TO THE HOUSE OF REPRESENTATIVES:

The Committee on Health Care to which was referred Senate Bill No. 252 entitled "An act relating to financing for Green Mountain Care" respectfully reports that it has considered the same and recommends that the House propose to the Senate that the bill be amended by striking out 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 how Vermonters currently pay for health care 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 doing so is not cost-effective for the residents of Vermont and for the State.

(g) The General Assembly must be satisfied that an appropriate plan of action is in place in order to accomplish the financial and health care operational 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.

(3) Vermont residents shall finance 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. The financing system shall maximize opportunities to pay for health care using pre-tax funds.

(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.

(6) The financing system for Green Mountain Care shall include an indexing mechanism that adjusts the level of individuals' and businesses' financial contributions to meet the health care needs of Vermont residents and

that ensures the sufficiency of funding in accordance with the principle expressed in 18 V.S.A. § 9371(11).

* * * 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.

* * * 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) ~~The benefits for~~ 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 quarter in ~~fiscal years 2007 and 2008~~ calendar year 2014, the amount of the Health Care Fund contribution shall be ~~$ 91.25~~ $119.12 for each full-time equivalent employee in excess of ~~eight~~ four. For each ~~fiscal~~ calendar 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~~ calendar year 2014, 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.

* * *

* * * 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

* * *

(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, and opportunities.

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

(3) recommendations on additional security protections that may be used 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, on or before February 3, 2015, the Secretary of Administration shall submit to the House Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare 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 how much individuals and businesses currently spend on health care, including the average percentage of income spent on health care premiums for plans in the Vermont Health Benefit Exchange by Vermont residents purchasing Exchange plans as individuals and by Vermont residents whose employers provide health coverage as an employment benefit, as well as data necessary to compare the proposal to the various ways health care is currently paid for, including as a percentage of employers' payroll;

(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) a thorough economic analysis of the impact of changing from a health care system financed through premiums to the system recommended in the financing proposal, taking into account the effect on wages and job growth and the impact on various wage levels;

(5) recommendations for addressing cross-border health care delivery issues;

(6) establishing provider reimbursement rates in Green Mountain Care;

(7) developing estimates of administrative savings to health care providers and payers from Green Mountain Care; and

(8) 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.

(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 February 3, 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 to the General Assembly a plan recommending the specific amounts and necessary mechanisms to finance Green Mountain Care.

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, in consultation with the Vermont League of Cities and Towns, Vermont School Boards Association, a coalition of labor organizations active in Vermont, and other interested stakeholders, shall develop a plan for transitioning all union employees with collectively bargained health benefits from their existing health insurance plans to Green Mountain Care, with the goal that all union

employees shall be enrolled in Green Mountain Care upon implementation, which is currently targeted for 2017. The Commissioners shall address the role of collective bargaining on the transition process and shall propose methods to mitigate the impact of the transition on employees' health care coverage and on their total compensation.

Sec. 30. FINANCIAL IMPACT OF HEALTH CARE REFORM INITIATIVES

(a) The Secretary of Administration or designee shall consult with the Joint Fiscal Office in collecting data and developing methodologies, assumptions, analytic models, and other factors related to the following:

(1) the distribution of current health care spending by individuals, businesses, and municipalities, including comparing the distribution of spending by individuals by income class with the distribution of other taxes;

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

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

(b) The Secretary or designee and the Joint Fiscal Committee shall explore ways to collaborate on the estimates required pursuant to subsection (a) of this section and may contract jointly, to the extent feasible, in order to use the same analytic models, data, or other resources.

(c) On or before December 1, 2014, the Secretary of Administration shall present his or her analysis to the General Assembly. On or before January 15, 2015, the Joint Fiscal Office shall evaluate the analysis and indicate areas of agreement and disagreement with the data, assumptions, and results.

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 Mean 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 November 15, 2014, 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) 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

(2) 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.

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE