S.252 - Senate conferees' proposal

Sec. 1. 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) 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.

(3) As provided in 33 V.S.A. § 1827, Green Mountain Care shall be the secondary payer for Vermont residents who continue to receive health care through plans provided by an employer, by another state, by a foreign government, or as a retirement benefit.

(4) Vermont's system for financing health care shall raise revenue sufficient to provide medically necessary health care services to all enrolled Vermont residents, including maternity and newborn care, pediatric care, vision and dental care for children, surgery and hospital care, emergency care, outpatient care, treatment for mental health conditions, and prescription drugs.

* * * Vermont Health Benefit Exchange * * *

Sec. 2. 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. 3. 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. 4. 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.

* * * Green Mountain Care * * *

Sec. 5. TREATMENT OF FEDERAL EMPLOYEES

The Health Care Reform Financing Plan submitted to the General Assembly by the Secretary of Administration and the Director of Health Care Reform on January 24, 2013 assumed that federal employees, including military, will not be integrated into Green Mountain Care for their primary coverage.

Sec. 6. 33 V.S.A. § 1824(f) is added to read:

(f)(1) Federal employees who participate in the Federal Employees Health Benefits Program (FEHBP) or TRICARE shall be deemed, by virtue of their participation in those plans, to be covered by Green Mountain Care. The Green Mountain Care benefit package for federal employees shall be the benefit package of their respective FEHBP or TRICARE plan. The premiums paid by federal employees for the FEHBP or TRICARE shall be deemed to be their share of contributions to the financing for Green Mountain Care.

(2) As used in this subsection, "federal employee" means a person employed by the U.S. government who is eligible for the FEHBP, a person retired from employment with the U.S. government who is eligible for the FEHBP, or an active or retired member of the U.S. Armed Forces who is eligible for a TRICARE plan.

Sec. 7. SUPPLEMENTAL PLANS FOR TRICARE PARTICIPANTS

In the event that the Agency of Human Services identifies significant gaps between the coverage available to federal employees participating in TRICARE and the coverage available in Green Mountain Care, the Agency shall propose to the General Assembly a supplemental benefit plan for TRICARE participants and a mechanism for TRICARE participants to pay for the cost of the plan.

Sec. 8. CONTRACT FOR ADMINISTRATION OF CERTAIN ELEMENTS OF GREEN MOUNTAIN CARE

(a) On or before February 1, 2015, the Agency of Human Services shall identify 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). By the same date, the Agency shall also prepare a description of the job or jobs to be performed, design the bid qualifications, and develop the criteria by which bids will be evaluated.

(b) On or before July 1, 2015, the Agency of Human Services shall solicit bids for administration of the elements of Green Mountain Care identified pursuant to subsection (a) of this section.

(c) On or before December 15, 2015, the Agency of Human Services shall award one or more contracts to public or private entities for administration of elements of Green Mountain Care pursuant to 33 V.S.A. § 1827(a).

Sec. 9. 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.

* * * Certificates of Need * * *

Sec. 10. 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. 11. 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. 12. 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. 13. 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.

* * * Reports * * *

Sec. 14. CHRONIC CARE MANAGEMENT; BLUEPRINT; REPORT

On or before October 1, 2014, the Secretary of Administration or designee shall report to the House Committees on Health Care and on Human Services, the Senate Committees on Health and Welfare and on Finance, and the Health Care Oversight Committee regarding the efficacy of the chronic care management initiatives currently in effect in Vermont, including recommendations about whether and to what extent to increase payments to health care providers and community health teams for their participation in the Blueprint for Health and whether to expand the Blueprint to include additional chronic conditions such as obesity, mental conditions, and oral health.

Sec. 15. 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 Commerce and on Ways and Means, the Senate Committee on Finance, and the Health Care Oversight Committee.

Sec. 16. BENCHMARK-EQUIVALENT HEALTH CARE COVERAGE

On or before October 1, 2014, the Secretary of Administration or designee shall provide the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Care Oversight Committee with a recommendation regarding whether it should be the policy of the State of Vermont that all Vermont residents should have health care coverage in effect prior to implementation of Green Mountain Care that is substantially equivalent to coverage available under the benchmark plan for the Vermont Health Benefit Exchange. If the Secretary or designee reports that substantially equivalent coverage for all Vermonters should be the policy of the State, the Secretary or designee shall propose ways to achieve this goal.

Sec. 17. TRANSITION PLAN FOR PUBLIC EMPLOYEES

The Secretary of Education and the Commissioner of Human Resources, in consultation with the Vermont State Employees' Association, the Vermont League of Cities and Towns, Vermont–NEA, Vermont School Boards Association, AFT Vermont, and other interested stakeholders, shall develop a plan for transitioning public employees from their existing health insurance plans to Green Mountain Care or another common risk pool, with the goal that all State employees, municipal employees, public school employees, and other persons employed by the State or an instrumentality of the State shall be enrolled in Green Mountain Care upon implementation, which is currently targeted for 2017, or in a common risk pool. The Secretary and Commissioner 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. 18. FINANCIAL IMPACT OF HEALTH CARE REFORM INITIATIVES

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

(1) the cost of Green Mountain Care, the universal and unified health care system established in 33 V.S.A. chapter 18, subchapter 2;

(2) the distribution of 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; and

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

(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 utilize 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. 19. INDEPENDENT PHYSICIAN PRACTICES; REPORT

On or before December 1, 2014, the Secretary of Administration or designee shall recommend to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance whether the State should prohibit health insurers from reimbursing physicians in independent practices at lower rates than those at which they reimburse physicians in hospital-owned practices for providing the same services.

Sec. 20. HEALTH INFORMATION TECHNOLOGY AND INTELLECTUAL PROPERTY; REPORT

On or before October 1, 2014, the Office of the Attorney General, in consultation with the Vermont Information Technology Leaders, shall report to

the House Committees on Health Care, on Commerce and Economic Development, and on Ways and Means and the Senate Committees on Health and Welfare, on Economic Development, Housing and General Affairs, and on Finance regarding the need for intellectual property protection with respect to Vermont's Health Information Exchange and other health information technology initiatives, including the potential for receiving patent, copyright, or trademark protection for health information technology functions, the estimated costs of obtaining intellectual property protection, and projected revenues to the State from protecting intellectual property assets or licensing protected interests to third parties.

Sec. 21. MEDICARE INTEGRATION; REPORT

On or before December 1, 2014, the Secretary of Administration or designee 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 options available to the State of Vermont with respect to the potential integration and coordination of Medicare with Green Mountain Care. The report shall include assessments of possible financing and coverage options for Vermont's Medicare population within Green Mountain Care and the potential continuation of Medicare supplemental insurance and Medicare Advantage plans.

* * * Repeal * * *

Sec. 22. 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. 23. EFFECTIVE DATES

This act shall take effect on passage, except that notwithstanding 1 V.S.A. § 214, Sec. 22 (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.