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H.766

Introduced by Representatives Black of Essex, Houghton of Essex Junction,
Andrews of Westford, Berbeco of Winooski, Bos-Lun of
Westminster, Carpenter of Hyde Park, Cina of Burlington,
Cordes of Lincoln, Demar of Enosburgh, Dodge of Essex,
Dolan of Essex Junction, Farlice-Rubio of Barnet, Garofano of
Essex, Goldman of Rockingham, Graning of Jericho, McCarthy
of St. Albans City, McFaun of Barre Town, Ode of Burlington,
Peterson of Clarendon, Roberts of Halifax, and Waters Evans of
Charlotte

Referred to Committee on

Date:

Subject: Health; health insurance; prior authorization requirements;
prescription drugs; step therapy; claims edits; cost-sharing collections

Statement of purpose of bill as introduced: This bill proposes to modify the
time frames within which health plans must respond to prior authorization
requests; limit the occasions on which reauthorization is necessary for a
previously approved treatment, service, or course of medication; require health
plans to grant exceptions to prescription drug step-therapy requirements under
certain circumstances; and direct the Department of Financial Regulation to
prohibit prior authorization requirements for generic medications and for items

1 and services with low variation and low denial rates across health care
2 providers. The bill would modify provisions relating to the contracts between
3 health insurers and health care providers and the processing of claims under
4 those contracts. It would also require health insurers, not health care providers,
5 to collect cost-sharing amounts from patients.

6 An act relating to prior authorization and step therapy requirements, health
7 insurance claims, provider contracts, and collection of cost sharing amounts

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

9 Sec. 1. 8 V.S.A. § 4089i(e) is amended to read:

10 (e)(1) A health insurance or other health benefit plan offered by a health
11 insurer or by a pharmacy benefit manager on behalf of a health insurer that
12 provides coverage for prescription drugs and uses step-therapy protocols shall:

13 (A) not require failure, including discontinuation due to lack of
14 efficacy or effectiveness, diminished effect, or an adverse event, on the same
15 medication on more than one occasion for ~~continuously enrolled members or~~
16 ~~subscribers~~ insureds who are continuously enrolled in a plan offered by the
17 insurer or its pharmacy benefit manager; and

18 (B) grant an exception to its step-therapy protocols upon request of
19 an insured or the insured's treating health care professional under the same

1 time parameters as set forth for prior authorization requests in 18 V.S.A.

2 § 9418b(g)(4) if any one or more of the following conditions apply:

3 (i) the prescription drug required under the step-therapy protocol
4 is contraindicated or will likely cause an adverse reaction or physical or mental
5 harm to the insured;

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

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

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

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

20 (I) pose a barrier to adherence;

21 (II) likely worsen a comorbid condition; or

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

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

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

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

14 § 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE
15 TO CODING RULES

16 (a) Health plans, contracting entities, covered entities, and payers shall
17 accept and initiate the processing of all health care claims submitted by a
18 health care provider pursuant to and consistent with the current version of the
19 American Medical Association’s Current Procedural Terminology (CPT)
20 codes, reporting guidelines, and conventions; the Centers for Medicare and
21 Medicaid Services Healthcare Common Procedure Coding System (HCPCS);

1 American Society of Anesthesiologists; the National Correct Coding Initiative
2 (NCCI); the National Council for Prescription Drug Programs coding; or other
3 appropriate nationally recognized standards, guidelines, or conventions
4 approved by the Commissioner.

5 (b) When editing claims, health plans, contracting entities, covered entities,
6 and payers shall adhere to the edit standards, processes, and guidelines adopted
7 by NCCI except as provided in subsection (c) of this section:

8 ~~(1) the CPT, HCPCS, and NCCI;~~

9 ~~(2) national specialty society edit standards; or~~

10 ~~(3) other appropriate nationally recognized edit standards, guidelines, or~~
11 ~~conventions approved by the Commissioner.~~

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

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

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

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

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

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

11 ~~(g)~~(i) Notwithstanding the provisions of subsection ~~(d)~~(f) of this section,
12 and other than the edits contained in the conventions in subsections (a) and (b)
13 of this section, health plans, contracting entities, covered entities, and payers
14 shall continue to have the right to deny, pend, or adjust claims for services on
15 other bases and shall have the right to reassign or reduce the code level for
16 selected claims for services based on a review of the clinical information
17 provided at the time the service was rendered for the particular claim or a
18 review of the information derived from a health plan's fraud or abuse billing
19 detection programs that create a reasonable belief of fraudulent or abusive
20 billing practices, provided that the decision to reassign or reduce is based
21 primarily on a review of clinical information.

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

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

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

11 (3) the payment percentages for modifiers; and

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

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

1 ~~(j)~~(l) For purposes of this section, “health plan” includes a workers’
2 compensation policy of a casualty insurer licensed to do business in Vermont.
3 ~~(k)~~(m) ~~BlueCross BlueShield of Vermont and the Vermont Medical~~
4 ~~Society are requested to continue convening a work group consisting of~~ There
5 is established a working group comprising the health plans, contracting
6 entities, covered entities, and payers subject to the reporting requirement in
7 subsection 9414a(b) of this title; representatives of hospitals and health care
8 providers; representatives of the Department of Financial Regulation and of
9 other relevant State agencies; and other interested parties to study the edit
10 standards in subsection (b) of this section, the edit standards in national class
11 action settlements, and edit standards and edit transparency standards
12 established by other states to determine the most appropriate way to ensure that
13 health care providers can access information about the edit standards
14 applicable to the health care services they provide trends in coding and billing
15 that health plans, contracting entities, covered entities, or payers, or a
16 combination of them, seek to address through claim editing. The work group
17 is requested to provide an annual progress report to the House Committee on
18 Health Care and the Senate Committees on Health and Welfare and on
19 Finance.
20 ~~(j)~~(n) With respect to the work group established under subsection ~~(k)~~(m)
21 of this section and to the extent required to avoid violations of federal antitrust

1 laws, the Department shall facilitate and supervise the participation of
2 members of the work group.

3 Sec. 3. 18 V.S.A. § 9418b(g)(4) is amended to read:

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

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

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

19 (B) For nonurgent prior authorization requests:

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

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

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

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

16 (D) Prior authorization approval for a prescribed treatment, service,
17 or course of medication shall be valid for the duration of a prescribed or
18 ordered course of treatment or one year, whichever is longer.

19 (E) For an insured who is stable on a treatment, service, or course of
20 medication, as determined by a health care provider, that was approved for
21 coverage under a previous health plan, a health plan shall not restrict coverage

1 of that treatment, service, or course of medication for at least 90 days upon the
2 insured's enrollment in the new health plan.

3 Sec. 4. 18 V.S.A. § 9418b(i) is added to read:

4 (i)(1) The Department of Financial Regulation shall adopt rules, bulletins,
5 or other guidance that prohibits carriers from imposing prior authorization
6 requirements for any generic medication or for any admission, item, service,
7 treatment, procedure, or medication, or for any category of these, that have low
8 variation across health care providers and denial rates of less than 10 percent
9 across carriers.

10 (2) In developing its rules, bulletins, or other guidance, the Department
11 may rely on prior authorization data submitted by the health plans pursuant to
12 subsection (h) of this section and to section 9414a of this chapter.

13 (3) It is the intent of the General Assembly that the rules, bulletins, or
14 other guidance that the Department develops pursuant to this subsection should
15 be designed to apply to frequently used medications and services, especially
16 those ordered by primary care providers, and to achieve consistency in prior
17 authorization exemptions across health plans in order to meaningfully reduce
18 the administrative burden on health care providers.

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

20 § 9418c. FAIR CONTRACT STANDARDS

21 (a) Required information.

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

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

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

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

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

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

21 (iii) payment percentages for modifiers; and

1 (f) For purposes of this section, a health care contract is deemed to be
2 amended when a contracting entity institutes a new policy or manual, or
3 amends an existing policy or manual that is incorporated into a contract by
4 reference, and the new or amended policy or manual impacts the health care
5 provider’s reimbursement.

6 Sec. 7. 18 V.S.A. § 9423 is added to read:

7 § 9423. COLLECTION OF COST-SHARING BY HEALTH PLAN OR
8 OTHER PAYER

9 (a) As used in this section:

10 (1) “Cost sharing” means the share of costs covered by a health plan for
11 which an insured is financially responsible.

12 (2)(A) “Cost sharing” includes deductibles, coinsurance, co-payments,
13 and similar charges.

14 (B) “Cost sharing” does not include premiums, balance billing
15 amounts for out-of-network providers, or the cost of noncovered health care
16 services.

17 (3) “Health benefit plan” means any individual or group health
18 insurance policy, any hospital or medical service corporation or health
19 maintenance organization subscriber contract, or any other plan offered,
20 issued, or renewed for any person in this State by a health plan or other payer,
21 as those terms are described in section 9418 of this title. The term does not

1 include benefit plans providing coverage for a specific disease or other limited
2 benefit coverage.

3 (4) “Health care services” means services for the diagnosis, prevention,
4 treatment, cure, or relief of a physical, dental, behavioral, or mental health
5 condition or substance use disorder, including procedures, products, devices,
6 and medications.

7 (b) A health plan or other payer shall:

8 (1) pay a health care provider the full amount due for health care
9 services under the terms of a health benefit plan, including any cost sharing;

10 (2) have the sole responsibility for collecting cost sharing from an
11 insured; and

12 (3) upon request of an insured, collect cost sharing throughout the plan
13 year in increments defined by the health plan or other payer.

14 (c) A health plan or other payer shall not:

15 (1) withhold any amount for cost sharing from the payment to a health
16 care provider; or

17 (2) require a health care provider to offer additional discounts to
18 insureds outside the terms of the health care contract between the health plan
19 or other payer and the health care provider.

1 (d) Any value of a co-payment assistance coupon or similar assistance
2 program shall be applied to an enrollee’s annual cost-sharing requirement and
3 may be paid directly to the health plan or other payer on the insured’s behalf.

4 (e) A health plan or other payer shall not cancel the health benefit plan of
5 an insured who does not remit or otherwise pay a cost-sharing amount due for
6 services rendered.

7 (f) Any expenses related to implementation of this section by a health plan
8 or other payer shall not be used as justification to increase premiums or
9 decrease payments to a health care provider.

10 (g) A violation of this section is an unfair or deceptive act or practice in the
11 business of insurance in violation of 8 V.S.A. § 4723. All remedies, penalties,
12 and authority granted to the Commissioner of Financial Regulation under
13 8 V.S.A. § 4726 shall be available to the Commissioner to enforce this section.

14 (h) The Department of Financial Regulation may adopt rules in accordance
15 with 3 V.S.A. chapter 25 as needed to implement and administer this section.

16 Sec. 8. EFFECTIVE DATES

17 (a) Sec. 4 (18 V.S.A. § 9418b(i)) and this section shall take effect on
18 passage, with the Department of Financial Regulation’s rules, bulletins, or
19 other guidance to be adopted on or before March 1, 2025 and applicable to all
20 health plans issued on and after January 1, 2026.

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