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MEMORANDUM

TO: Rep. Fisher, Chair, House Committee on Health Care
Rep. Ancel, Chair, House Committee on Ways and Means

FROM: Rep. Heath, Chair, House Committee on Appropriations

DATE: January 30, 2013

SUBJECT: Review of Specific Provisions of the Governor's Fiscal year 2014 Budget

The House Appropriations Committee is in the process of reviewing provisions included in the Governor's Fiscal year 2014 budget. There are some language sections that require the review of both the Committee on Health Care and the Committee on Ways and Means. These sections pertain to the request to extend the Global Commitment Medicaid waiver, provider reimbursement rates, state premium and cost-sharing assistance, the Vermont Health Benefit Exchange, and the health care claims tax. Please see the language sections below for your review.

Sec. E.301.1 Sec. 3 of No. 60 of the Acts of 2011 is amended to read:
Sec. 3. REQUEST FOR A WAIVER
By no later than July 1, 2012, the agency of human services shall include as a part of its application request for a demonstration project from the Centers for Medicare and Medicaid Services to integrate care for dual eligible individuals the additional proposal of allowing the state to provide for an "enhanced hospice access" benefit, whereby the definition of "terminal illness" is expanded from six months' life expectancy to that of 12 months and participants may access hospice without being required to first discontinue curative therapy. ~~Also, by no later than July 1, 2013, the agency of human services shall submit a Global Commitment Medicaid waiver amendment to provide funding for the same enhanced hospice access benefit.~~
EXPLANATION: The State wants to focus on extending the Global Commitment Medicaid waiver; any amendment to the waiver will complicate the extension request.

Sec. E.302 PAYMENT RATES FOR PRIVATE NONMEDICAL INSTITUTIONS PROVIDING RESIDENTIAL CHILD CARE SERVICES
(a) Notwithstanding any other provision of law, for the first quarter of state fiscal year 2014, the division of rate setting shall calculate payment rates for private nonmedical institutions (PNMI) providing residential child care services as 100 percent of each program's final per diem rate in effect on June 30, 2013.
(1) For programs whose final per diem rate as of June 30, 2013 includes an approved rate adjustment, the per diem rate for the first quarter of state fiscal year 2014 will include provisions from the division of rate setting's rate adjustment order.
(2) For programs whose final per diem rate as of June 30, 2013 is categorized as a start-up rate, the per diem rate for the first quarter of state fiscal year 2014 will include provisions from the division of rate setting's final order on the start-up rate.
(b) The division of rate setting shall propose a rule to set rates effective October 1, 2013 for PNMI facilities providing residential child care services based on actual historical costs in a base year.
EXPLANATION:This language is necessary to level-fund PNMI providers for the first quarter of state fiscal year 2014 and treat PNMI providers the same as other Medicaid providers. Beginning October 1, 2013, PNMI providers will be rebased based on actual historical costs.

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Sec. E.306 32 V.S.A. §305a(c) is amended to read:

(c) The January estimates shall include estimated caseloads and estimated per member per month expenditures for the current and next succeeding fiscal years for each Medicaid enrollment group as defined by the agency and the joint fiscal office for state health care assistance programs or premium assistance programs supported by the state health care resources and Global Commitment funds, ~~for VermontRx,~~ and for the programs under ~~the Choices for Care~~ any Medicaid Section 1115 waiver. The next succeeding fiscal year's estimated per member per month expenditures shall include an increase in Medicaid provider reimbursements in order to ensure that the expenditure estimates reflect amounts attributable to health care inflation as required by subdivisions 307(d)(5) and (d)(6) of this title. For VPharm, the January estimates shall include estimated caseloads and estimated per-member per-month expenditures for the current and next succeeding fiscal years by income category. The January estimates shall include the expenditures for the current and next succeeding fiscal years for the Medicare Part D phased-down state contribution payment and for the disproportionate share hospital payments. In July, the administration and the joint fiscal office shall make a report to the emergency board on the most recently ended fiscal year for all Medicaid and Medicaid-related programs, including caseload and expenditure information for each Medicaid eligibility group, and health care inflation estimates provided by the Green Mountain Care board developed under 18 V.S.A. Sec. 9375a. Based on this report, the emergency board may adopt revised estimates for the current fiscal year and estimates for the next succeeding fiscal year.

EXPLANATION: Clarifies that expenditure estimates include a reimbursement inflation factor in order to ensure Medicaid reimbursements do not increase the costs shifted to private payers.

Sec. E.306.1 32 V.S.A. §307(d) is amended to read:

(d) The governor's budget shall include his or her recommendations for an annual budget for Medicaid and all other health care assistance programs administered by the agency of human services. The governor's proposed Medicaid budget shall include a proposed annual financial plan, and a proposed five-year financial plan, with the following information and analysis:

* * *

(5) health care inflation trends consistent with provider reimbursements approved under 18 V.S.A. 9376 and hospital budgets approved by the Green Mountain Care Board under 18 V.S.A. chapter 221, subchapter 7.

(6) recommendations for funding provider reimbursement at levels sufficient to ensure reasonable access to care, and at levels at least equal to Medicare reimbursement;

* * *

EXPLANATION: Clarifies that health care inflation trends should include a reimbursement inflation factor consistent with the hospital budget approvals in order to ensure Medicaid reimbursements do not increase the costs shifted to private payers.

Sec. E.307 33 V.S.A. §1802(9) is added to read:

(9) "Modified adjusted gross income" shall have the same meaning as in 26 USC Section 36B (d)(2)(B).

EXPLANATION: Adds a definition of modified adjusted gross income to the Exchange subchapter to reflect the Affordable Care Act and the addition of state premium and cost-sharing assistance.

Sec. E.307.1 33 V.S.A. §1812 is added to read:

Sec. 1812. FINANCIAL ASSISTANCE TO INDIVIDUALS

(a)(1) An individual or family eligible for federal premium tax credits under 26 USC Section 36B with income less than or equal to 300 percent of federal poverty level shall be eligible for premium assistance.

(2) The department of Vermont health access shall establish a premium schedule on a sliding scale based on modified adjusted gross income for the individuals and families described in subdivision (1) of this subsection. The department shall reduce the premium contribution for these individuals and families by 1.5 percent below the premium amount established in 26 USC Section 36B.

(3) Premium assistance shall be available for the same qualified health benefit plans for which federal premium tax credits are available.

(b)(1) An individual or family with income at or below 350 percent of the federal poverty guideline shall be eligible for cost-sharing assistance, including a reduction in the out-of-pocket maximums established under Section 1402 of the Affordable Care Act.

(2) The department of Vermont health access shall establish cost-sharing assistance on a sliding scale based on modified adjusted gross income for the individuals and families described in subdivision (1) of this subsection. Cost-sharing assistance shall be established as follows:

(i) for households with income at or below 150 percent of the federal poverty level (FPL): 94 percent actuarial value;

(ii) for households with income above 150 percent FPL and at or below 200 percent FPL: 87 percent actuarial value;

(iii) for households with income above 200 percent FPL and at or below 250 percent FPL: 83 percent actuarial value;

(iv) for households with income above 250 percent FPL and at or below 300 percent FPL: 77 percent actuarial value;

(v) for households with income above 300 percent FPL and at or below 350 percent FPL: 73 percent actuarial value.

(3) Cost-sharing assistance shall be available for the same qualified health benefit plans for which federal cost-sharing assistance is available and administered using the same methods set forth in Section 1402 of the Affordable Care Act.

(c) To the extent feasible, the department shall use the same mechanisms provided in the Affordable Care Act to establish financial assistance under this section in order to minimize confusion and complication for individuals, families, and health insurers.

EXPLANATION: Adds authority to establish state premium and cost-sharing assistance to ensure affordable coverage for low and middle income Vermonters. This assistance is provided in addition to the federal premium tax credit and federal cost-sharing assistance and uses the same eligibility criteria and same methods of administration.

Sec. E.307.2 REDUCTION IN MEDICAID COST-SHIFT

(a) It is the intent of the general assembly to ensure that health care providers receive fair and reasonable reimbursement from the department of Vermont health access for services provided to individuals eligible for Medicaid and Dr. Dynasaur. Vermont's public programs should reimburse health care providers in a manner that recognizes inflation included in hospital budgets approved by the Green Mountain Care Board in order to avoid exacerbating the shift of costs to private payers.

(b) Beginning October 1, 2013, the agency of human services shall increase Medicaid reimbursements to health care providers, except nursing homes and private nonmedical institutions (PNMI), by an amount equal to 3 percent of fiscal year 2012 expenditures for those providers. The agency may vary the percentage increase to health care providers consistent with participation in payment and delivery system activities authorized under 18 V.S.A. Sec. 9375, or consistent with meeting health care cost and quality performance targets established by the department of Vermont health access (DVHA) under the Global Commitment to Health Section 1115 waiver.

EXPLANATION: Provides an inflation increase to reimbursements under Medicaid for all providers, except nursing homes, which have a statutory inflation factor, and PNMI providers, which will be rebased based on actual costs effective October 1, 2013. Delays the increase in hospital reimbursements to coincide with the hospital budget year which begins October 1. Also provides discretion for the Agency of Human Services to vary the increase consistent with participation in "payment reform" and cost and quality performance targets.

Sec. E.309 21 V.S.A. §2002(3) is amended to read:

(3) "Full-time equivalent" or "FTE" means the number of employees expressed as the number of employee hours worked during a calendar quarter divided by 520. "Full-time equivalent" shall not include any employee hours attributable to a seasonal employee or part-time employee of an employer who offers health care coverage to all of its regular full-time employees, provided that the seasonal employee or part-time employee has health care coverage under either a private or any public plan except ~~VHAP or~~ Medicaid.

EXPLANATION: With the advent of the Health Care Exchange, VHAP will be eliminated.

Sec. E.309.1 21 V.S.A. §2003 is amended to read:

Sec. 2003 Health care fund contribution assessment

* * *

(b) For any quarter in fiscal years 2007 and 2008, the amount of the health care fund contribution shall be $ 91.25 for each full-time equivalent employee in excess of eight. 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 the amount of the health care fund contribution shall be adjusted by a percentage equal to any

percentage change in premiums for ~~Catamount Health for that fiscal year~~ the second lowest cost silver plan in the Vermont health benefit exchange~~; provided, however, that to the extent that Catamount Health premiums decrease due to changes in benefit design or deductible amounts, the health care fund contribution shall not be decreased by the percentage change attributable to such benefit design or deductible changes~~.

* * *

(d) Revenues from the health care fund contributions collected shall be deposited into the state health care resources fund established under 33 V.S.A. § 1901d ~~for the purpose of financing health care coverage under Catamount Health assistance, as provided under 33 V.S.A. chapter 19, subchapter 3a~~.

EXPLANATION: Modifications to the employer assessment due to repeal of Catamount Health to maintain indexed amounts.

Sec. E.310 33 V.S.A. §1901d is amended to read:

Sec. 1901d State health care resources fund

(a) The state health care resources fund is established in the treasury as a special fund to be a source of financing health care coverage for beneficiaries of the state health care assistance programs under the Global Commitment to health waiver approved by the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act ~~and for the Catamount Health assistance program under subchapter 3A of chapter 19 of this title~~ and a source of financing for the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1.

(b) Into the fund shall be deposited:

(1) all revenue from the tobacco products tax and from the cigarette tax levied pursuant to 32 V.S.A. chapter 205;

(2) revenue from health care provider assessments pursuant to subchapter 2 of chapter 19 of this title;

(3) revenue from the employer health care premium contribution pursuant to 21 V.S.A. chapter 25;

(4) revenue from the health care claims ~~assessments~~ tax pursuant to ~~8 V.S.A. § 4089l~~ 32 V.S.A. Sec. 10402(b)(2);

(5) premium amounts paid by individuals unless paid directly to the insurer;

(6) the proceeds from grants, donations, contributions, taxes, and any other sources of revenue as may be provided by statute, rule, or act of the general assembly; and

(7) any remaining balance in the terminated Catamount fund as of June 30, 2012.

* * *

EXPLANATION: Allows funds deposited into the state health care resources fund to be used to fund the Vermont health benefit exchange.

Sec. E.310.1 33 V.S.A. §1901d is amended to read:

Sec. 1901d State health care resources fund

* * *

(d) All monies received by or generated to the fund shall be used only as allowed by appropriation of the general assembly for the administration and delivery of health care covered through state health care assistance programs administered by the agency under the Global Commitment for Health Medicaid Section 1115 waiver, ~~the Catamount Health assistance program under subchapter 3A of chapter 19 of this title, employer-sponsored insurance premium assistance under section 1974 of this title,~~ the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1, immunizations under 18 V.S.A. § 1130, and the development and implementation of the Blueprint for Health under 18 V.S.A. § 702.

EXPLANATION: Deletes references to Catamount Health and employer-sponsored insurance premium assistance .

Sec. E.310.2 32 V.S.A. chapter 243 is added to read:

CHAPTER 243. HEALTH CARE CLAIMS TAX

§10401. Definitions

(a) As used in this section:

(1) "Health insurance" means any group or individual health care benefit policy, contract, or other health benefit plan offered, issued, renewed, or administered by any health insurer, including any health care benefit plan offered, issued, renewed, or administered by any health insurance company, any nonprofit hospital and medical service corporation, or any managed care organization as defined in 18 V.S.A. § 9402. The term includes comprehensive major medical policies, contracts, or plans and Medicare supplemental policies, contracts, or plans, but does not include Medicaid, VHAP, or /any other state health care assistance program financed in whole or in part through a federal program, unless authorized by federal law and approved by the general assembly. The term

does not include policies issued for specified disease, accident, injury, hospital indemnity, dental care, long-term care, disability income, or other limited benefit health insurance policies.

(2) "Health insurer" means any person who offers, issues, renews or administers a health insurance policy, contract, or other health benefit plan in this state, and includes third party administrators or pharmacy benefit managers who provide administrative services only for a health benefit plan offering coverage in this state. The term does not include a third party administrator or pharmacy benefit manager to the extent that a health insurer has paid the fee which would otherwise be imposed in connection with health care claims administered by the third party administrator or pharmacy benefit manager. The term also does not include a health insurer with a monthly average of fewer than 200 Vermont insured lives.

§10402. Health Care Claims Tax

(a) There is imposed on every health insurer an annual tax in an amount equal to 0.999 percent of all health insurance claims paid by the health insurer for its Vermont members. The tax is imposed with respect to claims paid in the previous fiscal year ending June 30 and shall be paid to the commissioner of taxes in equal installments on the first day of November, January, April and June.

(b) Revenues paid and collected under this chapter shall be deposited as follows:

(1) 0.199 of one percent into the health IT fund established in 32 V.S.A. § 10301

(2) the balance into the state health care resources fund established in 33 V.S.A. § 1901d.

(c) The annual cost to obtain Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) data, pursuant to 18 V.S.A. Sec 9410, for use by the department of taxes shall be paid from the Vermont health IT fund and the health care resources fund in the same proportion as revenues are deposited into those funds.

(d) It is the intent of the general assembly that all health insurers shall contribute equitably through the tax imposed in subsection (a) of this section. In the event that tax is found not to be enforceable as applied to third party administrators or other entities, the tax owed by all other health insurers shall remain at the existing level and the general assembly shall consider alternative funding mechanisms that would be enforceable as to all health insurers.

§10403. Administration of Tax

(a) The commissioner of taxes shall administer and enforce the chapter and this tax. The commissioner may issue, amend, and withdraw from time to time, reasonable regulations to assist such administration and enforcement.

(b) All of the administrative provisions of chapter 151 of this title, including those relating to the collection and enforcement by the commissioner of the withholding tax and the income tax shall apply to the tax imposed by this chapter. Further, the provisions of chapter 103 of this title, including those relating to the imposition of interest and penalty for failure to pay the tax as provided in §10402, shall apply to the tax imposed by this chapter.

EXPLANATION: Consolidating the administration of the claims assessment and transferring the responsibility for collecting this revenue to the tax department.

§10404. Determination of deficiency, refund, penalty, or interest

(a) Within 60 days after the mailing of a notice of deficiency, denial or reduction of a refund claim, or assessment of penalty or interest, the taxpayer may petition the commissioner in writing for a determination of that deficiency, refund, or assessment. The commissioner shall thereafter grant a hearing upon the matter and notify the taxpayer in writing of his or her determination concerning the deficiency, penalty or interest. This is the exclusive remedy of a taxpayer with respect to these matters.

(b) Any hearing granted by the commissioner under this section shall be subject to and governed by chapter 25 of Title 3.

(c) Any aggrieved taxpayer may, within 30 days after a determination by the commissioner concerning a notice of deficiency, an assessment of penalty or interest, or a claim to refund, appeal that determination to the Washington superior court or the superior court of the county in which the taxpayer resides or has a place of business.

EXPLANATION: Establishes consistency with other Tax statutes.

Sec. E.310.3 32 V.S.A. § 3102(e) is amended to read:

(e) The commissioner may, in his or her discretion and subject to such conditions and requirements as he or she may provide, including any confidentiality requirements of the Internal Revenue Service, disclose a return or return information:

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(15) to the department of liquor control, provided that the information is limited to information concerning the sales and use tax and meals and rooms tax filing history with respect to the most recent five years of a person seeking a liquor license or a renewal of a liquor license; and

(16) to the commissioner of financial regulation and the commissioner of Vermont health access, if such return or return information relates to obligations of health insurers under chapter 243 of title 32.

EXPLANATION: Establishes consistency with other Tax statutes.

Sec. E.310.4 32 V.S.A. §10402(a) is amended to read:

(a) There is imposed on every health insurer an annual tax in an amount equal to 1.499 percent of all health insurance claims paid by the health insurer for its Vermont members. The tax is imposed with respect to claims paid in the previous fiscal year ending June 30 and shall be paid to the commissioner of taxes in equal installments on the first day of November, January, April and June.

EXPLANATION: See effective dates.

Sec. E.310.5 32 V.S.A. §10402(a) is amended to read:

(a) There is imposed on every health insurer an annual tax in an amount equal to 1.999 percent of all health insurance claims paid by the health insurer for its Vermont members. The tax is imposed with respect to claims paid in the previous fiscal year ending June 30 and shall be paid to the commissioner of taxes in equal installments on the first day of November, January, April and June.

EXPLANATION: See effective dates.

Sec. E.310.6 32 V.S.A. 10301 is amended to read:

Sec. 30301 Health IT-fund

* * *

(c) Into the fund shall be deposited:

(1) revenue from the ~~reinvestment fee~~ health care claims tax imposed on health insurers pursuant to ~~8 V.S.A. § 4089k~~ 32 V.S.A. Sec. 10402(b)(1).

* * *

EXPLANATION: Revenues are redirected, as one statute is being replaced by another.

Sec. E.310.7 REPEAL

(a) 8 V.S.A. Sec. 4089l (health care claims assessment) is repealed on July 1, 2013.

EXPLANATION: This health care claims assessment statute is being replaced by the health care claims tax, established above. No change in rate for FY 2014.

Sec. E.310.8 Sec. 9.001(g) of No. 192 of the Acts of the 2007 Adj. Sess. (2008) is amended to read:

(g) Sec. 7.005 of this act shall sunset July 1, ~~2015~~ 2013.

EXPLANATION: This health care information technology reinvestment fee statute is being replaced by the health care claims tax, established above. No change in rate for FY 2014. We are amending the existing 7/1/15 sunset date to make the transition effective for FY 2014.