[DRAFT] Report of Committee of Conference

S.252

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

The Committee of Conference, to which were referred the disagreeing votes of the two Houses upon Senate Bill, entitled:

S.252. An act relating to financing for Green Mountain Care.

Respectfully reports that it has met and considered the same and recommends that the House recede from its proposals of amendment and that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Vermont Health Benefit Exchange * * *

Sec. 1. 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. 2. 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. 3. 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.

* * * Health Insurance Rate Review * * *

Sec. 4. 8 V.S.A. § 4062(h) is amended to read:

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

(2) The policy forms for major medical insurance coverage, as well as the policy forms, premium rates, and rules for the classification of risk for the other lines of insurance described in subdivision (1) of this subsection shall be reviewed and approved or disapproved by the Commissioner. In making his or her determination, the Commissioner shall consider whether a policy form, premium rate, or rule is affordable and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. The Commissioner shall make his or her determination within 30 days after the date the insurer filed the policy form, premium rate, or rule with the Department. At the expiration of the 30-day period, the form, premium rate, or rule shall be deemed approved unless prior to then it has been affirmatively approved or disapproved by the Commissioner or found to be incomplete. The Commissioner shall notify an insurer in writing if the insurer files any form, premium rate, or rule containing a provision that does not meet the standards expressed in this subsection. In such notice, the Commissioner shall state that a hearing will be granted within 20 days upon the insurer's written request.

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

* * * Green Mountain Care * * *

Sec. 5. 33 V.S.A. § 1825 is amended to read:

§ 1825. HEALTH BENEFITS

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

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

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

* * *

Sec. 6. 33 V.S.A. § 1827 is amended to read:

§ 1827. ADMINISTRATION; ENROLLMENT

* * *

(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. 7. 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.

* * * Green Mountain Care Board * * *

Sec. 8. 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. 9. 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. 10. 2013 Acts and Resolves No. 79, Sec. 5b is amended to read:

Sec. 5b. STANDARDIZED HEALTH INSURANCE CLAIMS AND EDITS

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

* * *

* * * Certificates of Need * * *

Sec. 11. 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~~ nonprofit, 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. 12. 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. 13. 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. 14. 18 V.S.A. § 9492 is added to read:

§ 9492. NON-EMERGENCY WALK-IN CENTERS; NONDISCRIMINATION

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

* * * Pharmacy Benefit Managers * * *

Sec. 15. 18 V.S.A. § 9472 is amended to read:

§ 9472. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO HEALTH INSURERS

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

* * *

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

* * *

(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. 16. 18 V.S.A. § 9473 is redesignated to read:

§ ~~9473~~ 9474. ENFORCEMENT

Sec. 17. 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 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. 18. 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. 19. 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. 20. 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. 21. REPORT; BLUEPRINT FOR HEALTH

On or before December 15, 2014, the Director of the Blueprint for Health shall submit a report to the House Committee on Health Care and to the Senate Committee on Health and Welfare containing recommendations as to how screening for adverse childhood experiences and trauma-informed care may be incorporated into Blueprint for Health medical practices and community health teams, including any proposed evaluation measures and approaches; funding constraints; opportunities; availability of appropriate screening tools and evidence-based interventions for individuals; the additional resources, if any, that would be necessary to ensure adequate access to the interventions identified as needed as a result of the use of the screening tools; and additional security protections that may be necessary for information related to a patient's adverse childhood experiences.

Sec. 22. 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. 23. 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. 24. REPORT; DEPARTMENT OF HEALTH; GREEN MOUNTAIN CARE BOARD

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

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

(2) recommendations on the availability of appropriate screening tools and evidence-based interventions for individuals throughout their lives, including expectant parents, and the additional resources, if any, that would be necessary to ensure adequate access to the interventions identified as needed as a result of the use of the screening tools; and

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

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

* * * Reports * * *

Sec. 25. GREEN MOUNTAIN CARE FINANCING AND COVERAGE; REPORT

(a) Notwithstanding the January 15, 2013 date specified in 2011 Acts and Resolves No. 48, Sec. 9, no later than January 15, 2015, the Secretary of Administration shall submit to the House Committees on Health Care, on Appropriations, and on Ways and Means and the Senate Committees on Health and Welfare, on Appropriations, and on Finance a proposal to transition to and implement fully Green Mountain Care. The report shall include the following elements, as well as any other topics the Secretary deems appropriate:

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

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

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

(B) recommending financing options for wraparound coverage for individuals with other primary coverage, including evaluating the potential for

using financing tiers based on the level of benefits provided by Green Mountain Care; and

(C) addressing cross-border financing issues;

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

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

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

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

(7) information regarding Vermont's efforts to obtain a Waiver for State Innovation pursuant to Section 1332 of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, including submission of a conceptual waiver application as required by Sec. 10 of this act; and

(8) proposals for enhancing loan forgiveness programs and other opportunities and incentives for health care workforce development and enhancement.

(b) If the Secretary of Administration does not submit the Green Mountain Care financing and coverage proposal required by this section to the General Assembly by January 15, 2015, no portion of the unencumbered funds remaining as of that date in the fiscal year 2015 appropriation to the Agency of Administration for the planning and the implementation of Green Mountain Care shall be expended until the Secretary submits the required proposal.

Sec. 26. CHRONIC CARE MANAGEMENT; BLUEPRINT; REPORT

On or before October 1, 2014, the Secretary of Administration or designee shall recommend to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance 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 services or chronic conditions such as obesity, mental conditions, and oral health.

Sec. 27. 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. 28. TRANSITION PLAN FOR UNION EMPLOYEES

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

Sec. 29. FINANCIAL IMPACT OF HEALTH CARE REFORM INITIATIVES

The Joint Fiscal Committee shall:

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

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

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

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

Sec. 30. 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.

* * * Repeal * * *

Sec. 31. 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. 32. EFFECTIVE DATES

This act shall take effect on passage, except that:

(1) Notwithstanding 1 V.S.A. § 214, Sec. 31 (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. 17 (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 ON THE PART OF THE SENATE	COMMITTEE ON THE PART OF THE HOUSE
_____	_____
SEN. TIMOTHY R. ASHE	REP. MICHAEL FISHER
_____	_____
SEN. CLAIRE D. AYER	REP. JANET ANCEL
_____	_____
SEN. M. JANE KITCHEL	REP. SARAH L. COPELAND-HANZAS