Senate proposal of amendment

H. 766.

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

The Senate proposes to the House to amend the bill as follows:

First: By striking out Sec. 1, 8 V.S.A. § 4089i, in its entirety and inserting in lieu thereof a new Sec. 1 to read as follows:

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

§ 4089i. PRESCRIPTION DRUG COVERAGE

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(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;

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

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

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

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

(I) pose a barrier to adherence;

(II) likely worsen a comorbid condition; or

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

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

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

* * *

(i) 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 shall cover, without requiring prior authorization, at least one readily available asthma controller medication from each class of medication and mode of administration. As used in this subsection, "readily available" means that the medication is not listed on a national drug shortage list, including lists maintained by the U.S. Food and Drug Administration and by the American Society of Health-System Pharmacists.

(j) As used in this section:

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~~(j)~~(k) The Department of Financial Regulation shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

Second: By amending the bill in Sec. 3, 18 V.S.A. § 9418b(c) and (d), by striking out subsection (c) in its entirety and inserting in lieu thereof a new subsection (c) to read as follows:

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

(1)(A) Except as provided in subdivision (B) of this subdivision (1), a health plan shall not impose any prior authorization requirement for any admission, item, service, treatment, or procedure ordered by a primary care provider.

(B) The prohibition set forth in subdivision (A) of this subdivision (1) shall not be construed to prohibit prior authorization requirements for prescription drugs or for an admission, item, service, treatment, or procedure that is provided out-of-network.

(2) As used in this subsection, "primary care provider" has the same meaning as is used by the Vermont Blueprint for Health.

Third: By amending the bill in Sec. 9, effective dates, in subsection (b), by striking out "Sec. 3" both times it appears and inserting in lieu thereof Sec. 4