Introduced by Senator Lyons

Referred to Committee on

Date:

Subject: Health; Green Mountain Care Board; health insurers; health care providers; pay parity; transparency; contracts; primary care; Medicaid; Blueprint for Health; provider rates; workers’ compensation; prior authorization; pharmacy benefit managers; hospital budgets; Department of Financial Regulation

Statement of purpose of bill as introduced: This bill proposes to require the Green Mountain Care Board to review health care contracts and fee schedules between health plans and health care providers to increase transparency in health care. This bill would also increase primary care payments and spending and provide an exemption from prior authorization requirements. This bill proposes to allow a minor 12 years of age or older to consent to medical care for the prevention of a sexually transmitted infection and would also adjust the age at which an individual’s colorectal cancer screenings are covered by health insurance. This bill also proposes to make certain temporary prohibitions on pharmacy benefit managers permanent. This bill proposes to modify the nomination and appointment process for members of the Green Mountain Care Board. This bill would also add new filing and reporting requirements for
health insurers and would require the Department of Financial Regulation to
submit an analysis to the Green Mountain Care Board regarding hospital
budget proposals.

An act relating to pay parity and transparency in health care

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

* * * Contracts; Health Plans; Health Care Providers * * *

Sec. 1. GREEN MOUNTAIN CARE BOARD; HEALTH CARE
CONTRACTS; FEE SCHEDULES; REPORT

(a) The Green Mountain Care Board shall collect and review a
representative sample of health care contracts and fee schedules from health
insurers, including contracts and fee schedules with hospital-affiliated, non-
hospital-affiliated, and independent health care providers to inform the Board’s
development of a methodology for increasing the transparency around health
care contracts.

(b) On or before January 15, 2024, the Board shall provide information to
the House Committee on Health Care and the Senate Committees on Health
and Welfare and on Finance regarding the Board’s proposed methodology for
increasing the transparency around health care contracts, including the
standards and criteria that the Board intends to use for its reviews of health
care contracts and fee schedules, and any recommendations for legislative action.

(c) Confidential business information and trade secrets received from an insurer pursuant to subsection (a) of this section shall be exempt from public inspection and copying under 1 V.S.A. § 317(c)(9) and shall be kept confidential, except that the Board may disclose or release information publicly in summary or aggregate form if doing so would not disclose confidential business information or trade secrets.

* * * Blueprint for Health * * *

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

On or before January 15, 2024, the Director of Health Care Reform in the Agency of Human Services shall recommend to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare, on Appropriations, and on Finance the amounts by which health insurers and Vermont Medicaid should increase the amount of the per-person, per-month payments they make to patient centered medical homes participating in Blueprint for Health, in furtherance of the goal of providing additional resources necessary for delivery of comprehensive primary care services to Vermonters and to sustain access to primary care services in Vermont. The Agency shall also provide an estimate of the State funding that
would be needed to support the increase for Medicaid, both with and without

federal financial participation.

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

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

§ 1901a. MEDICAID BUDGET

(a) Financial plan. The General Assembly shall approve each year a

Medicaid budget. The annual Medicaid budget shall include an annual

financial plan, and a five-year financial plan accounting for expenditures and

revenues relating to Medicaid and any other health care assistance program

administered by the Agency of Human Services.

(b) Quarterly information and analysis. The Secretary of Human Services

or his or her the Secretary’s designee and the Commissioner of Finance and

Management shall provide quarterly to the Joint Fiscal Committee such

information and analysis as the Committee reasonably determines is necessary

to assist the General Assembly in the preparation of the Medicaid budget.

(c) Medicaid provider rates; primary care. It is the intent of the General

Assembly that Vermont’s health care system should reimburse all Medicaid

participating providers at rates that are equal to 100 percent of the Medicare

rates for the services provided, with first priority for primary care providers. In

support of this goal, in its annual budget proposal, the Department of Vermont

Health Access shall either provide reimbursement rates for Medicaid
participating providers for primary care services at rates that are equal to 100
percent of the Medicare rates for the services in effect in calendar year 2022,
with positive Consumer Price Index inflation adjustment rates in subsequent
years, or, in accordance with 32 V.S.A. § 307(d)(6), provide information on
the additional amounts that would be necessary to achieve full reimbursement
parity for primary care services with the Medicare rates.

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

§ 9414b. INCREASING PRIMARY CARE SPENDING ALLOCATIONS

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

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

(B) the State Employees’ Health Benefit Plan; and

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

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

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

(A) result in higher health insurance premiums;
(B) be achieved through increased fee-for-service payments to providers; or
(C) increase the plan’s or payer’s overall health care expenditures.

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

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

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

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

* * *
(d) The liability of the employer to pay for medical, surgical, hospital, and nursing services and supplies, prescription drugs, and durable medical equipment provided to the injured employee under this section shall not exceed the maximum fee for a particular service, prescription drug, or durable medical equipment as provided by a schedule of fees and rates prepared by the Commissioner. The Commissioner shall update the schedule of fees and rates on a consistent basis and not less than biennially. The reimbursement rate for services and supplies in the fee schedule shall include consideration of medical necessity, clinical efficacy, cost-effectiveness, and safety, and those services and supplies shall be provided on a nondiscriminatory basis consistent with workers’ compensation and health care law. The Commissioner shall authorize reimbursement at a rate higher than the scheduled rate if the employee demonstrates to the Commissioner’s satisfaction that reasonable and necessary treatment, prescription drugs, or durable medical equipment is not available at the scheduled rate. An employer shall establish direct billing and payment procedures and notification procedures as necessary for coverage of medically necessary prescription medications for chronic conditions of injured employees, in accordance with rules adopted by the Commissioner.
Sec. 6. 8 V.S.A. § 4062g is added to read:

§ 4062g. EXEMPTION FROM PRIOR AUTHORIZATION REQUIREMENTS

(a) Definitions. As used in this section:

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

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

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

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

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

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

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

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

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

(c) Duration of prior authorization exemption.

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

(A) the 30th day after the date the health insurer notifies the health
care provider of the health insurer’s determination to rescind the exemption
under this section if the health care provider does not appeal the health
insurer’s determination; or
(B) if the health care provider appeals the determination, the fifth day
after the date the independent review organization affirms the health insurer’s
determination to rescind the exemption.

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

(d) Denial or rescission of prior authorization exemption.

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

   (A) During January or June of each year.

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

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

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

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

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

(B) the health insurer provides the health care provider with actual statistics and data for the relevant prior authorization request evaluation period and detailed information sufficient to demonstrate that the health care provider does not meet the criteria for an exemption from prior authorization requirements for the particular health care service under this section.

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

(2) A health insurer shall pay:

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

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

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

(4) A health care provider may request that the independent review
organization consider another random sample of not less than five and not
more than 20 claims submitted to the health insurer by the health care provider
during the relevant evaluation period for the relevant health care service as part
of its review. If the health care provider makes such a request under this
subdivision, the independent review organization shall base its determination
on the medical necessity of claims reviewed by the health insurer under subdivision (d)(1)(B) of this section and those reviewed under this subdivision.

(f) Effect of appeal or independent review determination.

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

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

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

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

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

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

(h) Effect of prior authorization exemption.

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) If a health care provider submits a prior authorization request for a health care service for which the health care provider qualifies for an exemption from prior authorization requirements under subsection (b) of this section, the health insurer shall promptly provide a notice to the health care provider that includes:
(A) the information described by subdivision (4) of this subsection

(h); and

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

(6) Nothing in this section shall be construed to:

(A) authorize a health care provider to provide a health care service

outside the scope of the health care provider’s applicable license issued under

Title 26; or

(B) require a health insurer to pay for a health care service that is in

violation of the laws of this State.

* * * Preventive Services * * *

Sec. 7. 18 V.S.A. chapter 21, subchapter 3 is amended to read:

Subchapter 3. Venereal Diseases Sexually Transmitted Infections

* * *

§ 1107. CONSENT TO PREVENTATIVE SERVICES BY MINORS

(a) A minor 12 years of age or older may consent to medical care by a

licensed physician related to the prevention of a sexually transmitted infection.

(b) Consent under this section shall not be subject to disaffirmance due to

minority of the individual consenting. The consent of the parent or legal

guardian of a minor consenting under this section shall not be necessary to

authorize care as described in this subsection.
§ 1108. CONSENT TO TREATMENT BY MINORS

(a)(1) If a minor 12 years of age or older is suspected to have a sexually transmitted infection and the finding is verified by a licensed physician, the minor may give consent to medical treatment and hospitalization.

(2) Consent under this section shall not be subject to disaffirmance due to minority of the individual consenting. The consent of the parent or legal guardian of a minor consenting under this section shall not be necessary to authorize care as described in this subsection.

(b) The physician shall notify the parent, parents, or legal guardian of the minor if the condition of the minor child requires immediate hospitalization for treatment of the sexually transmitted infection.

Sec. 8. CONFORMING REVISION

When preparing the Vermont Statutes Annotated for publication, the Office of Legislative Counsel shall make the following revisions throughout the statutes as needed for consistency with Sec. 1 of this act, provided the revisions have no effect on the meaning of the affected statutes: replace “venereal disease” with “sexually transmitted infection.”

Sec. 9. 8 V.S.A. § 4100g is amended to read:

§ 4100g. COLORECTAL CANCER SCREENING, COVERAGE REQUIRED

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

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

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

(B) one colonoscopy every 10 years;

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

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*** Pharmacy Benefit Managers ***

Sec. 10. REPEAL OF PROSPECTIVE REPEAL OF 18 V.S.A. § 9473(g)

2021 Acts and Resolves No. 74, Sec. E.227.2, as amended by 2022 Acts and Resolves No. 131, Sec. 7, is repealed.

*** Green Mountain Care Board; Nomination and Appointment ***

Sec. 11. 18 V.S.A. chapter 220 is amended to read:

Chapter 220. GREEN MOUNTAIN CARE BOARD

***
§ 9374. BOARD MEMBERSHIP; AUTHORITY

* * *

(b)(1) The initial term of each member of the Board, including the Chair, shall be seven years, and the term of the Chair shall be six years thereafter.

(2) The term of each member other than the Chair shall be six years, except that of the members first appointed, one each shall serve a term of three years, four years, five years, and six years. [Repealed.]

(3) Subject to the nomination and appointment process, a member may serve more than one term. A member may be reappointed to an additional term subject to the requirements of section 9391 of this title.

* * *

§ 9391. NOMINATION AND APPOINTMENT PROCESS

(a) Whenever Candidate selection process.

(1) Unless a vacancy is filled by reappointment pursuant to subsection (c) of this section, not later than 90 days prior to a known vacancy occurring on the Green Mountain Care Board, or when an incumbent does not declare that he or she will be a candidate to succeed himself or herself, the Green Mountain Care Board Nominating Committee shall commence its nomination application process. The Committee shall select for consideration by the Committee, by majority vote; and provided that a quorum is present, from the applications for membership on the Green Mountain Care Board as
many candidates as it deems qualified for the position or positions to be filled. The Committee shall base its determinations on the qualifications set forth in section 9392 of this section title.

(2) A Board member who is resigning from the Board prior to the expiration of the member’s term shall notify the Committee Chair of the member’s anticipated resignation date. Once notified, the Committee Chair shall commence the nomination application process as soon as is practicable in light of the anticipated resignation date and shall notify the Governor of the anticipated vacancy.

(b) Nomination list. The Committee shall submit to the Governor the names of the persons it deems qualified to be appointed to fill the position or positions and the name of any incumbent member who was not re-appointed pursuant to subsection (c) of this section and who declares the Committee Chair that he or she wishes to be a candidate to succeed himself or herself nominated. An incumbent shall not be required to submit an application for nomination and appointment to the Committee under subsection (a) of this section.

(c) Reappointment; notification. To be considered for reappointment to the Green Mountain Care Board, a Board member whose term is expiring shall notify the Governor, not later than 120 days prior to the member’s term expiration date, that the member is seeking reappointment. If the Board
member is not reappointed by the Governor on or before 30 days after
notifying the Governor, the member’s term shall end on the expiration date of
the member’s current term, unless the member is nominated as provided in
subsection (b) of this section and subsequently appointed or as otherwise
provided by law. A Board member’s reappointment shall be subject to the
consent of the Senate.

(e)(d) Unless the Governor reappointed a Board member pursuant to
subsection (c) of this section, the Governor shall make an appointment to
the Green Mountain Care Board from the list of qualified candidates submitted
pursuant to subsection (b) of this section not later than 45 days after receipt of
the candidate list. The appointment shall be subject to the consent of the
Senate. The names of candidates submitted and not selected shall remain
confidential.

(d)(e) All proceedings of the Committee, including the names of candidates
considered by the Committee and information about any candidate submitted
by any source, shall be confidential.

* * * Regulation; Insurance Rates; Hospital Budgets * * *

Sec. 12. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

* * *
(b)(1) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of the proposed rate. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, the amount of total premium revenue expended on care coordination and management, and any other information required by the Board. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

* * *

Sec. 13. 18 V.S.A. § 9414a is amended to read:

§ 9414a. ANNUAL REPORTING BY HEALTH INSURERS

* * *

(b) Health insurers with a minimum of 2,000 Vermont lives covered at the end of the preceding year or who offer insurance through the Vermont Health Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall annually report the following information to the Commissioner of Financial
Regulation, in plain language, as an addendum to the health insurer’s annual statement:

* * *

(21) the health insurer’s legal expenses related to claims or service denials during the preceding year; and

(22) the amount and recipient of charitable contributions made by the health insurer during the preceding year; and

(23) risk-based capital reports.

* * *

Sec. 14. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

* * *

(d)(1) Annually, on or before September 15, followed by a written decision by October 1, the Board shall establish a budget for each hospital on or before September 15, followed by a written decision by October 1 that meets the acceptable range of comparison to the national, regional, or in-state peer group norms set forth in the indicators, ratios, and statistics pre-established by the Board as required by subdivision (c)(2) of this section, and is affordable:

promotes quality care; promotes access to health care; protects solvency; and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.

Each hospital shall operate within the budget established under this section.
Sec. 15. 18 V.S.A. § 9372 is amended to read:

§ 9372. PURPOSE

It is the intent of the General Assembly to create an independent board to promote the general good of the State by:

(1) improving the health of the population; and

(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers, while ensuring that access to care and quality of care are not compromised, through the review and approval of health insurance rates, hospital and accountable care organization (ACO) budgets and ACO certification, and data analytics.

(3) enhancing the patient and health care professional experience of care;

(4) recruiting and retaining high-quality health care professionals; and

(5) achieving administrative simplification in health care financing and delivery.

Sec. 16. 18 V.S.A. chapter 13, subchapter 2 is added to read:

Subchapter 2. Payment Reform

§ 721. INSURER PARTICIPATION IN MULTIPAYER ALTERNATIVE PAYMENT MODELS

It is the intent of the General Assembly first to provide commercial health insurers in the State with the opportunity to participate in Vermont’s
multipayer alternative payment model or models established pursuant to the State’s agreement with the Center for Medicare and Medicaid Innovation. In the event that no insurers elect to participate in Vermont’s multipayer alternative payment model or models, the Department of Financial Regulation shall require health insurers, as defined in 18 V.S.A. § 9402, to participate in Vermont’s multipayer alternative payment model as a condition of doing business in this State.

*** Effective Date ***

Sec. 17. EFFECTIVE DATES

This act shall take effect on July 1, 2023, except Sec. 6 (8 V.S.A. § 4062g; prior authorization requirements) applies only to a request for prior authorization of health care services made on or after January 1, 2024.