S.252

Representative Fisher of Lincoln moves to amend the House Proposal of Amendment as follows:

First: By adding a Sec. 6a to read as follows:

* * * Health Insurance Rate Review * * *

Sec. 6a. 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 thereto 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.

Second: By adding Secs. 15a–15c to read as follows:

* * * Certificates of Need * * *

Sec. 15a. 18 V.S.A. § 9432 is amended to read:

§ 9432. DEFINITIONS

As used in this subchapter:

* * *

(8) "Health care facility" means all persons or institutions, including mobile facilities, whether public or private, proprietary or not for profit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any institution operated by religious groups relying solely on spiritual means through prayer for healing, but shall include ~~but is not limited to~~:

(A) hospitals, including general hospitals, mental hospitals, chronic disease facilities, birthing centers, maternity hospitals, and psychiatric facilities including any hospital conducted, maintained, or operated by the ~~state~~ State of Vermont, or its subdivisions, or a duly authorized agency thereof; and

(B) nursing homes, health maintenance organizations, home health agencies, outpatient diagnostic or therapy programs, kidney disease treatment centers, mental health agencies or centers, diagnostic imaging facilities, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, ~~or~~ and any inpatient or ambulatory surgical, diagnostic, or treatment center, including non-emergency walk-in centers.

* * *

(15) "Non-emergency walk-in center" means an outpatient or ambulatory diagnostic or treatment center at which a patient without making an appointment may receive medical care that is not of an emergency,

life-threatening nature. The term includes facilities that are self-described as urgent care centers, retail health clinics, and convenient care clinics.

Sec. 15b. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the board. ~~For purposes of~~ As used in this subsection, a "new health care project" includes the following:

* * *

(6) The construction, development, purchase, lease, or other establishment of an ambulatory surgical center or non-emergency walk-in center.

* * *

Sec. 15c. 18 V.S.A. § 9435 is amended to read:

§ 9435. EXCLUSIONS

(a) Excluded from this subchapter are offices of physicians, dentists, or other practitioners of the healing arts, meaning the physical places which are occupied by such providers on a regular basis in which such providers perform the range of diagnostic and treatment services usually performed by such providers on an outpatient basis unless they are subject to review under subdivision 9434(a)(4) of this title.

* * *

(c) The provisions of subsection (a) of this section shall not apply to offices owned, operated, or leased by a hospital or its subsidiary, parent, or holding company, outpatient diagnostic or therapy programs, kidney disease treatment centers, independent diagnostic laboratories, cardiac catheterization laboratories, radiation therapy facilities, ambulatory surgical centers, non-emergency walk-in centers, and diagnostic imaging facilities and similar facilities owned or operated by a physician, dentist, or other practitioner of the healing arts.

* * *

Third: By striking out Sec. 16, 18 V.S.A. § 9472, in its entirety and inserting in lieu thereof a new Sec. 16 to read as follows:

Sec. 16. 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:

(1) Provide all financial and utilization information requested by a health insurer relating to the provision of benefits to beneficiaries through that health insurer's health plan and all financial and utilization information relating to services to that health insurer. A pharmacy benefit manager

providing information under this subsection may designate that material as confidential. Information designated as confidential by a pharmacy benefit manager and provided to a health insurer under this subsection may not be disclosed by the health insurer to any person without the consent of the pharmacy benefit manager, except that disclosure may be made by the health insurer:

(A) in a court filing under the consumer protection provisions of 9 V.S.A. chapter 63, provided that the information shall be filed under seal and that prior to the information being unsealed, the court shall give notice and an opportunity to be heard to the pharmacy benefit manager on why the information should remain confidential;

(B) when authorized by 9 V.S.A. chapter 63;

(C) when ordered by a court for good cause shown; or

(D) when ordered by the ~~commissioner~~ Commissioner as to a health insurer as defined in subdivision 9471(2)(A) of this title pursuant to the provisions of Title 8 and this title.

(2) Notify a health insurer in writing of any proposed or ongoing activity, policy, or practice of the pharmacy benefit manager that presents, directly or indirectly, any conflict of interest with the requirements of this section.

(3) With regard to the dispensation of a substitute prescription drug for a prescribed drug to a beneficiary in which the substitute drug costs more than the prescribed drug and the pharmacy benefit manager receives a benefit or payment directly or indirectly, disclose to the health insurer the cost of both drugs and the benefit or payment directly or indirectly accruing to the pharmacy benefit manager as a result of the substitution.

(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.

(5) Disclose to the health insurer all financial terms and arrangements for remuneration of any kind that apply between the pharmacy benefit manager and any prescription drug manufacturer that relate to benefits provided to beneficiaries under or services to the health insurer's health plan, including formulary management and drug-switch programs, educational support, claims processing, and pharmacy network fees charged from retail pharmacies and data sales fees. A pharmacy benefit manager providing information under this subsection may designate that material as confidential. Information designated as confidential by a pharmacy benefit manager and provided to a health insurer under this subsection may not be disclosed by the health insurer to any person

without the consent of the pharmacy benefit manager, except that disclosure may be made by the health insurer:

(A) in a court filing under the consumer protection provisions of 9 V.S.A. chapter 63, provided that the information shall be filed under seal and that prior to the information being unsealed, the court shall give notice and an opportunity to be heard to the pharmacy benefit manager on why the information should remain confidential;

(B) when authorized by 9 V.S.A. chapter 63;

(C) when ordered by a court for good cause shown; or

(D) when ordered by the ~~commissioner~~ Commissioner as to a health insurer as defined in subdivision 9471(2)(A) of this title pursuant to the provisions of Title 8 and this title.

(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.

Fourth: In Sec. 22, report; Blueprint for Health, by striking out the remainder of the section following the words "including any" and inserting in lieu thereof proposed evaluation measures and approaches; funding constraints; opportunities; availability of appropriate screening tools and evidence-based interventions for individuals; the additional resources, if any, that would be necessary to ensure adequate access to the interventions identified as needed as a result of the use of the screening tools; and additional security protections that may be necessary for information related to a patient's adverse childhood experiences.

Fifth: In Sec. 25, report; Department of Health; Green Mountain Care Board, by striking out subdivisions (a)(2) and (3) in their entirety and inserting in lieu thereof new subdivisions (2) and (3) to read:

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

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

Sixth: In Sec. 26, Green Mountain Care financing and coverage; report, in subdivision (a)(7), following the semicolon, by striking out the word "and", in subdivision (a)(8), following "Sec. 10 of this act", by inserting a semicolon and the word and, and by adding before the period a subdivision (a)(9) to read as follows:

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

Seventh: By adding a Sec. 26a to read as follows:

Sec. 26a. 18 V.S.A. § 9491 is amended to read:

§ 9491. HEALTH CARE WORKFORCE; STRATEGIC PLAN

* * *

(b) The director or designee shall collaborate with the area health education centers, the ~~workforce development council~~ Workforce Development Council established in 10 V.S.A. § 541, the ~~prekindergarten-16 council~~ Prekindergarten-16 Council established in 16 V.S.A. § 2905, the ~~department of labor, the department of health, the department of Vermont health access~~ Department of Labor, the Department of Health, the Department of Vermont Health Access, and other interested parties, to develop and maintain the plan. The ~~director of health care reform~~ Director of Health Care Reform shall ensure

that the strategic plan includes recommendations on how to develop Vermont's health care workforce, including:

* * *

(3) how ~~state~~ State government, universities and colleges, the ~~state's~~ State's educational system, entities providing education and training programs related to the health care workforce, and others may develop the resources in the health care workforce and delivery system to educate, recruit, and retain health care professionals to achieve Vermont's health care reform principles and purposes, including proposals for enhancing loan forgiveness programs and other opportunities and incentives for health care workforce development and enhancement.

* * *

Eighth: In Sec. 26, Green Mountain Care financing and coverage; report, in subsection (a), following "Health Care" by inserting , on Appropriations, and following "Health and Welfare" by inserting , on Appropriations,

Ninth: In Sec. 32, increasing Medicaid rates; report, following "Health Care" by striking out "Ways and Mean" and inserting in lieu thereof , on Appropriations, and on Ways and Means and following "Health and Welfare" by inserting , on Appropriations,

Tenth: In Sec. 34, health care workforce symposium, following the words "On or before", by striking out "November 15, 2014" and inserting in lieu thereof January 15, 2015