H.766: Side-by-side comparison of Sec. 3 as passed by House and as proposed by Senate

Sec. 3 as passed by House	Sec. 3 as passed by Senate
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. 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)(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. (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.