

S.252

An act relating to financing for Green Mountain Care.

The House proposes to the Senate to amend the bill by striking all after the enacting clause and inserting in lieu thereof the following:

\* \* \* Intent and Principles \* \* \*

Sec. 1. LEGISLATIVE INTENT; FINDINGS; PURPOSE

(a)(1) It is the intent of the General Assembly to continue moving forward toward implementation of Green Mountain Care, a publicly financed program of universal and unified health care.

(2) It is the intent of the General Assembly not to change in any way the benefits provided to Vermont residents by Medicare, the Federal Employees Health Benefit Program, TRICARE, a retiree health program, or any other health benefit program beyond the regulatory authority of the State of Vermont.

(b) The General Assembly finds that:

(1) It has been three years since the passage of 2011 Acts and Resolves No. 48 (Act 48), which established the Green Mountain Care Board, authorized payment reform initiatives, and created the framework for the Vermont Health Benefit Exchange and Green Mountain Care.

(2) The Green Mountain Care Board currently regulates health insurance rates, hospital budgets, and certificates of need. In 2013, the Green Mountain

Care Board's hospital budget review limited hospital growth to 2.7 percent, the lowest annual growth rate in Vermont for at least the last 15 years. The Green Mountain Care Board issued four certificates of need and one conceptual development phase certificate of need. It also issued 31 health insurance rate decisions and reduced by approximately five percent the rates proposed by insurers in the Vermont Health Benefit Exchange.

(3) In 2013, Vermont was awarded a three-year State Innovation Model (SIM) grant of \$45 million to improve health and health care and to lower costs for Vermont residents. The grant funds the creation of a sustainable model of multi-payer payment and delivery reform, encouraging providers to change the way they do business in order to deliver the right care at the right time in the right setting. The State has created a 300-person public-private stakeholder group to work collaboratively on creating appropriate payment and delivery system models. Through this structure, care management models are being coordinated across State agencies and health care providers, including the Blueprint for Health, the Vermont Chronic Care Initiative, and accountable care organizations.

(4) From the SIM grant funds, the State recently awarded \$2.6 million in grants to health care providers for innovative pilot programs improving care delivery or for creating the capacity and infrastructure for care delivery reforms.

(5) Three accountable care organizations (ACOs) have formed in Vermont: one led by hospitals, one led by federally qualified health centers, and one led by independent physicians. The Green Mountain Care Board has approved payment and quality measures for ACOs, which create substantial uniformity across payers and will provide consistent measurements for health care providers.

(6) The Vermont Health Benefit Exchange has completed its first open enrollment period. Vermont has more people enrolled through its Exchange per capita than are enrolled in any other state-based Exchange, but many Vermonters experienced difficulties during the enrollment period and not all aspects of Vermont's Exchange are fully functional.

(7) According to the 2013 Blueprint for Health Annual Report, Vermont residents receiving care from a patient-centered medical home and community health team had favorable outcomes over comparison groups in reducing expenditures and reducing inpatient hospitalizations. As of December 31, 2013, 121 primary care practices were participating in the Blueprint for Health, serving approximately 514,385 Vermonters.

(8) The Agency of Human Services has adopted the modified adjusted gross income standard under the Patient Protection and Affordable Care Act, further streamlining the Medicaid application process.

(9) Vermonters currently spend over \$2.5 billion per year on private funding of health care through health insurance premiums and out-of-pocket expenses. Act 48 charts a course toward replacing that spending with a publicly financed system.

(10) There is no legislatively determined time line in Act 48 for the implementation of Green Mountain Care. A set of triggers focusing on decisions about financing, covered services, benefit design, and the impacts of Green Mountain Care must be satisfied, and a federal waiver received, before launching Green Mountain Care. In addition, the Green Mountain Care Board must be satisfied that reimbursement rates for providers will be sufficient to recruit and retain a strong health care workforce to meet the needs of all Vermonters.

(11) Act 48 required the Secretary of Administration to provide a financing plan for Green Mountain Care by January 15, 2013. The financing plan delivered on January 24, 2013 did not “recommend the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private universal health care system,” or recommend solutions to cross-border issues, as required by Sec. 9 of Act 48. The longer it takes the Secretary to produce a complete financing plan, the longer it will be until Green Mountain Care can be implemented.

(c) In order to implement the next steps envisioned by Act 48 successfully, it is appropriate to update the assumptions and cost estimates that formed the basis for that act, evaluate the success of existing health care reform efforts, and obtain information relating to key outstanding policy decisions. It is the intent of the General Assembly to obtain a greater understanding of the impact of health care reform efforts currently under way and to take steps toward implementation of the universal and unified health system envisioned by Act 48.

(d) Before making final decisions about the financing for Green Mountain Care, the General Assembly must have accurate data on the direct and indirect costs of the current health care system and how the new system will impact individual decisions about accessing care.

(e) The General Assembly also must consider the benefits and risks of a new health care system on Vermont's businesses when there are new public financing mechanisms in place, when businesses no longer carry the burden of providing health coverage, when employees no longer fear losing coverage when they change jobs, and when business start-ups no longer have to consider health coverage.

(f) The General Assembly must ensure that Green Mountain Care does not go forward if the financing is not sufficient, fair, predictable, transparent, sustainable, and shared equitably.

(g) The General Assembly must be satisfied that an appropriate plan of action is in place in order to accomplish the transitions needed for successful implementation of Green Mountain Care.

Sec. 2. PRINCIPLES FOR HEALTH CARE FINANCING

The General Assembly adopts the following principles to guide the financing of health care in Vermont:

(1) All Vermont residents have the right to high-quality health care.

(2) All Vermont residents shall contribute to the financing for Green Mountain Care through taxes that are levied equitably, taking into account an individual's ability to pay and the value of the health benefits provided so that access to health care will not be limited by cost barriers.

(3) The financing system shall maximize opportunities to take advantage of federal tax credits and deductions.

(4) As provided in 33 V.S.A. § 1827, Green Mountain Care shall be the payer of last resort for Vermont residents who continue to receive health care through plans provided by an employer, by a federal health benefit plan, by Medicare, by a foreign government, or as a retirement benefit.

(5) Vermont's system for financing health care shall raise revenue sufficient to provide medically necessary health care services to all Vermont residents, including:

(A) ambulatory patient services;

(B) emergency services;

(C) hospitalization;

(D) maternity and newborn care;

(E) mental health and substance use disorder services, including behavioral health treatment;

(F) prescription drugs;

(G) rehabilitative and habilitative services and devices;

(H) laboratory services;

(I) preventive and wellness services and chronic care management; and

(J) pediatric services, including oral and vision care.

\* \* \* Vermont Health Benefit Exchange \* \* \*

Sec. 3. 33 V.S.A. § 1803 is amended to read:

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

\* \* \*

(b)(1)(A) The Vermont Health Benefit Exchange shall provide qualified individuals and qualified employers with qualified health benefit plans, including the multistate plans required by the Affordable Care Act, with effective dates beginning on or before January 1, 2014. The Vermont Health Benefit Exchange may contract with qualified entities or enter into

intergovernmental agreements to facilitate the functions provided by the Vermont Health Benefit Exchange.

\* \* \*

(4) To the extent permitted by the U.S. Department of Health and Human Services, the Vermont Health Benefit Exchange shall permit qualified employers to purchase qualified health benefit plans through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

\* \* \*

Sec. 4. 33 V.S.A. § 1811(b) is amended to read:

(b)(1) No person may provide a health benefit plan to an individual or ~~small employer~~ unless the plan is offered through the Vermont Health Benefit Exchange and ~~complies with the provisions of this subchapter.~~

(2) To the extent permitted by the U.S. Department of Health and Human Services, a small employer or an employee of a small employer may purchase a health benefit plan through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

(3) No person may provide a health benefit plan to an individual or small employer unless the plan complies with the provisions of this subchapter.

Sec. 5. PURCHASE OF SMALL GROUP PLANS DIRECTLY FROM  
CARRIERS

To the extent permitted by the U.S. Department of Health and Human Services and notwithstanding any provision of State law to the contrary, the Department of Vermont Health Access shall permit employers purchasing qualified health benefit plans on the Vermont Health Benefit Exchange to purchase the plans through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

Sec. 6. OPTIONAL EXCHANGE COVERAGE FOR EMPLOYERS WITH  
UP TO 100 EMPLOYEES

(a)(1) If permitted under federal law and notwithstanding any provision of Vermont law to the contrary, prior to January 1, 2016, health insurers may offer health insurance plans through or outside the Vermont Health Benefit Exchange to employers that employed an average of at least 51 but not more than 100 employees on working days during the preceding calendar year. Calculation of the number of employees shall not include a part-time employee who works fewer than 30 hours per week or a seasonal worker as defined in 26 U.S.C. § 4980H(c)(2)(B).

(2) Health insurers may make Exchange plans available to an employer described in subdivision (1) of this subsection if the employer:

(A) has its principal place of business in this State and elects to provide coverage for its eligible employees through the Vermont Health Benefit Exchange, regardless of where an employee resides; or

(B) elects to provide coverage through the Vermont Health Benefit Exchange for all of its eligible employees who are principally employed in this State.

(3) Beginning on January 1, 2016, health insurers may only offer health insurance plans to the employers described in this subsection through the Vermont Health Benefit Exchange in accordance with 33 V.S.A. chapter 18, subchapter 1.

(b)(1) As soon as permitted under federal law and notwithstanding any provision of Vermont law to the contrary, prior to January 1, 2016, employers may purchase health insurance plans through or outside the Vermont Health Benefit Exchange if they employed an average of at least 51 but not more than 100 employees on working days during the calendar year. Calculation of the number of employees shall not include a part-time employee who works fewer than 30 hours per week or a seasonal worker as defined in 26 U.S.C. § 4980H(c)(2)(B).

(2) An employer of the size described in subdivision (1) of this subsection may purchase coverage for its employees through the Vermont Health Benefit Exchange if the employer:

(A) has its principal place of business in this State and elects to provide coverage for its eligible employees through the Vermont Health Benefit Exchange, regardless of where an employee resides; or

(B) elects to provide coverage through the Vermont Health Benefit Exchange for all of its eligible employees who are principally employed in this State.

\* \* \* Health Insurance Rate Review \* \* \*

Sec. 6a. 8 V.S.A. § 4062(h) is amended to read:

(h)(1) ~~This~~ The authority of the Board under this section shall apply only to the rate review process for policies for major medical insurance coverage and shall not apply to the policy forms for major medical insurance coverage or to the rate and policy form review process for policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, student health insurance coverage, or other limited benefit coverage; to Medicare supplemental insurance; or to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred.

(2) The policy forms for major medical insurance coverage, as well as the policy forms, premium rates, and rules for the classification of risk for the other lines of insurance described in subdivision (1) of this subsection shall be

reviewed and approved or disapproved by the Commissioner. In making his or her determination, the Commissioner shall consider whether a policy form, premium rate, or rule is affordable and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. The Commissioner shall make his or her determination within 30 days after the date the insurer filed the policy form, premium rate, or rule with the Department. At the expiration of the 30-day period, the form, premium rate, or rule shall be deemed approved unless prior thereto it has been affirmatively approved or disapproved by the Commissioner or found to be incomplete. The Commissioner shall notify an insurer in writing if the insurer files any form, premium rate, or rule containing a provision that does not meet the standards expressed in this subsection. In such notice, the Commissioner shall state that a hearing will be granted within 20 days upon the insurer's written request.

(3) Medicare supplemental insurance policies shall be exempt only from the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care Board's approval on rate requests and shall be subject to the remaining provisions of this section.

\* \* \* Green Mountain Care \* \* \*

Sec. 7. UPDATES ON TRANSITION TO GREEN MOUNTAIN CARE

(a) The Secretary of Administration or designee shall provide updates at least quarterly to the House Committees on Health Care and on Ways and

Means and the Senate Committees on Health and Welfare and on Finance regarding the Agency's progress to date on:

(1) determining the elements of Green Mountain Care, such as claims administration and provider relations, for which the Agency plans to solicit bids for administration pursuant to 33 V.S.A. § 1827(a), and preparing a description of the job or jobs to be performed, the bid qualifications, and the criteria by which bids will be evaluated; and

(2) developing a proposal to transition to and fully implement Green Mountain Care as required by Sec. 26 of this act.

(b) The Green Mountain Care Board shall provide updates at least quarterly to the House Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare and on Finance regarding the Board's progress to date on:

(1) defining the Green Mountain Care benefit package;

(2) deciding whether to include dental, vision, hearing, and long-term care benefits in Green Mountain Care;

(3) determining whether and to what extent to impose cost-sharing requirements in Green Mountain Care; and

(4) making the determinations required for Green Mountain Care implementation pursuant to 33 V.S.A. § 1822(a)(5).

Sec. 8. 33 V.S.A. § 1825 is amended to read:

§ 1825. HEALTH BENEFITS

(a)(1) Green Mountain Care shall include primary care, preventive care, chronic care, acute episodic care, and hospital services and shall include at least the same covered services as ~~those included in the benefit package in effect for the lowest cost Catamount Health plan offered on January 1, 2011~~ are available in the benchmark plan for the Vermont Health Benefit Exchange.

(2) It is the intent of the General Assembly that Green Mountain Care provide a level of coverage that includes benefits that are actuarially equivalent to at least 87 percent of the full actuarial value of the covered health services.

(3) The Green Mountain Care Board shall consider whether to impose cost-sharing requirements; if so, ~~whether~~ how to make the cost-sharing requirements income-sensitized; and the impact of any cost-sharing requirements on an individual's ability to access care. The Board shall consider waiving any cost-sharing requirement for evidence-based primary and preventive care; for palliative care; and for chronic care for individuals participating in chronic care management and, where circumstances warrant, for individuals with chronic conditions who are not participating in a chronic care management program.

(4)(A) The Green Mountain Care Board established in 18 V.S.A. chapter 220 shall consider whether to include dental, vision, and hearing benefits in the Green Mountain Care benefit package.

(B) The Green Mountain Care Board shall consider whether to include long-term care benefits in the Green Mountain Care benefit package.

(5) Green Mountain Care shall not limit coverage of preexisting conditions.

(6) The Green Mountain Care ~~board~~ Board shall approve the benefit package and present it to the General Assembly as part of its recommendations for the Green Mountain Care budget.

(b)(1)(A) For individuals eligible for Medicaid or CHIP, the benefit package shall include the benefits required by federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

(B) Upon implementation of Green Mountain Care, the benefit package for individuals eligible for Medicaid or CHIP shall also include any optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services covered under the State plan for CHIP as provided in 42 U.S.C. § 1397cc for which these individuals are eligible on January 1, 2014. Beginning with the second year of Green Mountain Care and going forward, the Green Mountain Care Board may, consistent with federal law, modify these optional benefits, as long

as at all times the benefit package for these individuals contains at least the benefits described in subdivision (A) of this subdivision (b)(1).

(2) For children eligible for benefits paid for with Medicaid funds, the benefit package shall include early and periodic screening, diagnosis, and treatment services as defined under federal law.

(3) For individuals eligible for Medicare, the benefit package shall include the benefits provided to these individuals under federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

Sec. 9. 33 V.S.A. § 1827 is amended to read:

§ 1827. ADMINISTRATION; ENROLLMENT

(a)(1) The Agency shall, under an open bidding process, solicit bids from and award contracts to public or private entities for administration of certain elements of Green Mountain Care, such as claims administration and provider relations.

(2) The Agency shall ensure that entities awarded contracts pursuant to this subsection do not have a financial incentive to restrict individuals' access to health services. The Agency may establish performance measures that provide incentives for contractors to provide timely, accurate, transparent, and courteous services to individuals enrolled in Green Mountain Care and to health care professionals.

(3) When considering contract bids pursuant to this subsection, the Agency shall consider the interests of the State relating to the economy, the location of the entity, and the need to maintain and create jobs in Vermont. The ~~agency~~ Agency may utilize an econometric model to evaluate the net costs of each contract bid.

\* \* \*

(e) [Repealed.]

(f) Green Mountain Care shall be the ~~secondary~~ payer of last resort with respect to any health service that may be covered in whole or in part by any other health benefit plan, including Medicare, private health insurance, retiree health benefits, or federal health benefit plans offered by ~~the Veterans' Administration,~~ by the military, or to federal employees.

\* \* \*

#### Sec. 10. CONCEPTUAL WAIVER APPLICATION

On or before November 15, 2014, the Secretary of Administration or designee shall submit to the federal Center for Consumer Information and Insurance Oversight a conceptual waiver application expressing the intent of the State of Vermont to pursue a Waiver for State Innovation pursuant to Sec. 1332 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010,

Pub. L. No. 111-152, and the State's interest in commencing the application process.

\* \* \* Employer Assessment \* \* \*

Sec. 11. 21 V.S.A. § 2003(b) is amended to read:

(b) For ~~any~~ each quarter in fiscal ~~years 2007 and 2008~~ year 2015, the amount of the Health Care Fund contribution shall be ~~\$91.25~~ \$133.30 for each full-time equivalent employee in excess of ~~eight~~ four. For each fiscal year after fiscal year ~~2008, the number of excluded full-time equivalent employees shall be adjusted in accordance with subsection (a) of this section, and~~ 2015, the amount of the Health Care Fund contribution shall be adjusted by a percentage equal to any percentage change in premiums for the second lowest cost silver-level plan in the Vermont Health Benefit Exchange.

\* \* \* Green Mountain Care Board \* \* \*

Sec. 12. 18 V.S.A. § 9375(b) is amended to read:

(b) The Board shall have the following duties:

\* \* \*

(4) Review the Health Resource Allocation Plan created in chapter 221 of this title, including conducting regular assessments of the range and depth of health needs among the State's population and developing a plan for allocating resources over a reasonable period of time to meet those needs.

\* \* \*

Sec. 13. 18 V.S.A. § 9375(d) is amended to read:

(d) Annually on or before January 15, the Board shall submit a report of its activities for the preceding calendar year to the House Committee on Health Care ~~and~~ the Senate Committee on Health and Welfare, and the Joint Fiscal Committee.

\* \* \*

Sec. 14. 2000 Acts and Resolves No. 152, Sec. 117b, as amended by 2013 Acts and Resolves No. 79, Sec. 42, is further amended to read:

Sec. 117b. MEDICAID COST SHIFT REPORTING

\* \* \*

(b) Notwithstanding 2 V.S.A. § 20(d), annually on or before ~~December~~ January 15, the ~~chair~~ Chair of the Green Mountain Care Board, the Commissioner of Vermont Health Access, and each acute care hospital shall file with the Joint Fiscal Committee, the House Committee on Health Care, and the Senate Committee on Health and Welfare, in the manner required by the Joint Fiscal Committee, such information as is necessary to carry out the purposes of this section. Such information shall pertain to the provider delivery system to the extent it is available. The Green Mountain Care Board may satisfy its obligations under this section by including the information required by this section in the annual report required by 18 V.S.A. § 9375(d).

\* \* \*

Sec. 15. 2013 Acts and Resolves No. 79, Sec. 5b is amended to read:

Sec. 5b. STANDARDIZED HEALTH INSURANCE CLAIMS AND  
EDITS

(a)(1) As part of moving away from fee-for-service and toward other models of payment for health care services in Vermont, the Green Mountain Care Board, in consultation with the Department of Vermont Health Access, health care providers, health insurers, and other interested stakeholders, shall develop a complete set of standardized edits and payment rules based on Medicare or on another set of standardized edits and payment rules appropriate for use in Vermont. The Board and the Department shall adopt by rule the standards and payment rules that health care providers, health insurers, Medicaid, and other payers shall use beginning on ~~January 1, 2015 and that Medicaid shall use beginning on~~ January 1, 2017.

\* \* \*

\* \* \* Certificates of Need \* \* \*

Sec. 15a. 18 V.S.A. § 9432 is amended to read:

§ 9432. DEFINITIONS

As used in this subchapter:

\* \* \*

(8) "Health care facility" means all persons or institutions, including mobile facilities, whether public or private, proprietary or not for profit, which

offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any institution operated by religious groups relying solely on spiritual means through prayer for healing, but shall include ~~but is not limited to:~~

(A) hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the ~~state~~ State of Vermont, or its subdivisions, or a duly authorized agency thereof; and

(B) nursing homes, health maintenance organizations, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, ~~or~~ and any inpatient or ambulatory surgical, diagnostic, or treatment center, including non-emergency walk-in centers.

\* \* \*

(15) "Non-emergency walk-in center" means an outpatient or ambulatory diagnostic or treatment center at which a patient without making an appointment may receive medical care that is not of an emergency, life-threatening nature. The term includes facilities that are self-described as urgent care centers, retail health clinics, and convenient care clinics.

Sec. 15b. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the board. ~~For purposes of~~ As used in this subsection, a “new health care project” includes the following:

\* \* \*

(6) The construction, development, purchase, lease, or other establishment of an ambulatory surgical center or non-emergency walk-in center.

\* \* \*

Sec. 15c. 18 V.S.A. § 9435 is amended to read:

§ 9435. EXCLUSIONS

(a) Excluded from this subchapter are offices of physicians, dentists, or other practitioners of the healing arts, meaning the physical places which are occupied by such providers on a regular basis in which such providers perform the range of diagnostic and treatment services usually performed by such providers on an outpatient basis unless they are subject to review under subdivision 9434(a)(4) of this title.

\* \* \*

(c) The provisions of subsection (a) of this section shall not apply to offices owned, operated, or leased by a hospital or its subsidiary, parent, or holding company, outpatient diagnostic or therapy programs, kidney disease treatment centers, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, ambulatory surgical centers, non-emergency walk-in centers, and diagnostic imaging facilities and similar facilities owned or operated by a physician, dentist, or other practitioner of the healing arts.

\* \* \*

Sec. 15d. 18 V.S.A. § 9492 is added to read:

§ 9492. NON-EMERGENCY WALK-IN CENTERS;

NONDISCRIMINATION

A non-emergency walk-in center, as defined in subdivision 9432(15) of this title, shall accept patients of all ages for diagnosis and treatment of illness, injury, and disease during all hours that the center is open to see patients. A non-emergency walk-in center shall not discriminate against any patient or prospective patient on the basis of insurance status or type of health coverage.

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

Sec. 16. 18 V.S.A. § 9472 is amended to read:

§ 9472. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES

WITH RESPECT TO HEALTH INSURERS

(c) ~~Unless the contract provides otherwise, a~~ A pharmacy benefit manager that provides pharmacy benefit management for a health plan shall:

(1) Provide all financial and utilization information requested by a health insurer relating to the provision of benefits to beneficiaries through that health insurer's health plan and all financial and utilization information relating to services to that health insurer. A pharmacy benefit manager providing information under this subsection may designate that material as confidential. Information designated as confidential by a pharmacy benefit manager and provided to a health insurer under this subsection may not be disclosed by the health insurer to any person without the consent of the pharmacy benefit manager, except that disclosure may be made by the health insurer:

(A) in a court filing under the consumer protection provisions of 9 V.S.A. chapter 63, provided that the information shall be filed under seal and that prior to the information being unsealed, the court shall give notice and an opportunity to be heard to the pharmacy benefit manager on why the information should remain confidential;

(B) when authorized by 9 V.S.A. chapter 63;

(C) when ordered by a court for good cause shown; or

(D) when ordered by the ~~commissioner~~ Commissioner as to a health insurer as defined in subdivision 9471(2)(A) of this title pursuant to the provisions of Title 8 and this title.

(2) Notify a health insurer in writing of any proposed or ongoing activity, policy, or practice of the pharmacy benefit manager that presents, directly or indirectly, any conflict of interest with the requirements of this section.

(3) With regard to the dispensation of a substitute prescription drug for a prescribed drug to a beneficiary in which the substitute drug costs more than the prescribed drug and the pharmacy benefit manager receives a benefit or payment directly or indirectly, disclose to the health insurer the cost of both drugs and the benefit or payment directly or indirectly accruing to the pharmacy benefit manager as a result of the substitution.

(4) ~~If~~ Unless the contract provides otherwise, if the pharmacy benefit manager derives any payment or benefit for the dispensation of prescription drugs within the ~~state~~ State based on volume of sales for certain prescription drugs or classes or brands of drugs within the ~~state~~ State, pass that payment or benefit on in full to the health insurer.

(5) Disclose to the health insurer all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefit manager and any prescription drug manufacturer that relate to benefits provided to beneficiaries under or services to the health insurer's health plan, including formulary management and drug-switch programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees. A pharmacy benefit manager providing information under this subsection may designate that material as confidential. Information designated as confidential by a pharmacy benefit manager and provided to a health insurer under this subsection may not be disclosed by the health insurer to any person without the consent of the pharmacy benefit manager, except that disclosure may be made by the health insurer:

(A) in a court filing under the consumer protection provisions of 9 V.S.A. chapter 63, provided that the information shall be filed under seal and that prior to the information being unsealed, the court shall give notice and an opportunity to be heard to the pharmacy benefit manager on why the information should remain confidential;

(B) when authorized by 9 V.S.A. chapter 63;

(C) when ordered by a court for good cause shown; or

(D) when ordered by the ~~commissioner~~ Commissioner as to a health insurer as defined in subdivision 9471(2)(A) of this title pursuant to the provisions of Title 8 and this title.

(d) At least annually, a pharmacy benefit manager that provides pharmacy benefit management for a health plan shall disclose to the health insurer, the Department of Financial Regulation, and the Green Mountain Care Board the aggregate amount the pharmacy benefit manager retained on all claims charged to the health insurer for prescriptions filled during the preceding calendar year in excess of the amount the pharmacy benefit manager reimbursed pharmacies.

(e) Compliance with the requirements of this section is required for pharmacy benefit managers entering into contracts with a health insurer in this ~~state~~ State for pharmacy benefit management in this ~~state~~ State.

Sec. 17. 18 V.S.A. § 9473 is redesignated to read:

§ ~~9473~~ 9474. ENFORCEMENT

Sec. 18. 18 V.S.A. § 9473 is added to read:

§ 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES

WITH RESPECT TO PHARMACIES

(a) Within 14 calendar days following receipt of a pharmacy claim, a pharmacy benefit manager or other entity paying pharmacy claims shall do one of the following:

(1) Pay or reimburse the claim.

(2) Notify the pharmacy in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the pharmacy benefit manager or other payer to determine liability for the claim.

(b) A pharmacy benefit manager or other entity paying pharmacy claims shall:

(1) make available, in a format that is readily accessible and understandable by a pharmacist, a list of the drugs subject to maximum allowable cost, the actual maximum allowable cost for each drug, and the source used to determine the maximum allowable cost; and

(2) update the maximum allowable cost list at least once every seven calendar days.

(c) A pharmacy benefit manager or other entity paying pharmacy claims shall not:

(1) impose a higher co-payment for a prescription drug than the co-payment applicable to the type of drug purchased under the insured's health plan;

(2) impose a higher co-payment for a prescription drug than the maximum allowable cost for the drug; or

(3) require a pharmacy to pass through any portion of the insured's co-payment to the pharmacy benefit manager or other payer.

Sec. 19. 9 V.S.A. § 2466a is amended to read:

§ 2466a. CONSUMER PROTECTIONS; PRESCRIPTION DRUGS

(a) A violation of 18 V.S.A. § 4631 shall be considered a prohibited practice under section 2453 of this title.

(b) As provided in 18 V.S.A. § ~~9473~~ 9474, a violation of 18 V.S.A. § 9472 or 9473 shall be considered a prohibited practice under section 2453 of this title.

\* \* \*

\* \* \* Adverse Childhood Experiences \* \* \*

Sec. 20. FINDINGS AND PURPOSE

(a) It is the belief of the General Assembly that controlling health care costs requires consideration of population health, particularly Adverse Childhood Experiences (ACEs).

(b) The ACE Questionnaire contains ten categories of questions for adults pertaining to abuse, neglect, and family dysfunction during childhood. It is used to measure an adult's exposure to traumatic stressors in childhood. Based on a respondent's answers to the Questionnaire, an ACE Score is calculated, which is the total number of ACE categories reported as experienced by a respondent.

(c) In a 1998 article entitled "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults"

published in the American Journal of Preventive Medicine, evidence was cited of a “strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults.”

(d) The greater the number of ACEs experienced by a respondent, the greater the risk for the following health conditions and behaviors: alcoholism and alcohol abuse, chronic obstructive pulmonary disease, depression, obesity, illicit drug use, ischemic heart disease, liver disease, intimate partner violence, multiple sexual partners, sexually transmitted diseases, smoking, suicide attempts, and unintended pregnancies.

(e) ACEs are implicated in the ten leading causes of death in the United States and with an ACE score of six or higher, an individual has a 20-year reduction in life expectancy.

(f) An individual with an ACE score of two is twice as likely to experience rheumatic disease. An individual with an ACE score of four has a three-to-four-times higher risk of depression; is five times more likely to become an alcoholic; is eight times more likely to experience sexual assault; and is up to ten times more likely to attempt suicide. An individual with an ACE score of six or higher is 2.6 times more likely to experience chronic obstructive pulmonary disease; is three times more likely to experience lung cancer; and is 46 times more likely to abuse intravenous drugs. An individual

with an ACE score of seven or higher is 31 times more likely to attempt suicide.

(g) Physical, psychological, and emotional trauma during childhood may result in damage to multiple brain structures and functions.

(h) ACEs are common in Vermont. In 2011, the Vermont Department of Health reported that 58 percent of Vermont adults experienced at least one adverse event during their childhood, and that 14 percent of Vermont adults have experienced four or more adverse events during their childhood.

Seventeen percent of Vermont women have four or more ACEs.

(i) The impact of ACEs is felt across all socioeconomic boundaries.

(j) The earlier in life an intervention occurs for an individual with ACEs, the more likely that intervention is to be successful.

(k) ACEs can be prevented where a multigenerational approach is employed to interrupt the cycle of ACEs within a family, including both prevention and treatment throughout an individual's lifespan.

(l) It is the belief of the General Assembly that people who have experienced adverse childhood experiences can be resilient and can succeed in leading happy, healthy lives.

#### Sec. 21. VERMONT FAMILY BASED APPROACH PILOT

(a) The Agency of Human Services, through the Integrated Family Services initiative, within available Agency resources and in partnership with the

Vermont Center for Children, Youth, and Families at the University of Vermont, shall implement the Vermont Family Based Approach in one pilot region. Through the Vermont Family Based Approach, wellness services, prevention, intervention, and, where indicated, treatment services shall be provided to families throughout the pilot region in partnership with other human service and health care programs. The pilot shall be fully implemented by January 1, 2015 to the extent resources are available to support the implementation.

(b)(1) In the pilot region, the Agency of Human Services, community partner organizations, schools, and the Vermont Center for Children, Youth, and Families shall identify individuals interested in being trained as Family Wellness Coaches and Family Focused Coaches.

(2) Each Family Wellness Coach and Family Focused Coach shall:

(A) complete the training program provided by the Vermont Family Based Approach;

(B) conduct outreach activities for the pilot region; and

(C) serve as a resource for family physicians within the pilot region.

## Sec. 22. REPORT; BLUEPRINT FOR HEALTH

On or before December 15, 2014, the Director of the Blueprint for Health shall submit a report to the House Committee on Health Care and to the Senate Committee on Health and Welfare containing recommendations as to how

screening for adverse childhood experiences and trauma-informed care may be incorporated into Blueprint for Health medical practices and community health teams, including any proposed evaluation measures and approaches; funding constraints; opportunities; availability of appropriate screening tools and evidence-based interventions for individuals; the additional resources, if any, that would be necessary to ensure adequate access to the interventions identified as needed as a result of the use of the screening tools; and additional security protections that may be necessary for information related to a patient's adverse childhood experiences.

Sec. 23. RECOMMENDATION; UNIVERSITY OF VERMONT'S  
COLLEGE OF MEDICINE AND SCHOOL OF NURSING  
CURRICULUM

The General Assembly recommends to the University of Vermont's College of Medicine and School of Nursing that they consider adding or expanding information to their curricula about the Adverse Childhood Experience Study and the impact of adverse childhood experiences on lifelong health.

Sec. 24. TRAUMA-INFORMED EDUCATIONAL MATERIALS

(a) On or before January 1, 2015, the Vermont Board of Medical Practice, in collaboration with the Vermont Medical Society Education and Research Foundation, shall develop educational materials pertaining to the Adverse Childhood Experience Study, including available resources and

evidence-based interventions for physicians, physician assistants, and advanced practice registered nurses.

(b) On or before July 1, 2016, the Vermont Board of Medical Practice and the Office of Professional Regulation shall disseminate the materials prepared pursuant to subsection (a) of this section to all physicians licensed pursuant to 26 V.S.A. chapters 23 and 33, naturopathic physicians licensed pursuant to 26 V.S.A. chapter 81, physician assistants licensed pursuant to 26 V.S.A. chapter 31, and advanced practice registered nurses licensed pursuant to 26 V.S.A. chapter 28, subchapter 3.

Sec. 25. REPORT; DEPARTMENT OF HEALTH; GREEN MOUNTAIN  
CARE BOARD

(a) On or before November 1, 2014, the Department of Health, in consultation with the Department of Mental Health, shall submit a written report to the Green Mountain Care Board containing:

(1) recommendations for incorporating education, treatment, and prevention of adverse childhood experiences into Vermont's medical practices and the Department of Health's programs;

(2) recommendations on the availability of appropriate screening tools and evidence-based interventions for individuals throughout their lives, including expectant parents, and the additional resources, if any, that would be

necessary to ensure adequate access to the interventions identified as needed as a result of the use of the screening tools; and

(3) information about the costs and availability of, and recommendations on, additional security protections that may be necessary for information related to a patient's adverse childhood experiences.

(b) The Green Mountain Care Board shall review the report submitted pursuant to subsection (a) of this section and attach comments to the report regarding the report's implications on population health and health care costs. On or before January 1, 2015, the Board shall submit the report with its comments to the Senate Committees on Education and on Health and Welfare and to the House Committees on Education, on Health Care, and on Human Services.

\* \* \* Reports \* \* \*

Sec. 26. GREEN MOUNTAIN CARE FINANCING AND COVERAGE;

REPORT

(a) Notwithstanding the January 15, 2013 date specified in 2011 Acts and Resolves No. 48, Sec. 9, no later than January 15, 2015, the Secretary of Administration shall submit to the House Committees on Health Care, on Appropriations, and on Ways and Means and the Senate Committees on Health and Welfare, on Appropriations, and on Finance a proposal to transition to and

fully implement Green Mountain Care. The report shall include the following elements, as well as any other topics the Secretary deems appropriate:

(1) a detailed analysis of the direct and indirect financial impacts of moving from the current health care system to a publicly financed system, including the impact by income class and family size for individuals and by business size, economic sector, and total sales or revenue for businesses, as well as the effect on various wage levels and job growth;

(2) recommendations for the amounts and necessary mechanisms to finance Green Mountain Care, including:

(A) proposing the amounts to be contributed by individuals and businesses;

(B) recommending financing options for wraparound coverage for individuals with other primary coverage, including evaluating the potential for using financing tiers based on the level of benefits provided by Green Mountain Care; and

(C) addressing cross-border financing issues;

(3) wraparound benefits for individuals for whom Green Mountain Care will be the payer of last resort pursuant to 33 V.S.A. § 1827(f), including individuals covered by the Federal Employees Health Benefit Program, TRICARE, Medicare, retiree health benefits, or an employer health plan;

- (4) recommendations for addressing cross-border health care delivery issues;
- (5) establishing provider reimbursement rates in Green Mountain Care;
- (6) developing estimates of administrative savings to health care providers and payers from Green Mountain Care;
- (7) information regarding Vermont's efforts to obtain a Waiver for State Innovation pursuant to Section 1332 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, including submission of a conceptual waiver application as required by Sec. 10 of this act; and
- (8) proposals for enhancing loan forgiveness programs and other opportunities and incentives for health care workforce development and enhancement.
- (b) If the Secretary of Administration does not submit the Green Mountain Care financing and coverage proposal required by this section to the General Assembly by January 15, 2015, no portion of the unencumbered funds remaining as of that date in the fiscal year 2015 appropriation to the Agency of Administration for the planning and the implementation of Green Mountain Care shall be expended until the Secretary submits the required proposal.

Sec. 26a. 18 V.S.A. § 9491 is amended to read:

§ 9491. HEALTH CARE WORKFORCE; STRATEGIC PLAN

\* \* \*

(b) The director or designee shall collaborate with the area health education centers, the ~~workforce development council~~ Workforce Development Council established in 10 V.S.A. § 541, the ~~prekindergarten-16 council~~ Prekindergarten-16 Council established in 16 V.S.A. § 2905, the ~~department of labor, the department of health, the department of Vermont health access~~ Department of Labor, the Department of Health, the Department of Vermont Health Access, and other interested parties, to develop and maintain the plan. The ~~director of health care reform~~ Director of Health Care Reform shall ensure that the strategic plan includes recommendations on how to develop Vermont's health care workforce, including:

\* \* \*

(3) how ~~state~~ State government, universities and colleges, the ~~state's~~ State's educational system, entities providing education and training programs related to the health care workforce, and others may develop the resources in the health care workforce and delivery system to educate, recruit, and retain health care professionals to achieve Vermont's health care reform principles and purposes, including proposals for enhancing loan forgiveness programs

and other opportunities and incentives for health care workforce development and enhancement.

\* \* \*

Sec. 27. CHRONIC CARE MANAGEMENT; BLUEPRINT; REPORT

On or before October 1, 2014, the Secretary of Administration or designee shall provide to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance a proposal for modifications of the payment structure to health care providers and community health teams for their participation in the Blueprint for Health; a recommendation on whether to expand the Blueprint to include additional services or chronic conditions such as obesity, mental conditions, and oral health; and recommendations on ways to strengthen and sustain advanced practice primary care.

Sec. 28. HEALTH INSURER SURPLUS; LEGAL CONSIDERATIONS;  
REPORT

The Department of Financial Regulation, in consultation with the Office of the Attorney General, shall identify the legal and financial considerations involved in the event that a private health insurer offering major medical insurance plans, whether for-profit or nonprofit, ceases doing business in this State, including appropriate disposition of the insurer's surplus funds. On or before July 15, 2014, the Department shall report its findings to the House

Committees on Health Care, on Commerce, and on Ways and Means and the Senate Committees on Health and Welfare and on Finance.

Sec. 29. TRANSITION PLAN FOR UNION EMPLOYEES

The Commissioners of Labor and of Human Resources; one representative each from the Vermont League of Cities and Towns, the Vermont School Boards Association, and the Vermont School Board Insurance Trust; and five representatives from a coalition of labor organizations active in Vermont, in consultation with other interested stakeholders, shall develop a plan for transitioning employees with collectively bargained health benefits from their existing health insurance plans to Green Mountain Care, with the goal that union employees shall be enrolled in Green Mountain Care upon implementation, which is currently targeted for 2017. The transition plan shall be consistent with State and federal labor relations laws and public and private sector collective bargaining agreements and shall ensure that total employee compensation does not decrease significantly, nor financial costs to employers increase significantly, as a result of the transition of employees to Green Mountain Care.

Sec. 30. FINANCIAL IMPACT OF HEALTH CARE REFORM

INITIATIVES

The Joint Fiscal Committee shall:

(1) determine the distribution of current health care spending by individuals, businesses, and municipalities, including the direct and indirect costs by income class, family size, and other demographic factors for individuals and by business size, economic sector, and total sales or revenue for businesses;

(2) for each proposal for health care system reform, evaluate the direct and indirect impacts on individuals, businesses, and municipalities, including the direct and indirect costs by income class, family size, and other demographic factors for individuals and by business size, economic sector, and total sales or revenue for businesses;

(3) estimate the costs of and savings from current health care reform initiatives; and

(4) update the cost estimates for Green Mountain Care, the universal and unified health care system established in 33 V.S.A. chapter 18, subchapter 2.

Sec. 31. [Deleted.]

Sec. 32. INCREASING MEDICAID RATES; REPORT

On or before January 15, 2015, the Secretary of Administration or designee, in consultation with the Green Mountain Care Board, shall report to the House Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare and on Finance regarding the impact of

increasing Medicaid reimbursement rates to providers to match Medicare rates.

The issues to be addressed in the report shall include:

(1) the amount of State funds needed to effect the increase;

(2) the level of a payroll tax that would be necessary to generate the revenue needed for the increase;

(3) the projected impact of the increase on health insurance premiums; and

(4) to the extent that premium reductions would likely result in a decrease in the aggregate amount of federal premium tax credits for which Vermont residents would be eligible, whether there are specific timing considerations for the increase as it relates to Vermont's application for a Waiver for State Innovation pursuant to Section 1332 of the Patient Protection and Affordable Care Act.

Sec. 33. HEALTH CARE EXPENSES IN OTHER FORMS OF  
INSURANCE

The Secretary of Administration or designee, in consultation with the Departments of Labor and of Financial Regulation, shall collect the most recent available data regarding health care expenses paid for by workers' compensation, automobile, property and casualty, and other forms of non-medical insurance, including the amount of money spent on health care-related goods and services and the percentage of the premium for each type of policy

that is attributable to health care expenses. The Secretary of Administration or designee shall consolidate the data and provide it to the General Assembly on or before December 1, 2014.

\* \* \* Health Care Workforce Symposium \* \* \*

Sec. 34. HEALTH CARE WORKFORCE SYMPOSIUM

On or before January 15, 2015, the Secretary of Administration or designee, in collaboration with the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, and the Vermont Assembly of Home Health and Hospice Agencies, shall organize and conduct a symposium to address the impacts of moving toward universal health care coverage on Vermont's health care workforce and on its projected workforce needs.

\* \* \* Repeal \* \* \*

Sec. 35. REPEAL

3 V.S.A. § 635a (legislators and session-only legislative employees eligible to purchase State Employees Health Benefit Plan at full cost) is repealed.

\* \* \* Effective Dates \* \* \*

Sec. 36. EFFECTIVE DATES

This act shall take effect on passage, except that:

(1) Sec. 11, 21 V.S.A. § 2003(b), shall take effect on passage and shall apply beginning with the calculation of the Health Care Fund contributions payable in the first quarter of fiscal year 2015, which shall be based on the

number of an employer's uncovered employees in the fourth quarter of fiscal year 2014.

(2) Notwithstanding 1 V.S.A. § 214, Sec. 35 (repeal of legislator eligibility to purchase State Employees Health Benefit Plan) shall take effect on passage and shall apply retroactively to January 1, 2014, except that members and session-only employees of the General Assembly who were enrolled in the State Employees Health Benefit Plan on January 1, 2014 may continue to receive coverage under the plan through the remainder of the 2014 plan year; and

(3) Sec. 18 (18 V.S.A. § 9473; pharmacy benefit managers) shall take effect on July 1, 2014 and shall apply to contracts entered into or renewed on or after that date.