21 entity, covered entity, or payer may use the version of the edit standard,

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

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

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

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

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

15 (B) clearly supported by nationally recognized standards, guidelines,  
16 or conventions approved by the Commissioner of Financial Regulation; and

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

19 (d) Health plans, contracting entities, covered entities, and payers shall not  
20 release edits more than quarterly, to take effect on January 1, April 1, July 1, or  
21 October 1, as applicable, and the edits shall not be implemented without filing

1 with the Commissioner of Financial Regulation to ensure consistency with  
2 nationally recognized standards guidelines, and conventions, and at least 30  
3 days' advance notice to providers. Whenever Medicare changes an edit  
4 standard, process, or guideline that it applies to outpatient service, professional  
5 service, or facility claims, each health plan, contracting entity, covered entity,  
6 or payer shall incorporate those modifications into its next quarterly release of  
7 edits.

8 (e)(1) Except as otherwise provided in subdivision (2) of this subsection,  
9 no health plan, contracting entity, covered entity, or payer shall subject any  
10 health care provider to prepayment coding validation edit review. As used in  
11 this subsection, "prepayment coding validation edit review" means any action  
12 by the health plan, contracting entity, covered entity, or payer, or by a  
13 contractor, assignee, agent, or other entity acting on its behalf, requiring a  
14 health care provider to provide medical record documentation in conjunction  
15 with or after submission of a claim for payment for health care services  
16 delivered, but before the claim has been adjudicated.

17 (2) Nothing in this subsection shall be construed to prohibit targeted  
18 prepayment coding validation edit review of a specific provider, provider  
19 group, or facility under certain circumstances, including evaluating high-dollar  
20 claims; verifying complex financial arrangements; investigating member  
21 questions; conducting post-audit monitoring; addressing a reasonable belief of

1 fraud, waste, or abuse; or other circumstances determined by the  
2 Commissioner through a bulletin or guidance.

3 (f) Nothing in this section shall preclude a health plan, contracting entity,  
4 covered entity, or payer from determining that any such claim is not eligible  
5 for payment in full or in part, based on a determination that:

6 \* \* \*

7 ~~(e)~~(g) Nothing in this section shall be deemed to require a health plan,  
8 contracting entity, covered entity, or payer to pay or reimburse a claim, in full  
9 or in part, or to dictate the amount of a claim to be paid by a health plan,  
10 contracting entity, covered entity, or payer to a health care provider.

11 ~~(f)~~(h) No health plan, contracting entity, covered entity, or payer shall  
12 automatically reassign or reduce the code level of evaluation and management  
13 codes billed for covered services (downcoding), except that a health plan,  
14 contracting entity, covered entity, or payer may reassign a new patient visit  
15 code to an established patient visit code based solely on CPT codes, CPT  
16 guidelines, and CPT conventions.

17 ~~(g)~~(i) Notwithstanding the provisions of subsection ~~(d)~~(f) of this section,  
18 and other than the edits contained in the conventions in subsections (a) and (b)  
19 of this section, health plans, contracting entities, covered entities, and payers  
20 shall continue to have the right to deny, pend, or adjust claims for services on  
21 other bases and shall have the right to reassign or reduce the code level for

1 selected claims for services based on a review of the clinical information  
2 provided at the time the service was rendered for the particular claim or a  
3 review of the information derived from a health plan's fraud or abuse billing  
4 detection programs that create a reasonable belief of fraudulent or abusive  
5 billing practices, provided that the decision to reassign or reduce is based  
6 primarily on a review of clinical information.

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

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

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

17 (3) the payment percentages for modifiers; and

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

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

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

8       ~~(k)~~(m) ~~BlueCross BlueShield of Vermont and the Vermont Medical~~  
9       ~~Society are requested to continue convening a work group consisting of~~ There  
10      is established a working group comprising the health plans, contracting  
11      entities, covered entities, and payers subject to the reporting requirement in  
12      subsection 9414a(b) of this title; representatives of hospitals and health care  
13      providers; representatives of the Department of Financial Regulation and of  
14      other relevant State agencies; and other interested parties to study the edit  
15      standards in subsection (b) of this section, the edit standards in national class  
16      action settlements, and edit standards and edit transparency standards  
17      established by other states to determine the most appropriate way to ensure that  
18      health care providers can access information about the edit standards  
19      applicable to the health care services they provide trends in coding and billing  
20      that health plans, contracting entities, covered entities, or payers, or a  
21      combination of them, seek to address through claim editing. The work

1 ~~working~~ group ~~is requested to~~ shall provide ~~an annual~~ a progress report to the  
2 House Committee on Health Care and the Senate Committees on Health and  
3 Welfare and on Finance upon request.

4 ~~(h)(n)~~ With respect to the ~~work~~ working group established under subsection  
5 ~~(k)(m)~~ of this section and to the extent required to avoid violations of federal  
6 antitrust laws, the Department shall facilitate and supervise the participation of  
7 members of the ~~work~~ working group.

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

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

11 (1) It is the intent of the General Assembly to reduce variability in prior  
12 authorization requirements by aligning to the greatest extent possible with the  
13 prior authorization requirements in Vermont's Medicaid program.

14 (2) A health plan shall not impose any prior authorization requirement  
15 for any admission, item, service, treatment, or procedure that is more  
16 restrictive than the prior authorization requirements that the Department of  
17 Vermont Health Access would apply for the same admission, item, service,  
18 treatment, or procedure under Vermont's Medicaid program.

19 (3) Each health plan shall review the prior authorization requirements in  
20 effect in Vermont's Medicaid program at least once every six months to ensure

1 that the health plan is maintaining the prior authorization alignment required  
2 by subdivision (2) of this subsection.

3 (4) Nothing in this subsection shall be construed to:

4 (A) require prior authorization alignment with Vermont Medicaid for  
5 prescription drugs;

6 (B) prohibit prior authorization requirements for any admission, item,  
7 service, treatment, or procedure that is not covered by Vermont Medicaid;

8 (C) prohibit prior authorization requirements for an admission, item,  
9 service, treatment, or procedure that is provided out-of-network; or

10 (D) require a health plan to maintain the same provider network as  
11 Vermont Medicaid.

12 (d)(1) A health plan shall furnish, upon request from a health care provider,  
13 a current list of services and supplies requiring prior authorization.

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

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

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

1 ~~authorization and any needed missing information within 24 hours after~~  
2 ~~receipt.~~

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

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

11 (B) For nonurgent prior authorization requests:

12 (i) A health plan shall approve or deny a completed prior  
13 authorization request from an insured or a prescribing health care provider  
14 within two business days following receipt.

15 (ii) A health plan shall acknowledge receipt of the prior  
16 authorization request within 24 hours following receipt and shall inform the  
17 insured or health care provider at that time if any information is missing that is  
18 necessary for the health plan to make a determination on the request.

19 (iii) If a health plan notifies an insured or a health care provider  
20 that more information is necessary pursuant to subdivision (ii) of this

1 subdivision (4)(B), the health plan shall have 24 hours to approve or deny the  
2 request upon receipt of the necessary information.

3 (C) If a health plan does not, within the time limits set forth in this  
4 section, respond to a completed prior authorization request, acknowledge  
5 receipt of the request for prior authorization, or request missing information,  
6 the prior authorization request shall be deemed to have been granted.

7 (D) Prior authorization approval for a prescribed or ordered  
8 treatment, service, or course of medication shall be valid for the duration of the  
9 prescribed or ordered treatment, service, or course of medication or one year,  
10 whichever is longer; provided, however, that for a prescribed or ordered  
11 treatment, service, or course of medication that continues for more than one  
12 year, a health plan shall not require renewal of the prior authorization approval  
13 more frequently than once every five years.

14 (E) For an insured who is stable on a treatment, service, or course of  
15 medication, as determined by a health care provider, that was approved for  
16 coverage under a previous health plan, a health plan shall not restrict coverage  
17 of that treatment, service, or course of medication for at least 90 days upon the  
18 insured's enrollment in the new health plan.

19 Sec. 5. 18 V.S.A. § 9418c is amended to read:

20 § 9418c. FAIR CONTRACT STANDARDS

21 (a) Required information.

1           (1) Each contracting entity shall provide and each health care contract  
2 shall obligate the contracting entity to provide participating health care  
3 providers information sufficient for the participating provider to determine the  
4 compensation or payment terms for health care services, including all of the  
5 following:

6           (A) The manner of payment, such as fee-for-service, capitation, case  
7 rate, or risk.

8           (B) On request, the fee-for-service dollar amount allowable for each  
9 CPT code for those CPT codes that a provider in the same specialty typically  
10 uses or that the requesting provider actually bills. Fee schedule information  
11 may be provided by ~~CD-ROM~~ or electronically, at the election of the  
12 contracting entity, but a provider may elect to receive a hard copy of the fee  
13 schedule information instead of the ~~CD-ROM~~ or electronic version.

14           (C) A clearly understandable, readily available mechanism, such as a  
15 specific website address, that includes the following information:

16           (i) the name of the commercially available claims editing software  
17 product that the health plan, contracting entity, covered entity, or payer uses;

18           (ii) the specific standard or standards from subsection 9418a(c) of  
19 this title that the entity uses for claim edits and how those claim edits are  
20 supported by those specific standards;

21           (iii) payment percentages for modifiers; and





1 the impact of the prior authorization provisions of this act on the following  
2 during plan years 2025 and 2026:

3 (1) utilization of health care services covered by the insurer's plans;

4 (2) development of the insurer's premium rates for future plan years;

5 and

6 (3) the insurer's estimated avoided costs, including:

7 (A) the specific methodologies that the insurer uses to determine the  
8 amount of "savings" from avoided costs;

9 (B) the costs of the alternative tests, procedures, medications, and  
10 other items or services ordered for insureds as a result of the insurer's denials  
11 of requests for prior authorizations; and

12 (C) the costs of emergency department visits and inpatient stays,  
13 including stays in intensive care units, as a result of the insurer's denials of  
14 requests for prior authorizations.

15 **Sec. 7. PRIOR AUTHORIZATION; PROVIDER IMPACT REPORTS**

16 (a) The General Assembly requests that organizations representing  
17 Vermont's hospital-employed, federally qualified health center-employed, and  
18 independent health care providers who are affected by the prior authorization  
19 provisions of this act gather information from their members on or before  
20 January 1, 2025 and on or before July 1, 2026 regarding current circumstances  
21 and the impact of the prior authorization provisions of this act on their provider

1 members and the members' practices. To the extent practicable, the  
2 information gathered should align with survey questions published by  
3 nationally recognized provider organizations and include information  
4 regarding the impact of prior authorization processes and requirements on care  
5 delivery, quality of care, and staffing.

6 (b) On or before January 15, 2027, each provider organization that gathered  
7 information from its members in accordance with subsection (a) of this section  
8 is requested to summarize and report on that information to the House  
9 Committee on Health Care and the Senate Committees on Health and Welfare  
10 and on Finance, including providing a summary of the impact of the prior  
11 authorization provisions of this act on the organization's members' practices.

12 Sec. 8. REPEAL

13 18 V.S.A. § 9418(m) and (n) (claims edit working group) are repealed on  
14 January 1, 2028.

15 Sec. 9. EFFECTIVE DATES

16 (a) Secs. 6 (prior authorization; insurer impact reports) and 7 (prior  
17 authorization; provider impact reports) and this section shall take effect on  
18 passage.

19 (b) Sec. 3 (18 V.S.A. § 9418b(g)(4); prior authorization time frames) shall  
20 take effect on January 1, 2025, except that a health plan that must modify its  
21 technology in order to continue administering its own internal utilization

1 review process for certain services shall have until not later than January 1,  
2 2026 to come into compliance with the provisions of Sec. 3 as to those  
3 services.

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