

1 S.151

2 Introduced by Senator Lyons

3 Referred to Committee on

4 Date:

5 Subject: Health; Green Mountain Care Board; health insurers; health care

6 providers; pay parity; transparency; contracts; primary care;

7 Medicaid; Blueprint for Health; provider rates; workers'

8 compensation; prior authorization; pharmacy benefit managers;

9 hospital budgets; Department of Financial Regulation

10 Statement of purpose of bill as introduced: This bill proposes to require the  
11 Green Mountain Care Board to review health care contracts and fee schedules  
12 between health plans and health care providers to increase transparency in  
13 health care. This bill would also increase primary care payments and spending  
14 and provide an exemption from prior authorization requirements. This bill  
15 proposes to allow a minor 12 years of age or older to consent to medical care  
16 for the prevention of a sexually transmitted infection and would also adjust the  
17 age at which an individual's colorectal cancer screenings are covered by health  
18 insurance. This bill also proposes to make certain temporary prohibitions on  
19 pharmacy benefit managers permanent. This bill proposes to modify the  
20 nomination and appointment process for members of the Green Mountain Care  
21 Board. This bill would also add new filing and reporting requirements for

1 health insurers and would require the Department of Financial Regulation to  
2 submit an analysis to the Green Mountain Care Board regarding hospital  
3 budget proposals.

4 An act relating to pay parity and transparency in health care

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

6 \* \* \* Contracts; Health Plans; Health Care Providers \* \* \*

7 Sec. 1. GREEN MOUNTAIN CARE BOARD; HEALTH CARE

8 CONTRACTS; FEE SCHEDULES; REPORT

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

15 (b) On or before January 15, 2024, the Board shall provide information to  
16 the House Committee on Health Care and the Senate Committees on Health  
17 and Welfare and on Finance regarding the Board's proposed methodology for  
18 increasing the transparency around health care contracts, including the  
19 standards and criteria that the Board intends to use for its reviews of health

1 care contracts and fee schedules, and any recommendations for legislative  
2 action.

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

9 \* \* \* Blueprint for Health \* \* \*

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

12 On or before January 15, 2024, the Director of Health Care Reform in the  
13 Agency of Human Services shall recommend to the House Committees on  
14 Health Care and on Appropriations and the Senate Committees on Health and  
15 Welfare, on Appropriations, and on Finance the amounts by which health  
16 insurers and Vermont Medicaid should increase the amount of the per-person,  
17 per-month payments they make to patient centered medical homes  
18 participating in Blueprint for Health, in furtherance of the goal of providing  
19 additional resources necessary for delivery of comprehensive primary care  
20 services to Vermonters and to sustain access to primary care services in  
21 Vermont. The Agency shall also provide an estimate of the State funding that

1 would be needed to support the increase for Medicaid, both with and without  
2 federal financial participation.

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

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

5 § 1901a. MEDICAID BUDGET

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

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

16 (c) Medicaid provider rates; primary care. It is the intent of the General  
17 Assembly that Vermont's health care system should reimburse all Medicaid  
18 participating providers at rates that are equal to 100 percent of the Medicare  
19 rates for the services provided, with first priority for primary care providers. In  
20 support of this goal, in its annual budget proposal, the Department of Vermont  
21 Health Access shall either provide reimbursement rates for Medicaid

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

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

8 § 9414b. INCREASING PRIMARY CARE SPENDING ALLOCATIONS

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

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

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

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

20 (2) Upon achieving the 12 percent primary care spending allocation  
21 required by subdivision (1) of this subsection, each plan or payer shall

1 maintain or increase the percentage of total health care spending it allocates to  
2 primary care at or above 12 percent.

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

5 (A) result in higher health insurance premiums;

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

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

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

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

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

19 § 640. MEDICAL BENEFITS; ASSISTIVE DEVICES; HOME AND

20 AUTOMOBILE MODIFICATIONS

21 \* \* \*

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

20 \* \* \*

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

2 § 4062g. EXEMPTION FROM PRIOR AUTHORIZATION

3 REQUIREMENTS

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

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

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

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

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

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

19 (1) A health insurer that uses a prior authorization process for health  
20 care services may not require a health care provider to obtain prior  
21 authorization for any health care service if, in the most recent six-month

1 evaluation period, as described in subdivision (2) of this subsection, the health  
2 insurer has approved or would have approved not less than 90 percent of the  
3 prior authorization requests submitted by the health care provider for the  
4 particular health care service.

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

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

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

14 (c) Duration of prior authorization exemption.

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

17 (A) the 30th day after the date the health insurer notifies the health  
18 care provider of the health insurer's determination to rescind the exemption  
19 under this section if the health care provider does not appeal the health  
20 insurer's determination; or

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

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

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

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

11           (A) During January or June of each year.

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

20           (C) If the health insurer complies with other applicable requirements  
21           specified in this section, including notifying the health care provider not less

1 than 25 days before the proposed rescission is to take effect. The notice shall  
2 include the sample information used to make the determination under  
3 subdivision (1)(B) of this subsection (d) and a plain language explanation of  
4 how the health care provider may appeal and seek an independent review of  
5 the determination.

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

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

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

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

21 (e) Independent review of exemption determination.

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

6           (2) A health insurer shall pay:

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

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

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

16          (4) A health care provider may request that the independent review  
17          organization consider another random sample of not less than five and not  
18          more than 20 claims submitted to the health insurer by the health care provider  
19          during the relevant evaluation period for the relevant health care service as part  
20          of its review. If the health care provider makes such a request under this  
21          subdivision, the independent review organization shall base its determination

1 on the medical necessity of claims reviewed by the health insurer under  
2 subdivision (d)(1)(B) of this section and those reviewed under this subdivision.

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

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

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

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

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

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

18 (g) Eligibility for prior authorization exemption following finalized  
19 exemption rescission or denial. After a final determination or review affirming  
20 the rescission or denial of an exemption for a specific health care service under  
21 this section, a health care provider is eligible for consideration of an exemption

1 for the same health care service after the six-month evaluation period that  
2 follows the evaluation period that formed the basis of the rescission or denial  
3 of an exemption.

4 (h) Effect of prior authorization exemption.

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

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

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

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

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

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

20 (3) For a retrospective review described by subdivision (2)(B) of this  
21 subsection, nothing in this section may be construed to modify or otherwise

1 affect any other applicable law, except to prescribe the only circumstances  
2 under which:

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

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

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

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

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

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

16 (5) If a health care provider submits a prior authorization request for a  
17 health care service for which the health care provider qualifies for an  
18 exemption from prior authorization requirements under subsection (b) of this  
19 section, the health insurer shall promptly provide a notice to the health care  
20 provider that includes:



1     § 1108. CONSENT TO TREATMENT BY MINORS

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

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

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

12    Sec. 8. CONFORMING REVISION

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

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

19    § 4100g. COLORECTAL CANCER SCREENING, COVERAGE

20            REQUIRED

21                           \* \* \*

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~~ providing an insured ~~50 years of age or older~~ with the  
5 option of:

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

8 (B) one colonoscopy every 10 years;

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

12 \* \* \*

13 \* \* \* Pharmacy Benefit Managers \* \* \*

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

15 2021 Acts and Resolves No. 74, Sec. E.227.2, as amended by 2022 Acts

16 and Resolves No. 131, Sec. 7, is repealed.

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

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

19 Chapter 220. GREEN MOUNTAIN CARE BOARD

20 \* \* \*

1 § 9374. BOARD MEMBERSHIP; AUTHORITY

2 \* \* \*

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

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

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

11 \* \* \*

12 § 9391. NOMINATION AND APPOINTMENT PROCESS

13 (a) ~~Whenever~~ Candidate selection process.

14 (1) Unless a vacancy is filled by reappointment pursuant to subsection  
15 (c) of this section, not later than 90 days prior to a known vacancy ~~occurs~~  
16 occurring on the Green Mountain Care Board, or when an incumbent does not  
17 declare that he or she will be a candidate to succeed himself or herself, the  
18 Green Mountain Care Board Nominating Committee shall commence its  
19 nomination application process. The Committee shall select for consideration  
20 by the Committee, by majority vote, and provided that a quorum is present,  
21 from the applications for membership on the Green Mountain Care Board as

1 many candidates as it deems qualified for the position or positions to be filled.  
2 The Committee shall base its determinations on the qualifications set forth in  
3 section 9392 of this ~~section~~ title.

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

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

18 (c) Reappointment; notification. To be considered for reappointment to the  
19 Green Mountain Care Board, a Board member whose term is expiring shall  
20 notify the Governor, not later than 120 days prior to the member's term  
21 expiration date, that the member is seeking reappointment. If the Board

1 member is not reappointed by the Governor on or before 30 days after  
2 notifying the Governor, the member's term shall end on the expiration date of  
3 the member's current term, unless the member is nominated as provided in  
4 subsection (b) of this section and subsequently appointed or as otherwise  
5 provided by law. A Board member's reappointment shall be subject to the  
6 consent of the Senate.

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

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

17 \* \* \* Regulation; Insurance Rates; Hospital Budgets \* \* \*

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

19 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

20 \* \* \*

1 (b)(1) In conjunction with a rate filing required by subsection (a) of this  
2 section, an insurer shall file a plain language summary of the proposed rate.  
3 All summaries shall include a brief justification of any rate increase requested,  
4 the information that the Secretary of the U.S. Department of Health and  
5 Human Services (HHS) requires for rate increases over 10 percent, the amount  
6 of total premium revenue expended on care coordination and management, and  
7 any other information required by the Board. The plain language summary  
8 shall be in the format required by the Secretary of HHS pursuant to the Patient  
9 Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended  
10 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No.  
11 111-152, and shall include notification of the public comment period  
12 established in subsection (c) of this section. In addition, the insurer shall post  
13 the summaries on its website.

14 \* \* \*

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

16 § 9414a. ANNUAL REPORTING BY HEALTH INSURERS

17 \* \* \*

18 (b) Health insurers with a minimum of 2,000 Vermont lives covered at the  
19 end of the preceding year or who offer insurance through the Vermont Health  
20 Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall  
21 annually report the following information to the Commissioner of Financial

1 Regulation, in plain language, as an addendum to the health insurer's annual  
2 statement:

3 \* \* \*

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

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

8 (23) risk-based capital reports.

9 \* \* \*

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

11 § 9456. BUDGET REVIEW

12 \* \* \*

13 (d)(1) Annually, on or before September 15, followed by a written decision  
14 by October 1, the Board shall establish a budget for each hospital ~~on or before~~  
15 ~~September 15, followed by a written decision by October 1~~ that meets the  
16 acceptable range of comparison to the national, regional, or in-state peer group  
17 norms set forth in the indicators, ratios, and statistics pre-established by the  
18 Board as required by subdivision (c)(2) of this section, and is affordable;  
19 promotes quality care; promotes access to health care; protects solvency; and is  
20 not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.  
21 Each hospital shall operate within the budget established under this section.

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\* \* \*

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

1 multipayer alternative payment model or models established pursuant to the  
2 State's agreement with the Center for Medicare and Medicaid Innovation. In  
3 the event that no insurers elect to participate in Vermont's multipayer  
4 alternative payment model or models, the Department of Financial Regulation  
5 shall require health insurers, as defined in 18 V.S.A. § 9402, to participate in  
6 Vermont's multipayer alternative payment model as a condition of doing  
7 business in this State.

8 \* \* \* Effective Date \* \* \*

9 Sec. 17. EFFECTIVE DATES

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