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:

* * * Principles * * *

Sec. 1. PRINCIPLES FOR HEALTH CARE FINANCING

The General Assembly adopts the following principles to guide the financing of health care in Vermont:

(1) All Vermont residents have the right to high-quality health care.

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

(3) As provided in 33 V.S.A. § 1827, Green Mountain Care shall be the payer of last resort for Vermont residents who continue to receive health care

through plans provided by an employer, by another state, by a foreign government, or as a retirement benefit.

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

* * * Vermont Health Benefit Exchange * * *

Sec. 2. 33 V.S.A. § 1803 is amended to read:

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

* * *

(b)(1)(A) The Vermont Health Benefit Exchange shall provide qualified individuals and qualified employers with qualified health benefit plans, including the multistate plans required by the Affordable Care Act, with effective dates beginning on or before January 1, 2014. The Vermont Health Benefit Exchange may contract with qualified entities or enter into intergovernmental agreements to facilitate the functions provided by the Vermont Health Benefit Exchange.

* * *

(4) To the extent permitted by the U.S. Department of Health and Human Services, the Vermont Health Benefit Exchange shall permit qualified

employers to purchase qualified health benefit plans through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

* * *

Sec. 3. 33 V.S.A. § 1811(b) is amended to read:

(b)(1) No person may provide a health benefit plan to an individual ~~or small employer~~ unless the plan is offered through the Vermont Health Benefit Exchange ~~and complies with the provisions of this subchapter~~.

(2) To the extent permitted by the U.S. Department of Health and Human Services, a small employer or an employee of a small employer may purchase a health benefit plan through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

(3) No person may provide a health benefit plan to an individual or small employer unless the plan complies with the provisions of this subchapter.

Sec. 4. PURCHASE OF SMALL GROUP PLANS DIRECTLY FROM CARRIERS

To the extent permitted by the U.S. Department of Health and Human Services and notwithstanding any provision of State law to the contrary, the Department of Vermont Health Access shall permit employers purchasing qualified health benefit plans on the Vermont Health Benefit Exchange to

purchase the plans through the Exchange website, through navigators, by telephone, or directly from a health insurer under contract with the Vermont Health Benefit Exchange.

* * * Health Insurance Rate Review * * *

Sec. 5. 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. 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. CONTRACT FOR ADMINISTRATION OF CERTAIN ELEMENTS OF GREEN MOUNTAIN CARE; REPORT

On or before January 15, 2015, the Secretary of Human Services shall report to the General Assembly 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), as well as the dates by which the Agency will solicit bids for administration of those elements and by which it will award the contracts.

Sec. 8. 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. 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, and other payers shall use beginning on January 1, ~~2015~~ 2016 and that Medicaid shall use beginning on January 1, 2017.

* * *

* * * Non-Emergency Walk-In Centers * * *

Sec. 11. 18 V.S.A. § 9492 is added to read:

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

(a) A non-emergency walk-in center 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.

(b) As used in this section, "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.

* * * Pharmacy Benefit Managers * * *

Sec. 12. 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. 13. 18 V.S.A. § 9473 is redesignated to read:

§ ~~9473~~ 9474. ENFORCEMENT

Sec. 14. 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. 15. 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. 16. ADVERSE CHILDHOOD EXPERIENCES; REPORT

On or before January 15, 2015, the Director of the Blueprint for Health and the Chair of the Green Mountain Care Board or their designees shall review evidence-based materials on the relationship between adverse childhood experiences (ACEs) and population health and recommend to the General

Assembly whether, how, and at what expense ACE-informed medical practice should be integrated into Blueprint practices and community health teams. The Director and the Chair or their designees shall also develop a methodology by which the Blueprint will evaluate emerging health care delivery quality initiatives to determine whether, how, and to what extent they should be integrated into the Blueprint for Health.

* * * Reports * * *

Sec. 17. 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. 18. 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. 19. INDEPENDENT PHYSICIAN PRACTICES; REPORT

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

Sec. 20. INCREASING MEDICAID RATES; REPORT

On or before January 15, 2015, the Secretary of Administration or designee, in consultation with the Green Mountain Care Board, 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 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 projected impact of the increase on health insurance premiums; and

(3) 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. 21. HEALTH INFORMATION TECHNOLOGY AND INTELLECTUAL PROPERTY; REPORT

On or before October 1, 2014, the Office of the Attorney General, in consultation with the Vermont Information Technology Leaders, shall report to the House Committees on Health Care, on Commerce and Economic Development, and on Ways and Means and the Senate Committees on Health and Welfare, on Economic Development, Housing and General Affairs, and on Finance regarding the need for intellectual property protection with respect to Vermont's Health Information Exchange and other health information technology initiatives, including the potential for receiving patent, copyright, or trademark protection for health information technology functions, the estimated costs of obtaining intellectual property protection, and projected revenues to the State from protecting intellectual property assets or licensing protected interests to third parties.

* * * Health Care Workforce Symposium * * *

Sec. 22. HEALTH CARE WORKFORCE SYMPOSIUM

On or before January 15, 2015, the Secretary of Administration or designee, in collaboration with the Vermont Medical Society, the Vermont Association of Hospitals and Health Systems, and the Vermont Assembly of Home Health and Hospice Agencies, 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.

* * * Global Hospital Budgets * * *

Sec. 23. GREEN MOUNTAIN CARE BOARD; GLOBAL HOSPITAL PILOT PROJECTS

(a) The Green Mountain Care Board may develop and implement global budgeting pilot projects involving multiple payers at up to two hospitals in this State. The Board shall ensure that a hospital's existing or pending contracts with accountable care organizations and any shared savings or other financial arrangements related to such contracts are accurately accounted for when establishing global hospital budgets pursuant to this section.

(b) The Green Mountain Care Board may take such steps as are necessary to include all payers in the global hospital budget pilot projects, including negotiating with the federal Center for Medicare & Medicaid Innovation to involve Medicare and Medicaid.

(c) In the event that at least one pilot project authorized under this section is being developed or implemented on or before January 15, 2015, on that date and quarterly thereafter through January 2017, the Green Mountain Care Board shall provide updates 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 development and implementation of the global hospital budget pilot projects authorized by this section, including any effect on hospital budget growth, any impact on care delivery and patient outcomes, and recommendations about whether to continue global hospital budgets at the participating hospital or hospitals and whether to implement global hospital budgets for other Vermont hospitals.

* * * Repeal * * *

Sec. 24. 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. 25. EFFECTIVE DATES

This act shall take effect on passage, except that:

(1) 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; and

(2) Sec. 14 (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