TO THE HONORABLE SENATE:

The Committee on Health and Welfare to which was referred Senate Bill No. 151 entitled "An act relating to pay parity and transparency in health care" 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. § 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. 2. 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~~ 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~~ for an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

* * *

~~Sec. 3. 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.~~

Sec. 4. 18 V.S.A. chapter 21, subchapter 3 is amended to read:

Subchapter 3. ~~Venereal Diseases~~ Sexually Transmitted Infections

* * *

§ 1107. CONSENT TO PREVENTIVE SERVICES AND TREATMENT 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.

(c) A minor 12 years of age or older who has or is suspected to have a sexually transmitted infection may consent to treatment in accordance with the provisions of section 4226 of this title.

Sec. 5. 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. 4 of this act, provided the revisions have no effect on the meaning of the affected statutes: replace "venereal disease" with "sexually transmitted infection."

Sec. 6. 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. 7. 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. 8. 18 V.S.A. chapter 220 is amended to read:

CHAPTER 220. GREEN MOUNTAIN CARE BOARD

* * *

§ 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.~~

* * *

§ 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~~ 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 ~~occurs~~ 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~~ individuals it deems qualified to be appointed to fill the position or positions and the name of any incumbent member who was not reappointed pursuant to subsection (c) of this section and who ~~declares~~ notifies the Committee Chair that ~~he or she~~ the incumbent 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.

~~(c)~~(d) ~~The~~ **Appointment; Senate consent.** 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) **Confidentiality.** 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.

Sec. 8a. 18 V.S.A. § 9406 is added to read: **(NEW; from S.211)**

§ 9406. GREEN MOUNTAIN CARE BOARD; MEDIATION PRIOR TO TERMINATION OR NONRENEWAL

At least 60 days prior to the termination of a contract between a health care provider, including a health care facility, and a health plan issued or offered by a health insurer, the parties shall utilize the mediation services of the Green Mountain Care Board to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on the parties.

Sec. 8b. 18 V.S.A. § 9453 is amended to read: (NEW)

§ 9453. POWERS AND DUTIES

(a) The Board shall:

(1) adopt uniform formats that hospitals shall use to report financial, scope-of-services, and utilization data and information;

(2) designate a data organization with which hospitals shall file financial, scope-of-services, and utilization data and information; ~~and~~

(3) designate a data organization or organizations to process, analyze, store, or retrieve data or information**; and**

(4) develop a methodology for establishing hospital global budgets.

(b) To effectuate the purposes of this subchapter, the Board may adopt rules under 3 V.S.A. chapter 25.

Sec. 9. 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.

* * *

(e)**(1)** The Board may establish a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks. **Any such criteria or benchmarks shall be set at the hospital level or across the health care system, and not at an individual cost center or service level. The Board shall consult with stakeholders prior to establishing any such criteria or benchmarks; any criteria or benchmarks shall be established not later than March 31 annually and shall not be adjusted or amended during the budget process except by mutual agreement of the affected parties. (NEW; from S.211)**

(2) The Board may waive one or more of the review processes listed in subsection (b) of this section.

* * *

Sec. 10. 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~~ medically necessary prescription medications for chronic conditions of injured employees, in accordance with rules adopted by the Commissioner.

* * *

Sec. 11. 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. 11a. AHEAD MODEL; LEGISLATIVE INTENT (NEW)

(a) It is the intent of the General Assembly that the State of Vermont apply for and consider participating in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model with the Centers for Medicare and Medicaid Services, which includes hospital global budgets, increased investment in primary care, continued investment in the Support and Services at Home (SASH) program, and improvements in health equity. If the State of Vermont is selected, it is the intent of the General Assembly that the State participate in the Model beginning on January 1, 2026, provided the Model is determined to be beneficial in addressing the State's goals of improving affordability, access to care, quality of care, health equity, and hospital sustainability.

(b) It is the intent of the General Assembly that global hospital budgets include the participation of all major payers and insurers and of Vermont hospitals, and that the budgets will be sustainable for all types of hospitals in the State, with the goal of improving affordability, accessibility, and quality of care for Vermonters.

(c) It is the intent of the General Assembly that any agreement entered into between the State and the federal government for Vermont's participation in the AHEAD Model:

(1) acknowledges the decades of successful implementation of payment reform initiatives that have made Vermont one of the lowest Medicare-spending states, despite having one of the oldest populations, by investing in primary care, integration of health and human services, SASH, the rural health system, and critical hospital transformation efforts;

(2) accounts for the savings generated by these initiatives to achieve the sustainability of the rural health care system; and

(3) acknowledges the continued costs to the system due to ongoing pressures from the global COVID-19 pandemic and health care inflation, including the increased costs of staffing to meet workforce needs, by ensuring a model that creates transparent and sustainable payments to providers.

(d) It is the intent of the General Assembly that the Administration and the Green Mountain Care Board, in their negotiations and plan for the AHEAD Model with the Centers for Medicare and Medicaid Services, identify any necessary modifications to the regulatory structures in Vermont law and recommend those changes to the General Assembly in a timely manner in order to have them considered prior to the Model's implementation.

Sec. 12. GREEN MOUNTAIN CARE BOARD; HEALTH CARE CONTRACTS; FEE SCHEDULES; REPORT

(a)**(1)** 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.

(2) The Board shall examine reimbursement rates for different types of health care professionals, including primary care providers, physical therapists, and other allied health professionals, and identify opportunities to modify reimbursement rates in a manner that increases equity across health care providers and health care settings.

(b) On or before January 15, 2025, 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. **The Board shall also recommend ways to create greater equity in reimbursement rates across health care providers and health care settings.**

(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.

Sec. 12b. GREEN MOUNTAIN CARE BOARD REGULATORY REVIEW; REALIGNMENT REPORT **(NEW; from S.211)**

The Green Mountain Care Board, in consultation with the Director of Health Care Reform in the Agency of Human Services, shall evaluate realignment of the timing of the Green Mountain Care Board's regulatory processes. The evaluation shall build and expand upon the Board's regulatory alignment efforts and may include considering alternative models such as multi-year budget reviews, multi-year financial stability audits, and other regulatory processes that achieve the State's goals of improving the health of the population and reducing the per capita rate of cost growth while ensuring access to and quality of health care. The Board shall report its findings and recommendations to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on or before January 15, 2025.

Sec. 13. EFFECTIVE DATE

This act shall take effect on July 1, 2024.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE