TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred House Bill No. 766 entitled "An act relating to prior authorization and step therapy requirements, health insurance claims, provider contracts, and collection of cost sharing amounts" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

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;

(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.

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

§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other

appropriate nationally recognized standards, guidelines, or conventions approved by the Commissioner.

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

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

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

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

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

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

90 days prior to the date of the claim submission, the health plan, contracting entity, covered entity, or payer may use the version of the edit standard, process, or guideline that Medicare had applied prior to the most recent change if the health plan, contracting entity, covered entity, or payer has not yet released an updated version of its edits in accordance with subsection (d) of this section.

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

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

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

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

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

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

(d) Health plans, contracting entities, covered entities, and payers shall not release edits more than quarterly, to take effect on January 1, April 1, July 1, or October 1, as applicable, and the edits shall not be implemented without filing with the Commissioner of Financial Regulation to ensure consistency with nationally recognized standards guidelines, and conventions, and at least 30 days' advance notice to providers. Whenever Medicare changes an edit standard, process, or guideline that it applies to outpatient service, professional service, or facility claims, each health plan, contracting entity, covered entity, or payer shall incorporate those modifications into its next quarterly release of edits.

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

(2) Nothing in this subsection shall be construed to prohibit targeted prepayment coding validation edit review of a specific provider, provider

group, or facility under certain circumstances, including evaluating high-dollar claims; verifying complex financial arrangements; investigating member questions; conducting post-audit monitoring; addressing a reasonable belief of fraud, waste, or abuse; or other circumstances determined by the Commissioner through a bulletin or guidance.

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

* * *

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

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

~~(g)~~(i) Notwithstanding the provisions of subsection ~~(d)~~(f) of this section, and other than the edits contained in the conventions in subsections (a) and (b)

of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for services on other bases and shall have the right to reassign or reduce the code level for selected claims for services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

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

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

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

(3) the payment percentages for modifiers; and

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

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

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

~~(k)~~(m) ~~BlueCross BlueShield of Vermont and the Vermont Medical Society are requested to continue convening a work group consisting of~~ There is established a working group comprising the health plans, contracting entities, covered entities, and payers subject to the reporting requirement in subsection 9414a(b) of this title; representatives of hospitals and health care providers~~,~~; representatives of the Department of Financial Regulation and of other relevant State agencies~~,~~; and other interested parties to study ~~the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that~~

~~health care providers can access information about the edit standards applicable to the health care services they provide~~ trends in coding and billing that health plans, contracting entities, covered entities, or payers, or a combination of them, seek to address through claim editing. The ~~work~~ working group ~~is requested to~~ shall provide ~~an annual~~ a progress report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance upon request.

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

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

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

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

(2) A health plan shall not impose any prior authorization requirement for any admission, item, service, treatment, or procedure that is more restrictive than the prior authorization requirements that the Department of

Vermont Health Access would apply for the same admission, item, service, treatment, or procedure under Vermont's Medicaid program.

(3) Each health plan shall review the prior authorization requirements in effect in Vermont's Medicaid program at least once every six months to ensure that the health plan is maintaining the prior authorization alignment required by subdivision (2) of this subsection.

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

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

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

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

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

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

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

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

~~(4) A health plan shall respond to a completed prior authorization request from a prescribing health care provider within 48 hours after receipt for urgent requests and within two business days after receipt for nonurgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours after receipt.~~

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

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

(B) For nonurgent prior authorization requests:

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

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

(iii) If a health plan notifies an insured or a health care provider that more information is necessary pursuant to subdivision (ii) of this subdivision (4)(B), the health plan shall have 24 hours to approve or deny the request upon receipt of the necessary information.

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

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

(E) For an insured who is stable on a treatment, service, or course of medication, as determined by a health care provider, that was approved for

coverage under a previous health plan, a health plan shall not restrict coverage of that treatment, service, or course of medication for at least 90 days upon the insured's enrollment in the new health plan.

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

§ 9418c. FAIR CONTRACT STANDARDS

(a) Required information.

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

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

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

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

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

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

(iii) payment percentages for modifiers; and

(iv) any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product, which are made at the request of the health plan, contracting entity, covered entity, or payer, and which have been approved by the Commissioner pursuant to subsection 9418a(b) or (c) of this title.

(D) Any policies for prepayment or postpayment audits, or both, including whether the policies include limits on the number of medical records a contracting entity may request for audit in any calendar year.

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(5)(A) If a contracting entity uses policies or manuals to augment the content of the contract with a health care provider, the contracting entity shall ensure that those policies or manuals contain sufficient information to allow providers to understand and comply with the content.

(B) For any new policy or manual, or any change to an existing policy or manual, the contracting entity shall do all of the following:

(i) Provide notice of the new policy, manual, or change to each participating provider in writing not fewer than 60 days prior to the effective date of the policy, manual, or change, which notice shall be conspicuously entitled "Notice of Policy Change" and shall include:

(I) a summary of the new policy, manual, or change;

(II) an explanation of the policy, manual, or change;

(III) the effective date of the policy, manual, or change; and

(IV) a notice of the right to object in writing to the policy, manual, or change, along with a timeframe for objection and where and how to send the objection.

(ii) Provide the participating provider 60 days after receiving the notice and summary to object in writing to the new policy, manual, or change. If the participating provider objects to the new policy, manual, or change, the contracting entity shall provide an initial substantive response to the objection within 30 days following the contracting entity's receipt of the written objection, and the contracting entity shall work together with the provider to achieve a reasonable resolution to the objection within 60 days following the provider's receipt of contracting entity's initial substantive response. If the provider is not satisfied with the proposed resolution, the provider may pursue any remedy available to the provider under the health care contract or under applicable law.

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Sec. 6. PRIOR AUTHORIZATION; INSURER IMPACT REPORTS

On or before January 15, 2027, each health insurer with at least 2,000 covered lives in Vermont shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding the impact of the prior authorization provisions of this act on the following during plan years 2025 and 2026:

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

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

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

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

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

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

Sec. 7. PRIOR AUTHORIZATION; PROVIDER IMPACT REPORTS

(a) The General Assembly requests that organizations representing Vermont's hospital-employed, federally qualified health center-employed, and independent health care providers who are affected by the prior authorization provisions of this act gather information from their members on or before January 1, 2025 and on or before July 1, 2026 regarding current circumstances and the impact of the prior authorization provisions of this act on their provider members and the members' practices. To the extent practicable, the information gathered should align with survey questions published by nationally recognized provider organizations and include information regarding the impact of prior authorization processes and requirements on care delivery, quality of care, and staffing.

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

Sec. 8. REPEAL

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

Sec. 9. EFFECTIVE DATES

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

(b) Sec. 3 (18 V.S.A. § 9418b(g)(4); prior authorization time frames) shall take effect on January 1, 2025, except that a health plan that must modify its technology in order to continue administering its own internal utilization review process for certain services shall have until not later than January 1, 2026 to come into compliance with the provisions of Sec. 3 as to those services.

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

and that after passage the title of the bill be amended to read: "An act relating to prior authorization and step therapy requirements, health insurance claims, and provider contracts"

(Committee vote: _____)

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Representative _____

FOR THE COMMITTEE