H.444

An act relating to health care reform

The Senate proposes to the House to amend the bill as follows:

First: In Sec. 1, 18 V.S.A. § 9352, in subdivision (j)(2), following "exchange network", by adding "as long as nothing in such exchange or operation constitutes the practice of medicine pursuant to chapter 23 or 33 of Title 26"

Second: By inserting a new Sec. 17 to read as follows:

Sec. 17. SPECIAL ENROLLMENT PERIOD

(a) An individual who does not have an election of continuation of coverage as described in 18 V.S.A. § 4090a(a) in effect on the effective date of this act but who is an assistance eligible individual under Section 3001 of Title III of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (ARRA), may elect continuation coverage pursuant to this subsection by making such election within 60 days following the date the issuer of the policy provides notice of the right to elect coverage as required by Section 3001(a)(7) of the ARRA. The issuer of the policy shall provide such notice of the right to elect coverage no later than 30 days following the effective date of this act.

(b) Continuation coverage for an individual who elects coverage pursuant to subsection (a) of this section shall commence on the first day of the first

month beginning on or after the effective date of this act and shall not extend beyond the period of continuation coverage that would have applied if the coverage had instead been elected pursuant to 18 V.S.A. § 4090a(a).

(c) Notwithstanding any provision of law to the contrary, for an individual who elects continuation coverage pursuant to this section, the period beginning on the date of the qualifying event pursuant to 18 V.S.A. § 4090a(b) and ending on the first day of the first month beginning on or after the effective date of this act shall be disregarded for purposes of determining the 63-day periods referred to in connection with preexisting condition exclusions in Section 701(c)(2) of the Employee Retirement Income Security Act of 1974, Section 9801(c)(2) of the Internal Revenue Code of 1986, and Section 2701(c)(2) of the Public Health Service Act, and the 90-day period referred to in connection with preexisting condition exclusions in 18 V.S.A. § 4080a(g).

Third: By striking out Sec. 21 in its entirety

Fourth: In Sec. 21a, by striking out the date "February 1, 2010" and inserting in lieu thereof the words upon approval of the waiver amendment pursuant to Sec. 21(a)(2) of this act and by redesignating Sec. 21a as Sec. 22

Fifth: By striking out the existing Sec. 22 in its entirety and inserting in lieu thereof a new section to be redesignated as Sec. 21 to read:

Sec. 21. GLOBAL COMMITMENT WAIVER AMENDMENTS; RULEMAKING

(a) No later than September 1, 2009, the secretary of human services shall request approval from the Centers for Medicare and Medicaid Services for amendments to the Global Commitment for Health Medicaid Section 1115 waiver to:

(1) implement the self-employment exception to the Catamount Health waiting period set forth in Sec. 15 of this act; and

(2) permit the agency of human services to amend the rules for the Vermont health access plan, the Catamount Health premium assistance program, and the employer-sponsored insurance premium-assistance programs to designate depreciation as an allowable business expense when determining countable income for eligibility purposes.

(b) During the pendency of the waiver amendment request pursuant to subdivision (a)(2) of this section, the agency of human services shall amend the rules for the Vermont health access plan, the Catamount Health premium assistance program, and the employer-sponsored insurance premium-assistance programs to designate depreciation as an allowable business expense when determining countable income for eligibility purposes. The amended rules shall take effect upon approval of the waiver amendment, but in no event earlier than February 1, 2010.

Sixth: In Sec. 23, 2 V.S.A. § 903, in subdivision (b)(1)(D), by striking out "is requested to" preceding "report its findings" and inserting in lieu thereof the word shall

Seventh: In Sec. 26, 21 V.S.A. § 640a, by adding subsections (j), (k), and (l) as follows:

(j) An employer or insurance carrier shall not impose on any health care provider any retrospective denial of a previously paid medical bill or any part of that previously paid medical bill, unless:

(1) The employer or insurance carrier has provided at least 30 days' notice of any retrospective denial or overpayment recovery or both in writing to the health care provider. The notice must include:

(A) the injured employee's name;

(B) the service date;

(C) the payment amount;

(D) the proposed adjustment; and

(E) a reasonably specific explanation of the proposed adjustment.

(2) The time that has elapsed does not exceed 12 months from the later of the date of payment of the previously paid medical bill or the date of a final determination of compensability.

(k) The retrospective denial of a previously paid medical bill shall be permitted beyond 12 months from the later of the date of payment or the date of a final determination of compensability for any of the following reasons:

(1) The employer or insurance carrier has a reasonable belief that fraud or other intentional misconduct has occurred;

(2) The medical bill payment was incorrect because the health care provider was already paid for the health services identified in the medical bill;

(3) The health care services identified in the medical bill were not delivered by the health care provider;

(4) The medical bill payment is the subject of adjustment with another workers' compensation or health insurer; or

(5) The medical bill is the subject of legal action.

(l)(1) For purposes of subsections (j) and (k) of this section, for routine recoveries as described in subdivisions (A) through (J) of this subdivision (1), retrospective denial or overpayment recovery of any or all of a previously paid medical bill shall not require 30 days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies:

(A) Duplicate payment to a health care provider for the same professional service;

(B) Payment with respect to an individual for whom the employer or insurance carrier is not liable as of the date the service was provided;

(C) Payment for a noncovered service, not to include services denied as not medically necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism;

(D) Erroneous payment for services due to employer or insurance carrier administrative error;

(E) Erroneous payment for services where the medical bill was processed in a manner inconsistent with the data submitted by the health care provider;

(F) Payment where the health care provider provides the employer or insurance carrier with new or additional information demonstrating an overpayment;

(G) Payment to a health care provider at an incorrect rate or using an incorrect fee schedule;

(H) Payment of medical bills for the same injured employee that are received by the employer or insurance carrier out of the chronological order in which the services were performed;

(I) Payment where the health care provider has received payment for the same services from another payer whose obligation is primary; or

(J) Payments made in coordination with a payment by a government payer that require adjustment based on an adjustment in the government-paid portion of the medical bill.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, recoveries which, in the reasonable business judgment of the employer or insurance carrier, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more of the situations in subdivisions (1)(A) through (J) of this subsection apply.

(3) Nothing in this subsection shall be construed to affect the time frames established in subdivision (j)(2) or subsection (k) of this section.

Eighth: By striking out Sec. 27 in its entirety

Ninth: In Sec. 29, 18 V.S.A. § 9418, in subsection (a)(8), by striking out the words "a workers' compensation policy of a casualty insurer,"

Tenth: In Sec. 29, 18 V.S.A. § 9418, in subsection (c), by inserting the words ", contracting entity, or payer" preceding "shall have ~~45~~ 30 days"

Eleventh: In Sec. 29, 18 V.S.A. § 9418, in subdivision (i)(2), by inserting the words "health care" preceding "provider" and by striking out the words of the insured following "provider"

Twelfth: In Sec. 29, 18 V.S.A. § 9418, in subdivision (i)(4), by striking out the word "insurer" and inserting in lieu thereof the word plan

Thirteenth: In Sec. 29, 18 V.S.A. § 9418, in subdivision (i)(5), by striking out the word "payment"

Fourteenth: In Sec. 29, 18 V.S.A. § 9418, in subsection (m), by striking out the second sentence in its entirety

Fifteenth: In Sec. 30, 18 V.S.A. § 9418a, in subsection (g), by striking out the word "covered" in both instances in which it appears

Sixteenth: In Sec. 30, 18 V.S.A. § 9418a, in subsection (h), by inserting "if applicable" following "provider newsletter" and in subdivision (h)(1), by striking out the words "the" preceding "commercially available" and inserting in lieu thereof the word any

Seventeenth: In Sec. 30, 18 V.S.A. § 9418a, by inserting a new subsection (j) to read as follows:

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

and by redesignating subsection (j) as subsection (k)

Eighteenth: In Sec. 32, 18 V.S.A. § 9418c, in subdivision (b)(4), following "List of products", by inserting ", product types," preceding "or networks"

Nineteenth: In Sec. 32, 18 V.S.A. § 9418c, in subsection (c), by striking out "subdivision (a)(1)" and inserting in lieu thereof subdivisions (a)(1)(A) and (B)

Twentieth: In Sec. 32, 18 V.S.A. § 9418c, by striking out subsection (f) in its entirety

Twenty-first: In Sec. 33, 18 V.S.A. § 9418d, in subdivision (c)(5), by striking out the period following "subdivision" and inserting in lieu thereof a colon

Twenty-second: In Sec. 33, 18 V.S.A. § 9418d, by striking out subsection (f) in its entirety

Twenty-third: In Sec. 34, 18 V.S.A. § 9418d, by striking out subsection (b) in its entirety

Twenty-fourth: In Sec. 35, 18 V.S.A. § 9418f, by striking out subdivisions (a)(1), (2), and (3) in their entirety and by renumbering the remaining subdivisions to be numerically correct; and by striking out the second sentence of subdivision (c)(4) in its entirety and inserting in lieu thereof "Fees collected under this subdivision shall be deposited into the health care special fund, number 21070, and shall be available to the commissioner to offset the cost of administering the registration process."

Twenty-fifth: In Sec. 35, 18 V.S.A. § 9418f, by striking out subsection (g) in its entirety

Twenty-sixth: In Sec. 38, by striking out "sections 9418c" and inserting in lieu thereof sections 9418b

Twenty-seventh: By striking out Sec. 40 in its entirety

Twenty-eighth: In Sec. 41, in the first sentence, by striking out the word "physicians" following "American College of Emergency" and inserting in lieu thereof the word Physicians

Twenty-ninth: In Sec. 43, 18 V.S.A. § 1130, in subsection (i), by striking out the word "establish" and inserting in lieu thereof the word adopt

Thirtieth: By inserting a new Sec. 44 to read as follows:

* * * Healthy Workers Program * * *

Sec. 44. INTENT

It is the intent of the general assembly to establish a healthy workers program to provide preventive health services, prenatal care, outreach, and education to workers employed in the Vermont agricultural sector.

Thirty-first: By adding a Sec. 45 to read as follows:

Sec. 45. HEALTHY WORKERS PROGRAM; REPORT

(a) As used in this section:

(1) "Health service" means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services ordered by a health care professional and medically necessary services to assist in activities of daily living.

(2) "Immunizations" means vaccines and the application of the vaccines as recommended by the practice guidelines for children and adults established

by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention.

(3) "Vermont farm health connection" means a consortium comprising Vermont's clinics for the uninsured, federally qualified health centers, and the Bi-State Primary Care Association working together to implement pilot programs in Addison and Franklin Counties to test design principles for a replicable system of high-quality health care for farm workers.

(b) The department of health shall collaborate with the Vermont farm health connection to:

(1) participate in the development of a sustainable, statewide infrastructure to provide outreach and health services to farm workers.

(2) provide access to:

(A) screening for communicable diseases;

(B) immunizations; and

(C) prenatal services.

(3) in consultation with the office of Vermont health access, research the required federal authority and fiscal implications of extending public health program benefits to pregnant women identified through the consortium's work.

(c) No later than January 15, 2010, the department of health and the Vermont farm health connection shall report to the senate committee on health and welfare and the house committee on health care regarding the status of the

program's implementations and recommendations for any legislative action necessary to advance the goal of statewide outreach and access to health services for farm workers.

(d) No later than March 1, 2010, the Vermont farm health connection shall report to the senate committee on health and welfare and the house committee on health care regarding the results of its assessment of the needs of three to five additional Vermont counties for health care services for farm workers.

Thirty-second: By adding a Sec. 46 to read as follows:

Sec. 46. 9 V.S.A. chapter 80 is added to read:

CHAPTER 80. FLAME RETARDANTS

§ 2971. BROMINATED FLAME RETARDANTS

(a) As used in this section:

(1) "Brominated flame retardant" means any chemical containing the element bromine that is added to plastic, foam, or textile to inhibit flame formation.

(2) "Congener" means a specific PBDE molecule.

(3) "DecaBDE" means decabromodiphenyl ether or any technical mixture in which decabromodiphenyl ether is a congener.

(4) "Flame retardant" means any chemical that is added to a plastic, foam, or textile to inhibit flame formation.

(5) "Manufacturer" means any person who manufactures a final product containing a regulated brominated flame retardant or any person whose brand-name is affixed to a product containing a regulated brominated flame retardant.

(6) "Motor vehicle" means every vehicle intended primarily for use and operation on the public highways, and shall include farm tractors and other machinery used in the production, harvesting, and care of farm products.

(7) "OctaBDE" means octabromodiphenyl ether or any technical mixture in which octabromodiphenyl ether is a congener.

(8) "PentaBDE" means pentabromodiphenyl ether or any technical mixture in which a pentabromodiphenyl ether is a congener.

(9) "PBDE" means polybrominated diphenyl ether.

(10) "Technical mixture" means a PBDE mixture that is sold to a manufacturer. A technical mixture is named for the predominant congener in the mixture, but is not exclusively made up of that congener.

(b) As of July 1, 2010, no person may offer for sale, distribute for sale, distribute for promotional purposes, or knowingly sell at retail a product containing octaBDE or pentaBDE.

(c) Except for inventory purchased prior to July 1, 2009, a person may not, as of July 1, 2010, manufacture, offer for sale, distribute for sale, or knowingly sell at retail the following products containing decaBDE:

(1) A mattress or mattress pad; or

(2) Upholstered furniture.

(d) Except for inventory purchased prior to July 1, 2009, a person may not, as of July 1, 2012, manufacture, offer for sale, distribute for sale, or knowingly sell at retail a television or computer with a plastic housing containing decaBDE.

(e) This section shall not apply to:

(1) the sale or resale of used products; or

(2) motor vehicles or parts for use on motor vehicles.

(f) As of July 1, 2010, a manufacturer of a product that contains decaBDE and that is prohibited under subsection (c) or (d) of this section shall notify persons that sell the manufacturer's product of the requirements of this section.

(g) A manufacturer shall not replace decaBDE, pursuant to this section, with a chemical that is:

(1) Classified as "known to be a human carcinogen" or "reasonably anticipated to be a human carcinogen" in the most recent report on carcinogens by the National Toxicology Program in the U.S. Department of Health and Human Services;

(2) Classified as a "human carcinogen" or "probable human carcinogen" in the U.S. Environmental Protection Agency's most recent list of chemicals evaluated for carcinogenic potential; or

(3) Identified by the U.S. Environmental Protection Agency as causing birth defects, hormone disruption, or harm to reproduction or development.

(h) A violation of this section shall be deemed a violation of the Consumer Fraud Act, chapter 63 of Title 9. The attorney general has the same authority to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring civil actions, and private parties have the same rights and remedies as provided under subchapter 1 of chapter 63 of Title 9.

(i) In addition to any other remedies and procedures authorized by this section, the attorney general may request a manufacturer of upholstered furniture, mattresses, mattress pads, computers, or televisions offered for sale or distributed for sale in this state to provide the attorney general with a certificate of compliance with this section with respect to such products. Within 10 days of receipt of the request for a certificate of compliance, the manufacturer shall:

(1) Provide the attorney general with a certificate declaring that its product complies with the requirements of this section; or

(2) Notify persons who sell in this state a product of the manufacturer's which does not comply with this section that sale of the product is prohibited, and submit to the attorney general a list of the names and addresses of those notified.

(j) The attorney general shall consult with retailers and retailer associations in order to assist retailers in complying with the requirements of this section.

Thirty-third: By adding a Sec. 47 to read as follows:

Sec. 47. 8 V.S.A. chapter 107, subchapter 11 is added to read:

Subchapter 11. Orally Administered Anticancer Medication

§ 4100g. ORALLY ADMINISTERED ANTICANCER MEDICATION; COVERAGE REQUIRED

(a) A health insurer that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is no less favorable on a financial basis than intravenously administered or injected anticancer medications covered under the insured's plan.

(b) As used in this section, "health insurer" means any insurance company that provides health insurance as defined in subdivision 3301(a)(2) of this title, nonprofit hospital and medical service corporations, and health maintenance organizations. The term does not apply to coverage for specified disease or other limited benefit coverage.

Thirty-fourth: By adding a Sec. 48 to read as follows:

Sec. 48. ORALLY ADMINISTERED ANTICANCER MEDICATION STUDY

(a) The department of banking, insurance, securities, and health care administration shall study the impact of implementing a requirement for health insurance coverage of orally administered anticancer medication. In conducting the study, the department shall consider:

(1) projected impacts on health insurance premiums;

(2) options for mitigating the impact on premiums of the coverage requirement;

(3) the administrative complexities associated with the coverage requirement;

(4) the public policy implications of expanding required coverage for treatment-specific medications and procedures;

(5) appropriate safeguards for accomplishing the purpose of the coverage requirement; and

(6) such other factors as the department deems appropriate.

(b) No later than January 15, 2010, the department shall report its findings and recommendations to the senate committee on health and welfare and the house committee on health care.

Thirty-fifth: By adding a Sec. 49 to read as follows:

Sec. 49. APPROPRIATION

In fiscal year 2010, the sum of $3,000.00 is appropriated to the department of banking, insurance, securities, and health care administration from the

health care special fund, number 21070, for the purpose of administering the registration fee pursuant to 18 V.S.A. § 9418f.

Thirty-sixth: By adding a new Sec. 50 to read as follows:

Sec. 50. HOSPITAL BUDGETS

(a) A number of health care reform initiatives in Vermont, including the Blueprint for Health, health information technology, and an exploration of the variations in hospital utilization, are expected to yield results in containing health care costs in this state. As Vermont is able to rein in health care spending, it is anticipated that hospitals will also play an important role by continuing to slow the increase in hospital budget growth.

(b) In approving hospital budgets for fiscal years 2010, 2011, and 2012, the goal of the commissioner of banking, insurance, securities, and health care administration shall be to lower the average systemwide rate increase for all Vermont hospital budgets below the average systemwide rate increase for all Vermont hospitals during the previous three years. As part of his or her efforts, the commissioner may:

(1) Establish an annual systemwide target rate increase;

(2) Limit expenditure growth, including restricting the introduction of new programs and program enhancements;

(3) Limit capital spending; or

(4) Implement other reasonable means to achieve the purposes of this section.

(c) In approving hospital budgets pursuant to section 9456 of Title 18, nothing in this section shall be deemed to limit the authority of the commissioner to consider individual hospital circumstances or the impact of individual budget increases on the overall cost of Vermont's health care system.

(d) No later than January 15 in the years 2010, 2011, and 2012, the commissioner of banking, insurance, securities, and health care administration shall report the results of the annual hospital budget approvals to the senate committee on health and welfare and the house committee on health care.

Thirty-seventh: By striking out the existing Sec. 44 in its entirety and inserting in lieu thereof the following to be renumbered Sec. 51:

Sec. 51. EFFECTIVE DATES

(a) Secs. 14 through 17, inclusive, of this act shall take effect upon passage."

(b) Sec. 18, 8 V.S.A. § 4089k, of this act shall take effect on July 1, 2009, and the amendments to that section shall apply to the calculation, assessment, and payment of the health information technology reinvestment fee beginning on October 1, 2009.

(c) Secs. 19 and 20 (Catamount Health) shall take effect April 1, 2010.

(d) Sec. 21(b) (rulemaking on depreciation) shall take effect for the purposes of the rulemaking process on July 1, 2009, but the rule shall not take effect earlier than February 1, 2010.

(e) Health plans and contracting entities and payers shall comply with the amendments to Sec. 30, 18 V.S.A. § 9418(b), (c), (d), and (e) (payment for health care services), no later than July 1, 2010.

(f) Sec. 31, 18 V.S.A. § 9418a(c) and (d) (edit standards), shall take effect July 1, 2011.

(g) Sec. 33, 18 V.S.A. § 9418c(a)(1) through (4) (disclosure of payment information), with the exception of subdivision (a)(1)(C) (disclosure of claim edit information), shall take effect as follows:

(1) Contracting entities shall provide the information required in subdivisions (a)(1) through (3) beginning on July 1, 2009.

(2) Contracts shall obligate contracting entities to provide the information required in subdivision (a)(1) of this section, with the exception of subdivision (a)(1)(C), upon request beginning no later than September 1, 2009, and for all participating health care providers no later than January 1, 2010.

(3) Contracting entities and contracts shall comply with the provisions of subdivision (a)(1)(C) of this section no later than July 1, 2010.

(h) The summary disclosure form required by Sec. 33, 18 V.S.A. § 9418c(d), shall be included in all contracts entered into or renewed on or

after July 1, 2009 and shall be provided for all other existing contracts no later than July 1, 2014.

(i) Contracting entities and covered entities shall comply with the provisions of Sec. 36, 18 V.S.A. § 9418f (rental networks), no later than January 1, 2010.

(j) This section, Sec. 38 (statutory revision), and Sec. 42 (stroke treatment study) shall take effect on passage.

(k) Sec. 47 shall take effect on April 1, 2010 and shall apply to all health benefit plans on and after April 1, 2010 on such date as a health insurer offers, issues, or renews the health benefit, but in no event later than April 1, 2011.

(l) All remaining sections shall take effect on July 1, 2009.

and by renumbering all sections of the bill to be numerically correct