Side-by-side comparison of S.252, *An act relating to financing for Green Mountain Care*, as passed by House and Senate

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Subject	***As passed by Senate***	***As passed by House***
Legislative intent; findings; purpose	**Sec. 1** It has been three years since Act 48 passed, the Affordable Care Act has been in effect for four years, and Vermont's Exchange is operational. Need to update assumptions and cost estimates, understand impact of health care reform efforts under way, take steps toward implementing Act 48.	**Sec. 1** Legislative intent to continuing moving toward implementation of GMC. Intent not to change benefits provided by Medicare, FEHBP, TRICARE, retiree health benefit program, or any other health benefit program beyond State's regulatory authority. Findings: 1. Three years since passage of Act 48 2. GMC Board regulates health insurance rates, hospital budgets, certificates of need 3. Vermont was awarded three-year, $45 M SIM grant to improve health and health care and lower costs 4. State awarded $2.6 M in grants to health care providers 5. Three ACOs have formed 6. Exchange completed its first open enrollment period 7. Blueprint achieving positive results 8. AHS is using modified adjusted gross income 9. Vermonters currently spend over $2.5 B per on health insurance premiums and out of pocket costs 10. No set timeline for GMC implementation. Triggers must be satisfied, federal waiver received, and GMC Board satisfied that providers will be sufficiently reimbursed. 11. Financing plan submitted in January 2013 did not comply with Act 48 requirements. Before making final decisions about GMC financing, Legislature needs accurate data on direct and indirect costs

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		of current health care system. Legislature must ensure GMC does not go forward if financing is not sufficient, fair, predictable, transparent, sustainable, and shared equitably. Legislature must be satisfied that appropriate plan of action is in place to accomplish transitions needed for successful implementation of GMC.
Principles for health care financing	**Sec. 2** 1. All Vermont residents have the right to high-quality health care 2. Vermont residents shall finance Green Mountain Care (GMC) through taxes that are levied equitably, taking into account an individual's ability to pay and the value of the health benefits provided 3. GMC will be secondary payer for Vermont residents who continue to receive health care through plans provided by employer, another state, foreign government, or as retirement benefit 4. Vermont's system for financing health care will raise enough revenue to provide medically necessary services to all enrolled Vermont residents, including: a. maternity/newborn care b. pediatric care c. vision and dental for children d. surgery/hospital care e. emergency care f. outpatient care g. mental health treatment h. prescription drugs	**Sec. 2** 1. All Vermont residents have the right to high-quality health care 2. All Vermont residents shall contribute to GMC financing through taxes that are levied equitably, taking into account an individual's ability to pay and the value of the health benefits provided so that access to health care will not be limited by cost barriers. 3. Financing system to maximize opportunities to take advantage of federal tax credits/deductions 4. GMC will be payer of last resort for Vermont residents who continue to receive health care through plans provided by employer, federal health benefit plan, Medicare, foreign government, or as retirement benefit 5. Vermont's system for financing health care will raise enough revenue to provide medically necessary services to all Vermont residents, including: a. ambulatory patient services b. emergency services c. hospitalization d. maternity/newborn care e. mental health and substance use disorder services f. prescription drugs g. rehabilitative/habilitative services and devices h. laboratory services

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		i. preventive/wellness services, chronic care management j. pediatric services, including oral and vision care
Vermont Health Benefit Exchange	**Secs. 3–5** If federal government allows (which it currently does, through the end of 2015), small employers and their employees can buy health plans through Exchange website or navigator, by phone, or directly from a carrier	**Secs. 3–5** *Same as Senate version*
Optional Exchange coverage for employers with 51-100 employees	*No similar provision*	**Sec. 6** If permitted under federal law (which it currently is not), employers with 51–100 employees would be allowed, but not required, to purchase insurance through the Exchange prior to January 1, 2016
Health insurance rate review	*No similar provision*	**Sec. 6a** Department of Financial Regulation (DFR) maintains rate review authority over non-major medical health insurance policies and form review authority over all health insurance policies. Sets forth review process.
Treatment of federal employees	**Secs. 6–7a** 2013 financing plan assumed federal employees will not be integrated into GMC for their primary coverage. Federal employees who participate in the Federal Employees Health Benefits Program (FEHBP) or TRICARE will be deemed to be covered by GMC. The FEHBP or TRICARE benefit package will be their GMC benefits. Their FEHBP or TRICARE premium will be their contribution to GMC. If the Agency of Human Services (AHS)	*No similar provision*

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	finds major gaps between GMC and TRICARE, AHS must propose a supplemental benefit plan for TRICARE participants and a funding.	
Updates on transition to GMC	*No similar provision (but see Sec. 9 of Senate version requiring timeline for contracting out elements of GMC administration)*	**Sec. 7** Secretary of Administration or designee to provide updates at least quarterly regarding progress on determining which elements of GMC to contract out and on developing a GMC transition and implementation proposal. GMC Board to provide updates at least quarterly on Board's progress in defining GMC benefit package; deciding whether GMC should include dental, vision, hearing, and long-term care benefits; determining whether/to what extent to have cost-sharing in GMC; and making determinations necessary for GMC implementation
GMC benefits	**Sec. 8** Benefits in GMC to be the benefits in Exchange benchmark plan	**Sec. 8** Benefits in GMC to be ***at least*** the benefits in Exchange benchmark plan. Requires any cost-sharing requirements to be income-sensitized.
Contract for administration of certain elements of GMC	**Sec. 9** By 2/1/2015, AHS to identify elements of GMC to contract out and prepare a description of job(s) to be performed, design bid qualifications, and develop criteria for bid evaluation. By 7/1/2015, AHS to solicit bids and by 12/15/2015, AHS to award contracts.	*No similar provision (but see Sec. 7 of HHC amendment requiring updates on elements of GMC to contract out)*
Administration of and enrollment in GMC	*No similar provision*	**Sec. 9** Repeals provision requiring AHS to seek federal permission to be administrator of Medicare in Vermont. Makes GMC the payer of last resort, instead of secondary payer, for any health service covered in whole or in part by any other health benefit plan.

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Conceptual waiver application	**Sec. 10** By 10/1/2014, Secretary of Administration must submit a conceptual waiver application to the federal government expressing Vermont's intent to pursue a Waiver for State Innovation and its interest in starting the application process.	**Sec. 10** Same, except deadline moved to 11/15/2014
Employer assessment for employers with full-time employees on Medicaid	**Secs. 10–11** Employer assessment imposed for employees who are offered and eligible for employer's coverage but do not take it and have no other coverage under Medicare or a private plan	*No similar provision*
Employer assessment	**Sec. 13** Resets employer assessment at $119.12, changes index from fiscal to calendar year	**Sec. 11** Resets employer assessment at $133.30, maintains index on fiscal year basis
Green Mountain Care Board duties	*No similar provision*	**Secs. 12–14** Includes in Green Mountain Care Board's review of Health Resource Allocation Plan duties of conducting regular assessments of Vermonters' health needs and developing a plan to allocate resources to meet those needs. Allows Board to include its Medicaid cost shift reporting in its annual report and adds Joint Fiscal Committee as a recipient of the annual report.
Standardized health insurance claims and edits	*No similar provision*	**Sec. 15** Delays for two years, until 1/1/2017, date on which health care providers and health insurers must begin using the standardized edits and payment rules to be adopted by the GMC Board and Department of Vermont Health Access by rule
Certificate of need	*No similar provision*	**Secs. 15a-15c** Requires certificate of need for non-emergency walk-in centers (urgent care clinics)

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Non-emergency walk-in centers	*No similar provision*	**Sec. 15d** Requires non-emergency walk-in centers to accept patients of all ages and prohibits them from discriminating on the basis of insurance status or type of health coverage.
Pharmacy benefit managers (PBMs)	*No similar provision (but see PBM report in Sec. 19 of Senate version)*	**Secs. 16-19** Removes PBMs' ability to impose contract terms that limit disclosure of financial information to a health insurer. Requires PBMs to disclose annually to health insurers, DFR, and GMC Board the aggregate amount the PBM kept on all prescription drug claims for which PBM charged the insurer during the previous calendar year in excess of the amount the PBM paid to pharmacies. Requires PBMs to pay pharmacy claims or notify the pharmacy that a claim is contested or denied within 14 calendar days of receipt of the claim. Requires PBMs to provide pharmacists with a list of all drugs subject to maximum allowable cost (MAC), the MAC for each drug on the list, and the source of the MAC, and to update the list at least every seven days. Prohibits PBMs from imposing higher co-payments than the co-payment applicable under an insured's policy, from imposing a higher co-payment than the MAC, and from requiring pharmacies to pass through any portion of a co-payment to the PBM. Except for the annual disclosure requirement, PBM provisions take effect on July 1, 2014 and apply to contracts entered into or renewed on or after that date.
Adverse childhood experiences (ACEs)	*No similar provision*	**Secs. 20–25** Expresses General Assembly's belief that controlling health care costs requires consideration of population health, particularly ACEs. The greater the number of ACEs a person experiences, the greater the risk for many health conditions and behaviors. Directs AHS, through its

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		Integrated Family Services initiative and in partnership with Vermont Center for Children, Youth, and Families at UVM, to fully implement the Vermont Family Based Approach in one pilot region by 1/1/2015. By 1/15/ 2014, Director of Blueprint for Health must submit report with recommendations for incorporating screening for ACEs and trauma-informed care into Blueprint medical practices and community health teams. Recommends that UVM's College of Medicine and School of Nursing consider adding or expanding information in their curricula about ACEs and their impacts. By 1/15/2015, Board of Medical Practice must develop materials regarding the ACE Study for physicians, physician assistants, and advanced practice registered nurses. By 7/1/2016, Board of Medical Practice and Office of Professional Regulation must distribute materials to all physicians, naturopathic physicians, physician assistants, and advanced practice registered nurses. By 11/1/2014, Department of Health, in consultation with Department of Mental Health, must submit a written report with recommendations about incorporating ACE education, treatment, and prevention into medical practices and the Health Department's programs; about screening tools and interventions and resources needed to ensure access to the interventions; and about security protections for patient information to GMC Board for its review and comments about impacts on public health and health care costs. GMC Board must submit the report with its comments to the General Assembly by 1/1/2015.
Green Mountain Care financing and coverage	*No similar provision*	**Sec. 26** By 1/15/2015, Secretary of Administration must submit to the Legislature a proposal to transition to and fully

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report		implement GMC. The report must include: 1. a detailed analysis of the direct and indirect impacts of moving from current health care system to publicly financed system, including impacts by income class and family size for individuals and by business size, economic, sector, and total sales/revenue for businesses, as well as effect on various wage levels and job growth 2. recommendations for amounts and necessary mechanisms to finance GMC 3. wraparound benefits for people for whom GMC will be payer of last resort 4. recommendations for addressing cross-border delivery issues 5. establishing provider rates in GMC 6. estimates of administrative savings to providers and payers 7. efforts to obtain federal Waiver for State Innovation 8. proposals for enhancing loan forgiveness programs and other workforce development incentives If Secretary of Administration does not submit proposal by 1/15/2015, the unencumbered remainder of the Agency of Administration's FY 2015 appropriation for GMC planning and implementation will be frozen until Secretary submits the proposal
Health care workforce	*No similar provision*	**Sec. 26a** Workforce strategic plan to include proposals for enhancing loan forgiveness programs and other workforce development incentives
Chronic care/Blueprint report	**Sec. 14** By 10/1/2014, Secretary of Administration to report on efficacy of chronic care management initiatives,	**Sec. 27** By 10/1/2014, Secretary of Administration to provide proposal for changing payment structure to Blueprint

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	including whether/to what extent to increase payments to Blueprint participating providers and whether to include additional chronic conditions such as obesity, mental conditions, oral health	participating providers; recommendation on whether to expand Blueprint to include additional services or chronic conditions such as obesity, mental conditions, oral health; and recommendations on strengthening and sustaining advanced practice primary care
Health insurer surplus report	**Sec. 15** By 7/15/2014, Department of Financial Regulation (DFR), in consultation with the Attorney General's Office, to report on legal and financial considerations if private health insurer stops doing business in Vermont, including appropriate disposition of insurer's surplus.	**Sec. 28** *Same as Senate version*
Benchmark-equivalent health care coverage	**Sec. 16** By 10/1/2014, Secretary of Administration to recommend whether it should be State policy that all Vermont residents should have health care coverage before GMC that is substantially equivalent to Exchange coverage.	*No similar provision*
Transition plan for public/union employees	**Sec. 17** Secretary of Education and Commissioner of Human Resources, in consultation with VSEA, VLCT, Vermont-NEA, Vermont School Boards Ass'n, AFT Vermont, other interested stakeholders, to develop a plan to transition State, municipal, public school, and other public employees to GMC or another common risk pool, including addressing role of collective bargaining and proposing methods to mitigate impact on health care coverage and total compensation.	**Sec. 29** Commissioners of Labor and of Human Resources; one representative each from VLCT, Vermont School Boards Ass'n, and Vermont School Board Insurance Trust; and five representatives from a coalition of labor organizations active in Vermont, in consultation with interested stakeholders, to develop plan to transition employees with collectively bargained health benefits to GMC. Transition plan to be consistent with State and federal labor relations laws and public and private collective bargaining agreements and ensure that total employee compensation does not decrease significantly, nor financial costs to employers increase significantly, as result of transition of employees to GMC.

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Financial impact of health care reform initiatives	**Sec. 18** Secretary of Administration to consult with JFO in developing data, assumptions, analytic models, and other work related to cost of GMC; distribution of health care spending by individuals, businesses, and municipalities; and costs of/savings from current health care reform initiatives. Secretary and JFO to explore ways to collaborate, contract jointly to use same models, data, etc. By 12/1/2014, Secretary to present analysis to Legislature; by 1/15/2015, JFO to evaluate.	**Sec. 30** Joint Fiscal Committee to determine distribution of current health care spending by individuals, businesses, and municipalities, including direct and indirect costs by income class, family size, other demographic factors for individuals and by business size, economic sector, total sales/ revenue for businesses; evaluate the each proposal for health care system reform based on the same criteria; estimate costs of/savings from current health care reform initiatives; and update cost estimates for GMC.
Pharmacy benefit management report	**Sec. 19** By 10/1/2014, Secretary of Administration to report on feasibility and benefits of the State acting as its own pharmacy benefit manager (PBM) for the State's health plans.	*No similar provision (but see PBM provisions in Secs. 16-19 of House Health Care version)*
Independent physician practices report	**Sec. 20** By 12/1/2014, Secretary of Administration to report on the State policy regarding independent physician practices, including whether the State wants to encourage them to remain independent and whether it wants to encourage new practices to open. The Secretary also must consider whether the State should prohibit insurers from reimbursing independent physicians at lower rates than those at hospital-owned practices.	*No similar provision*
Health information technology (HIT) and intellectual property	**Sec. 21** By 10/1/2014, Attorney General, in consultation with VITL, to report on need for and opportunities from obtaining intellectual property protection for Health Information Exchange and other HIT functions.	*No similar provision*

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Medicare integration report	**Sec. 22** By 12/1/2014, Secretary of Administration to report about options for integration and coordination of Medicare with GMC, including assessments of possible financing and coverage options and potential continuation of Medicare supplemental and Medicare Advantage plans.	*No similar provision (but see Sec. 26 for concept of wraparound benefits for Medicare and other coverage)*
Increasing Medicaid rates	*No similar provision*	**Sec. 32** By 1/15/2015, Secretary of Administration, in consultation with GMC Board, to report on potential impact of increasing Medicaid reimbursement rates to Medicare levels.
Health care expenses in other forms of insurance	*No similar provision*	**Sec. 33** Secretary of Administration, in consultation with Departments of Labor and of Financial Regulation, to collect most recent available data on health care expenses paid for by workers' compensation, automobile insurance, and property and casualty insurance, and other non-medical insurance. Secretary to consolidate and present data by 12/1/2014.
Health care workforce symposium	**Sec. 23** By 11/15/2014, Secretary of Administration, in collaboration with Vermont Medical Society and Vermont Ass'n of Hospitals and Health Systems, to conduct symposium to address impacts of moving toward universal health care coverage on Vermont's health care workforce and projected workforce needs.	**Sec. 34** *Same as Senate version* except that deadline extended to 1/15/2015
Repeal	*No similar provision*	**Sec. 35** Repeals provision making legislators and session-only legislative employees eligible to purchase State Employees Health Benefit Plan at full cost.

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Effective dates	**Sec. 24** Takes effect on passage, except that employer assessment for employees on Medicaid applies beginning in 1st quarter of FY15.	**Sec. 36** Takes effect on passage, except: 1. Employer assessment amendments in Sec. 11 (fourth instance of amendment) take effect on passage and apply beginning with calculation of employer assessment payable in first quarter of FY 2015, which will be based on uncovered employees from fourth quarter of FY 2014 2. Repeal of legislator eligibility to buy State Employees Health Benefit Plan takes effect on passage and applies retroactively to 1/1/2014, except that people who were enrolled on that date may continue to receive coverage under plan through end of 2014 plan year 3. PBM prompt pay, MAC list, and cost-sharing limitations take effect on 7/1/2014 and apply to contracts entered into or renewed on/after that date