H.29

Representative Lippert of Hinesburg moves that the House concur in the Senate Proposal of Amendment with further amendment by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Medicare Supplemental Plans * * *

Sec. 1. 8 V.S.A. § 4080e is amended to read:

§ 4080e. MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES; COMMUNITY RATING; DISABILITY

(a) A health insurance company, hospital or medical service corporation, or health maintenance organization shall use a community rating method acceptable to the Commissioner for determining premiums for Medicare supplemental insurance policies.

(b)(1) The Commissioner shall adopt rules for standards and procedure for permitting health insurance companies, hospital or medical service organizations, or health maintenance organizations that issue Medicare supplemental insurance policies to use one or more risk classifications in their community rating method. The premium charged shall not deviate from the community rate and the rules shall not permit medical underwriting and screening, except that a health insurance company, hospital or medical service corporation, or health maintenance organization may set different community

1 rates for persons eligible for Medicare by reason of age and persons eligible for
2 Medicare by reason of disability.
3 (2)(A) A health insurance company, hospital or medical service
4 corporation, or health maintenance organization that issues Medicare
5 supplemental insurance policies may offer expense discounts to encourage
6 timely, full payment of premiums. Expense discounts may include premium
7 reductions for advance payment of a full year's premiums, for paperless
8 billing, for electronic funds transfer, and for other activities directly related to
9 premium payment. The availability of one or more expense discounts shall not
10 be considered a deviation from community rating.
11 (B) A health insurance company, hospital or medical service
12 corporation, or health maintenance organization that issues Medicare
13 supplemental insurance policies shall not offer reduced premiums or other
14 discounts related to a person's age, gender, marital status, or other
15 demographic criteria.
16 * * *
17 * * * Health Care Professional Payment Parity * * *
18 Sec. 2. FINDINGS
19 The General Assembly finds:

1 (1) Commercial health insurers in Vermont reimburse health care
2 professionals significantly different amounts for delivering the same health
3 care services in different settings.
4 (2) In recent years, many independent physician practices in Vermont
5 have closed or have become affiliated with an academic medical center or
6 community hospital. The causes of these closures and affiliations are
7 uncertain, and the impacts of the disparities in reimbursement amounts
8 between individual physician practices and hospital-owned physician practices
9 on consumers and the health care system remain unclear.
10 (3) Community hospitals in Vermont often face disparities in their
11 physician reimbursement rates that are similar to those of independent
12 practices.
13 (4) The General Assembly asked the Green Mountain Care Board, the
14 commercial insurers, and others to address the issue of the disparity in
15 reimbursement amounts to health care professionals in 2014 Acts and Resolves
16 No. 144, Sec. 19; 2015 Acts and Resolves No. 54, Sec 23; and 2016 Acts and
17 Resolves No. 143, Sec. 5.
18 Sec. 3. GREEN MOUNTAIN CARE BOARD; HEALTH CARE
19 PROFESSIONAL PAYMENT PARITY WORK GROUP
20 (a) The Green Mountain Care Board shall convene the Health Care
21 Professional Payment Parity Work Group to:

1 (1) examine the reasons why health care professionals in independent
2 practices are closing their practices or joining hospital-owned practices, or
3 both;
4 (2) identify the causes and extent of disparities in reimbursement
5 amounts to health care professionals for providing the same services in
6 different settings; and
7 (3) consider whether, how, and under what circumstances disparities
8 should be reduced in order to provide fair and equitable reimbursement
9 amounts to health care professionals for providing the same health care
10 services in different settings.
11 (b) The Work Group shall be composed of the following members:
12 (1) the Chair of the Green Mountain Care Board or designee;
13 (2) the Commissioner of Vermont Health Access or designee;
14 (3) a representative of each commercial health insurer with 5,000 or
15 more covered lives in Vermont;
16 (4) a representative of independent physician practices, appointed by
17 Health First;
18 (5) a representative of physicians employed by hospital-owned practices,
19 appointed by the Vermont Medical Society;
20 (6) a representative of the University of Vermont Medical Center;

1 (7) a representative of Vermont's community hospitals, appointed by the
2 Vermont Association of Hospitals and Health Systems;
3 (8) a representative of each accountable care organization in this State;
4 (9) a representative of Vermont's federally qualified health centers and
5 rural health clinics, appointed by the Bi-State Primary Care Association;
6 (10) a representative of naturopathic physicians, appointed by the
7 Vermont Association of Naturopathic Physicians;
8 (11) a representative of chiropractors, appointed by the Vermont
9 Chiropractic Association; and
10 (12) the Chief Health Care Advocate or designee from the Office of the
11 Health Care Advocate.
12 (c) The Green Mountain Care Board, in consultation with the other
13 members of the Work Group, shall:
14 (1) examine hospital acquisitions and transfers of health care
15 professionals to understand the reasons why health care professionals in
16 independent practices choose to become employed by hospitals and hospital-
17 owned practices and the net effect of these transitions on growth in health care
18 spending across the entire health care system;
19 (2) analyze the retention of independent practices and health care
20 professionals in this State, including assessing the factors that may influence
21 health care professionals' choice of practice location and ownership, such as

1 administrative burden, schedule flexibility, compensation and benefits,
2 financial risks, and business and contracting complexities; and
3 (3) develop a plan for reimbursing health care professionals in a more
4 fair and equitable manner, including the following:
5 (A) proposing a process for reducing existing disparities in
6 reimbursement amounts for health care professionals across all settings on such
7 terms as the Green Mountain Care Board deems appropriate, which process
8 shall include:
9 (i) evaluating the potential impacts of increasing reimbursement
10 amounts for lower paid providers and reducing reimbursement amounts for the
11 highest paid providers;
12 (ii) evaluating the potential impacts of requiring health insurers to
13 modify their reimbursement amounts to health care professionals across all
14 settings for nonemergency evaluation and management office visit codes to the
15 amount of the insurer's average payment for that code across all settings in
16 Vermont on January 1, 2017 or on another specified date;
17 (iii) limiting any negative net impact on reimbursement amounts
18 for providers in independent practices and community hospitals;
19 (iv) considering the impacts of any adjusted reimbursement
20 amounts on medical costs, health insurance premiums, and consumer out-of-
21 pocket costs;

1 (v) considering the impacts of any adjusted reimbursement
2 amounts on the implementation of value-based reimbursement models,
3 including the all-payer model;
4 (vi) evaluating the impacts of any adjusted reimbursement
5 amounts on recruitment and retention of high-quality health care professionals
6 and on the sustainability of the health care system; and
7 (vii) developing a mechanism through which the Green Mountain
8 Care Board shall monitor the alignment between reimbursement amounts to
9 providers, hospital budget revenues, and health insurance premiums;
10 (B) identifying the time frame for adjusting the reimbursement
11 amounts for each category of health care services that the Green Mountain
12 Care Board has identified as appropriate for modification; and
13 (C) identifying enforcement and accountability provisions to ensure
14 measurable results.
15 (d)(1) The Green Mountain Care Board shall provide an update on its
16 progress toward achieving provider payment parity at each meeting of the
17 Health Reform Oversight Committee between May 2017 and January 2018.
18 (2) On or before November 1, 2017, the Green Mountain Care Board
19 shall submit its conclusions, a timeline, and an implementation plan, and
20 propose any necessary legislative changes, to the Health Reform Oversight

1 Committee, the House Committee on Health Care, and the Senate Committees
2 on Health and Welfare and on Finance.
3 (3) Implementation of the provider payment parity plan established
4 pursuant to this section shall begin on or before January 1, 2018.
5 Sec. 4. REIMBURSEMENT AMOUNTS FOR NEWLY ACQUIRED OR
6 NEWLY AFFILIATED PRACTICES
7 (a) Health care professionals employed by practices newly acquired by or
8 newly affiliated with an academic medical center in this State on or after the
9 date of passage of this act shall continue to be reimbursed the same
10 professional fees as they were prior to the date of the acquisition or affiliation,
11 subject to any modifications resulting from implementation of the provider
12 payment parity plan required by Sec. 3 of this act.
13 (b) The Green Mountain Care Board shall ensure compliance with
14 subsection (a) of this section through its review of hospital budgets pursuant to
15 18 V.S.A. chapter 221, subchapter 7.
16 * * * Health Insurer Bill Back * * *
17 Sec. 5. GREEN MOUNTAIN CARE BOARD; FISCAL YEAR 2018 BILL
18 BACK ALLOCATION
19 (a) Notwithstanding any provision of 18 V.S.A. § 9374(h) to the contrary
20 and except as otherwise provided in subsection (b) of this section, for fiscal
21 year 2018 only, expenses incurred by the Green Mountain Care Board to

1 obtain information, analyze expenditures, review hospital budgets, and for any
2 other contracts authorized by the Board shall be borne as follows:
3 (1) 40 percent by the State from State monies;
4 (2) 15 percent by the hospitals; and
5 (3) 45 percent by nonprofit hospital and medical service corporations
6 licensed under 8 V.S.A. chapter 123 or 125, health insurance companies
7 licensed under 8 V.S.A. chapter 101, and health maintenance organizations
8 licensed under 8 V.S.A. chapter 139.
9 (b) The Board may determine the scope of the incurred expenses to be
10 allocated pursuant to the formula set forth in subsection (a) of this section if, in
11 the Board's discretion, the expenses to be allocated are in the best interests of
12 the regulated entities and of the State.
13 (c) Expenses under subdivision (a)(3) of this section shall be billed to
14 persons licensed under Title 8 based on premiums paid for health care
15 coverage, which for the purposes of this section shall include major medical,
16 comprehensive medical, hospital or surgical coverage, and comprehensive
17 health care services plans, but shall not include long-term care or limited
18 benefits, disability, credit or stop loss, or excess loss insurance coverage.
19 * * * Effective Dates * * *
20 Sec. 6. EFFECTIVE DATES

1 (a) Secs. 1 (Medicare supplemental plans) and 5 (health insurer bill back)
2 shall take effect on July 1, 2017.
3 (b) Secs. 2–4 (payment parity) and this section shall take effect on passage.