S.252 - House Health Care Committee consolidated amendments

Sec. 1. **PURPOSE;** LEGISLATIVE INTENT ***(Fisher)***

(a) The General Assembly finds that:

(1) It has been three years since the passage of 2011 Acts and Resolves No. 48 (Act 48). ~~**Several health care reform initiatives have been implemented or are preparing to launch the,**~~

(2) The Blueprint for Health has advanced significantly since 2011. The Blueprint now encompasses 121 primary care medical home practices serving a total of 514,385 Vermonters. In 2012, total annual health care expenditures were substantially reduced for both children and adults.

(3) Vermont was awarded a three-year State Innovation Model (SIM) grant of $45 million to improve health and health care and 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 the right 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, Vermont Chronic Care Initiative, and accountable care organizations.

(4) From the SIM grant funds, the State has 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) The Green Mountain Care Board 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 also issued four certificates of need and one conceptual development phase certificate of need. It issued 31 health insurance rate decisions and reduced by approximately five percent the rates proposed by insurers in the Vermont Health Benefit Exchange.

(6) 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.

(7) 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.

(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 timeline in Act 48 for the implementation of Green Mountain Care. A set of five triggers focusing on decisions about financing, covered services, benefit design, impacts of Green Mountain Care, and receipt of a federal waiver must be satisfied 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.

(b) In order to successfully implement the ~~**reforms**~~ **next steps** envisioned by ~~**that act**~~ **Act 48**, it is appropriate to update the assumptions and cost estimates that formed the basis for ~~**Act 48**~~ **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.

(c) Before making final decisions about the financing for Green Mountain Care, the General Assembly must have accurate data about how Vermonters currently pay for health care and how the new system will impact individual decisions about accessing care.

(d) 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 be satisfied that appropriate plan of operations is in place in order to accomplish the transitions needed for successful implementation of Green Mountain Care.

Sec. 2. PRINCIPLES FOR HEALTH CARE FINANCING ***(Fisher)***

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~~ **a federal health benefit plan, by Medicare**, 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 **ambulatory patient services, emergency services, hospitalization,** 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~~ **mental health and substance use disorder services**, prescription drugs**, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic care management, and pediatric services**.

Sec. 2. PRINCIPLES FOR HEALTH CARE FINANCING ***(Spengler)***

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 **through Green Mountain Care, Vermont's universal and unified health system**.

(2) ~~**Vermont residents shall finance**~~ Green Mountain Care **shall be financed** through taxes that are levied equitably**,** ~~**taking into account an individual's ability to pay and the value of the health benefits provided**~~

ensuring that individuals and businesses are taxed in direct proportion to their earned and unearned income, wealth, and business size in order to account fully for their ability to pay.

(3) **~~As provided in 33 V.S.A. § 1827,~~** Green Mountain Care shall be **~~the~~ a** 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 **all 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~~ diagnostic testing, preventive services, treatment of a condition, after-care, equipment, and pharmaceuticals that a treating health care professional determines to be appropriate for a patient's diagnosis or condition in terms of type, amount, frequency, level, setting, and duration**.

(5) The State shall develop an indexing mechanism for Green Mountain Care financing that adjusts the level of individuals' and businesses' financial contributions to meet population health needs 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. X. OPTIONAL EXCHANGE COVERAGE FOR EMPLOYERS WITH UP TO 100 EMPLOYEES *(Till)*

(a)(1) As soon as 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. 6. TREATMENT OF FEDERAL EMPLOYEES**~~ ***(Fisher, Spengler)***

~~**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. 7. 33 V.S.A. § 1824(f) is added to read:**~~ ***(Fisher, Spengler)***

~~**(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. 7a. SUPPLEMENTAL PLANS FOR TRICARE PARTICIPANTS~~

(Fisher, Spengler)

~~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. A. GREEN MOUNTAIN CARE AS INSURER OF LAST RESORT

(Pearson)

On or before December 1, 2014, the Secretary of Administration or designee shall determine how best to make Green Mountain Care the insurer of last resort for any Vermont resident covered by another health benefit plan, including the Federal Employees Health Benefit Plan, Medicare, and retiree health benefits. The Secretary or designee shall also recommend financing options for individuals covered by another health

plan, including using financing tiers based on the level of benefits provided by Green Mountain Care.

Sec. X. INTEGRATION REPORT *(Spengler)*

On or before January 15, 2015, 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 with respect to the integration and coordination of groups for which Green Mountain Care will be a secondary payer pursuant to 33 V.S.A. § 1827(e) and (f), including federal employees, TRICARE enrollees, and Medicare beneficiaries. The report shall include assessments of possible financing and coverage options, which may include tax credits for premiums paid for primary health care coverage.

Sec. 8. 33 V.S.A. § 1825 is amended to read: ***(Fisher, Poirier)***

§ 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~~ ~~**consist of the benefits**~~ **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 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. 8. 33 V.S.A. § 1825 is amended to read: ***(Spengler)***

§ 1825. HEALTH BENEFITS

(a)(1) ~~**The benefits for**~~ Green Mountain Care shall **provide health services that** 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~~ ~~**consist of the benefits**~~ **are available in the benchmark plan for the Vermont Health Benefit ~~Exchange~~ be at least as comprehensive as those in the State employees' SelectCare POS offered on January 1, 2014**.

* * *

(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. **It is the intent of the General Assembly that these benefits shall be included in the Green Mountain Care benefit package within four years following implementation.**

(B) The Green Mountain Care Board shall consider whether to include long-term care benefits in the Green Mountain Care benefit package.

* * *

Sec. 9. ~~**CONTRACT FOR ADMINISTRATION OF CERTAIN ELEMENTS OF**~~ **UPDATES ON TRANSITION TO** GREEN MOUNTAIN CARE ***(Fisher)***

(a) ~~On or before February 1, 2015, the Agency of Human Services shall identify~~ The Secretary of Administration or designee shall provide updates at least quarterly to the House Committees on Health Care and

on Ways and Means, the Senate Committees on Health and Welfare and on Finance, and the Health Care Oversight Committee 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)**~~. By the same date, the Agency shall also prepare~~ and preparing** 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).~~

(2) developing a plan for financing the amounts needed for Green Mountain Care, including addressing cross-border issues and financing mechanisms for Vermont's Medicare population;

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

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

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

(6) assessing coverage options for Vermont's Medicare population within Green Mountain Care and the potential continuation of Medicare supplemental insurance and Medicare Advantage plans; and

(8) identifying growth and trends in health care system costs.

(b) The Green Mountain Care Board shall provide updates at least quarterly to the House Committees on Health Care and on Ways and Means, the Senate Committees on Health and Welfare and on Finance, and the Health Care Oversight Committee 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. 9. CONTRACT FOR ADMINISTRATION OF CERTAIN ELEMENTS OF GREEN MOUNTAIN CARE ***(Spengler, Poirier)***

(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**, which shall be consistent with 33 V.S.A. § 1827(a)(2). To improve transparency, the Agency shall require each bidder to disclose its financial and other interests in Vermont and in multistate health systems reform.**

(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. X. 33 V.S.A. § 1827(a) is amended to read: ***(Spengler)***

(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**:**

(A) ~~**consider**~~ **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.

(B) Evaluate not only financial costs but the social value that may be created by each contract bid, taking into account improvements to the social and economic well-being of State residents that may occur in addition to the specific benefits produced by the services rendered under the contract.

Sec. X. 33 V.S.A. § 1827(a) is amended to read: ***(Poirier)***

(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**:**

(A) ~~**consider**~~ **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.

(B) Evaluate not only financial costs but also the social value that may be created by a contract bidder through improvements to the social and economic well-being of State residents, consistent with the requirement of advancing dignity and equity in 32 V.S.A. § 306a(a). These improvements should occur in addition to the specific benefits produced by the services rendered under the contract.

(4) On or before January 15, 2020, the Secretary of Administration or designee shall report to the General Assembly with an assessment of the cost-effectiveness of contracting with an external entity for the supply of administrative services related to Green Mountain Care. The report shall include an analysis of administrative change options, including administration within the Department of Vermont Health Access.

Sec. 10. CONCEPTUAL WAIVER APPLICATION

On or before October 1, 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. § 2001 is amended to read:

§ 2001. PURPOSE

For the purpose of more equitably distributing the costs of health care to uninsured residents of this ~~state~~ State, an employers' health care fund contribution is established to provide a fair and reasonable method for sharing health care costs with employers who do not offer their employees health care coverage and employers who offer insurance but whose employees enroll in Medicaid.

Sec. 12. 21 V.S.A. § 2002 is amended to read:

§ 2002. DEFINITIONS

As used in this chapter:

* * *

(5) "Uncovered employee" means:

(A) an employee of an employer who does not offer to pay any part of the cost of health care coverage for its employees;

(B) an employee who is not eligible for health care coverage offered by an employer to any other employees; or

(C) an employee who is offered and is eligible for coverage by the employer but elects not to accept the coverage and either:

(i) has no other health care coverage under either Medicare or a private ~~or public~~ health plan; or

(ii) has purchased health insurance coverage as an individual through the Vermont Health Benefit Exchange.

* * *

Sec. 13. 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.

*** * * Pharmacy Benefit Managers * * ***

Sec. A. 18 V.S.A. § 9472 is redesignated to read: ***(Copeland Hanzas)***

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

Sec. X. 18 V.S.A. § 9472 is amended to read: ***(Fisher)***

§ 9472. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES

*** * ***

(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:

(1) the percentage or dollar amount that the pharmacy benefit manager retains on each claim charged to the health insurer in excess of the amount the pharmacy benefit manager reimburses the pharmacy for filling and dispensing the prescription; and

(2) 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 for pharmacy benefit management in this state.

Sec. B. 18 V.S.A. § 9473 is redesignated to read: *(Copeland Hanzas)*

§ ~~9473~~ 9474. ENFORCEMENT

Sec. C. 18 V.S.A. § 9473 is added to read: *(Copeland Hanzas)*

§ 9473. PHARMACY BENEFIT MANAGERS; REQUIRED PRACTICES WITH RESPECT TO PHARMACIES

(a) Within 14 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 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 days.

(c) A pharmacy benefit manager or other payer 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; or

(2) require a pharmacy to pass any portion of the insured's co-payment through to the pharmacy benefit manager or other payer.

Sec. D. 9 V.S.A. § 2466a is amended to read: *(Copeland Hanzas)*

§ 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.

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* * * Reports * * *

Sec. X. GREEN MOUNTAIN CARE FINANCING AND COVERAGE; REPORT *(Poirier)*

Notwithstanding the January 15, 2013 date specified in 2011 Acts and Resolves No. 48, Sec. 9, on or before February 1, 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 recommending the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private universal health care system. The proposal shall also identify which Vermont residents should be included and excluded from Green Mountain Care for purposes of health care coverage and financing.

Sec. 14. CHRONIC CARE MANAGEMENT; BLUEPRINT; REPORT ***(Poirier)***

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~~ Legislative Health Care Reform 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 ***(Poirier)***

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**~~ **Legislative Health Care Reform Oversight Committee**.

Sec. 16. BENCHMARK-EQUIVALENT HEALTH CARE COVERAGE ***(Poirier)***

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 Legislative Health Care Reform 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. 16. BENCHMARK-EQUIVALENT HEALTH CARE COVERAGE**~~

~~***(Fisher, Spengler)***~~

~~**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 ***(Fisher)***

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~~ ensure a fair and timely transition of public employees from existing health insurance plans to Green Mountain Care [*School Boards Ass'n*]**.

Sec. 18. FINANCIAL IMPACT OF HEALTH CARE REFORM INITIATIVES ***(Fisher)***

(a) The Secretary of Administration or designee shall consult with the Joint Fiscal Office in **identifying data and** developing **~~and selecting data~~ methodologies**, assumptions, analytic models, and other **~~work~~ factors** 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 **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;

~~and~~

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

and

(3) ~~the~~ updated cost estimates ~~of~~ 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 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. PHARMACY BENEFIT MANAGEMENT ***(Poirier)***

On or before October 1, 2014, the Secretary of Administration or designee shall report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the **Health Care Oversight Committee Legislative Health Care Reform Oversight Committee** regarding the feasibility and benefits to the State of Vermont of the State acting as its own pharmacy benefit manager for the State employees' health benefit

plan, Vermont's Medicaid program, Green Mountain Care, and any other health care plan financed or administered in whole or in part by the State.

~~**Sec. 19. PHARMACY BENEFIT MANAGEMENT** *(Fisher)*~~

~~**On or before October 1, 2014, the Secretary of Administration or designee shall report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the Health Care Oversight Committee regarding the feasibility and benefits to the State of Vermont of the State acting as its own pharmacy benefit manager for the State employees' health benefit plan, Vermont's Medicaid program, Green Mountain Care, and any other health care plan financed or administered in whole or in part by the State.**~~

Sec. 20. INDEPENDENT PHYSICIAN PRACTICES; REPORT *(Poirier)*

On or before December 1, 2014, the Secretary of Administration or designee shall report to the House Committee on Health Care~~, and~~ the Senate Committees on Health and Welfare and on Finance**, and the Legislative Health Care Reform Oversight Committee** regarding the policy of the State of Vermont with respect to independent physician practices, including whether the State wishes to encourage existing physician practices to remain independent and whether the State wishes to encourage new independent physician practices to open, and, if it is the policy of the State to encourage these independent physician practices, recommending ways to increase the number of these practices in Vermont. The Secretary or designee shall also consider 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. INDEPENDENT PHYSICIAN PRACTICES; REPORT ***(Fisher)***

On or before December 1, 2014, the Secretary of Administration or designee**, in consultation with the Vermont Medical Society,** shall report to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance regarding the ~~**policy of the State of Vermont with respect to**~~ **financial viability of** independent physician practices **in this State** ~~**, including whether the State wishes to encourage existing physician practices to remain independent and whether the State wishes to encourage new independent physician practices to open, and, if it is the policy of the State to encourage these independent physician practices, recommending ways to increase the number of these practices in Vermont**~~. The Secretary or designee shall also consider 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. 21. HEALTH INFORMATION TECHNOLOGY AND INTELLECTUAL PROPERTY; REPORT ***(Poirier)***

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**, and the Legislative Health Care Reform Oversight Committee** 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. HEALTH INFORMATION TECHNOLOGY AND INTELLECTUAL PROPERTY; REPORT~~ ***~~(Fisher)~~***

~~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. 22. MEDICARE INTEGRATION; REPORT ***(Poirier)***

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**, and the Legislative Health Care Reform Oversight Committee** regarding the options available to the State of Vermont with respect to ~~**the potential integration and coordination of**~~ **individuals who are eligible for** Medicare ~~**with**~~ **and wish to receive supplemental coverage through or outside of** Green Mountain Care. The report shall include assessments of possible financing and **supplemental** coverage options for Vermont's Medicare population within Green Mountain Care ~~**and**~~ **as well as** the potential continuation of Medicare supplemental insurance and Medicare Advantage plans.

Sec. 22. ~~**MEDICARE INTEGRATION**~~ **HEALTH PROGRAM COORDINATION WITH GREEN MOUNTAIN CARE**; REPORT ***(Fisher)***

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**, the Federal Employees**

Health Benefit Program, TRICARE, and other employment-based or retiree health coverage 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.**~~

~~**Sec. 22. MEDICARE INTEGRATION; REPORT** ***(Spengler)***~~

~~**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.**~~

Sec. B. INCREASING MEDICAID RATES; REPORT ***(Pearson)***

On or before January 15, 2015, the Secretary of Administration or designee 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. C. UNIVERSAL COVERAGE WORK GROUP; REPORT *(Pearson)*

(a) There is created a Universal Coverage Work Group to develop a strategy for achieving universal health coverage in Vermont by the end of 2015.

(b) The Work Group shall comprise the following members:

(1) two current members of the House of Representatives, who shall be appointed by the Speaker of the House;

(2) two current members of the Senate, who shall be appointed by the Committee on Committees;

(3) the Secretary of Administration or one or more designees.

(c) The Work Group shall have the administrative, technical, and legal assistance of the Agency of Administration, the Office of Legislative Council, and the Joint Fiscal Office.

(e) On or before December 1, 2014, the Work Group shall report its strategy for universal coverage to the General Assembly and any recommendations for legislative action.

(f)(1) The Secretary of Administration or designee shall call the first meeting of the Work Group to occur on or before July 1, 2014.

(2) The Secretary of Administration or designee shall be the chair.

(3)(A) A majority of the members of the Work Group shall be physically present at the same location to constitute a quorum.

(B) A member may vote only if physically present at the meeting location.

(C) Action shall be taken only if there is both a quorum and a majority vote of all members of the Work Group.

(4) The Work Group shall cease to exist on January 1, 2015.

(g) For attendance at meetings during adjournment of the General Assembly, legislative members of the Work Group shall be entitled to per diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 406 for no more than six meetings outside of the legislative session.

Sec. D. UNCOMPENSATED CARE REDUCTION; TAX; REPORT

(Pearson)

On or before February 1, 2015, the Secretary of Administration or designee shall propose to the House Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare and on Finance a strategy for taxing hospitals based on the decrease in uncompensated care provided as the result of universal health care coverage for all Vermont residents. The Secretary or designee shall take into account any corresponding decrease in federal funds provided to hospitals as a direct result of the decrease in uncompensated care.

Sec. E. INTEGRATION OF WORKERS' COMPENSATION WITH GREEN MOUNTAIN CARE; REPORT *(Pearson)*

On or before December 1, 2014, the Secretary of Administration or designee shall provide the General Assembly with a detailed plan to integrate workers' compensation health benefits into Green Mountain Care, including projecting the likely savings to Vermont businesses as a result of the integration and estimating any increased costs to the health care system.

Sec. Y. INTEGRATION OF WORKERS' COMPENSATION; REPORT *(Spengler)*

On or before December 1, 2014, the Secretary of Administration or designee shall report to the General Assembly regarding specific design options for integrating or aligning Vermont's workers' compensation system with Green Mountain Care. The report shall include an examination of case studies of workers' experiences with accessing health

care in the current system; an analysis and model of costs and savings offered by integration or alignment, including an analysis of cost-shifting in the current system; and technical design options for integration or alignment.

Sec. F. HEALTH CARE PREMIUM AS A PERCENTAGE OF INCOME; REPORT *(Pearson)*

On or before November 15, 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 a comparison of 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.

* * * Health Care Workforce Symposium * * *

Sec. 23. HEALTH CARE WORKFORCE SYMPOSIUM

On or before November 15, 2014, the Secretary of Administration or designee, in collaboration with the Vermont Medical Society and the Vermont Association of Hospitals and Health Systems, 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.

*** * * Green Mountain Care Board * * ***

Sec. X. 18 V.S.A. § 9375(b) is amended to read: *(Spengler)*

(b) The Board shall have the following duties:

* * *

(4) Review the Health Resource Allocation Plan created in chapter 221 of this title**, conduct regular assessments of the range and depth of health needs among the State's population, and develop a plan for allocating resources over a reasonable period of time to meet those needs**.

* * *

Sec. X. 18 V.S.A. § 9375(d) is amended to read: *(GMCB)*

(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. X. 2000 Acts and Resolves No. 152, Sec. 117b, as amended by 2013 Acts and Resolves No. 79, Sec, 42, is further amended to read: *(GMCB)*

Sec. 117b. MEDICAID COST SHIFT REPORTING

* * *

(b) Notwithstanding 2 V.S.A. § 20(d), annually on or before ~~December~~ January 15, the 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. X. 2013 Acts and Resolves No. 79, Sec. 5b is amended to read:

(GMCB)

(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.

*** * ***

*** * * Legislative Oversight * * ***

Sec. X. LEGISLATIVE HEALTH CARE REFORM OVERSIGHT COMMITTEE *(Poirier)*

(a) There is created a Legislative Health Care Reform Oversight Committee to monitor the implementation of health care reform activities in Vermont during 2014 and 2015 when the General Assembly is not in session. The Committee shall comprise six members:

(1) three current members of the House of Representatives, not all from the same political party, who shall be appointed by the Speaker of the House; and

(2) three current members of the Senate, not all from the same political party, who shall be appointed by the Committee on Committees.

(b) The Legislative Health Care Reform Oversight Committee shall monitor and oversee the implementation of health care reform activities, including receiving reports and updates from the Administration and Green Mountain Care Board.

(c) The Committee shall have the administrative, technical, and legal assistance of the Office of Legislative Council and the Joint Fiscal Office.

(d)(1) The first member named by the Speaker of the House and by the Committee on Committees shall jointly call the first meeting of the Committee to occur on or before July 1, 2014. The Committee shall select a chair from among its members at the first meeting.

(2) The Committee shall cease to exist on December 31, 2015.

(e) For attendance at meetings during adjournment of the General Assembly, members of the Committee shall be entitled to per diem

compensation and reimbursement of expenses pursuant to 2 V.S.A. § 406 for no more than six meetings.

*** * * Repeal * * ***

Sec. 24. REPEAL *(Fisher)*

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 Date * * *

Sec. **25**. EFFECTIVE DATE ***(Fisher)***

This act shall take effect on passage, except that**:**

(1) the amendments in Sec. 12 to 21 V.S.A. § 2002 shall apply beginning in the first quarter of fiscal year 2015**; and**

(2) Notwithstanding 1 V.S.A. § 214, Sec. 24 (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.