House Health Care Bills passed 2015-2016

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Act 34

An act relating to payment for medical examinations for victims of sexual assault

Act 34

- Prohibits health insurers from imposing cost-sharing requirements on victims of alleged sexual assault
  - For services identified in memorandum of understanding (MOU) between insurer and Vermont Center for Crime Victim Services
- State will bear costs of medical care for victims of crimes committed in Vermont only if:
  - Victim does not have health insurance; or
  - Victim's health insurance does not cover all of the care
- Doctors and hospitals will bill victim's insurance first
  - If no insurance or if claim denied, Victim's Compensation Fund will reimburse at 60% of billed charges

Act 34

- Department of Vermont Health Access (Medicaid), three largest insurers, and Center for Crime Victim Services required to enter into MOU to ensure that:
  - Victims of sexual assault can change address where they receive explanation of benefits (EOB)
    - Can provide alternative address or have EOB sent care of the Center for Crime Victim Services
  - Center for Crime Victim Services, not victim, is billed for any non-covered services and amounts toward deductible

Act 54

An act relating to health care

Act 54

62 sections on various health care issues, including:

- Direct enrollment for individuals in Exchange plans
- Delaying entrance of large group market into Exchange from 2017 to 2018
- Study of costs of universal primary care
- Study of health care coverage for public employees
  - Must be cost-effective, not trigger “Cadillac” tax
- Reenacting until July 1, 2020 provisions allowing presuit mediation in medical malpractice claims

Act 54

- Suspending or transferring Department of Financial Regulation duties to Green Mountain Care Board, Department of Health
- Medicaid coverage for primary care telemedicine delivered outside a health care facility
- Adding three positions to Green Mountain Care Board
- Increasing cigarette and other tobacco product taxes by equivalent of $0.33 per pack beginning July 1, 2015
- Appropriating $6.5 million (gross) to increase Medicaid reimbursement rates and for other health care initiatives in fiscal year 2016

Act 67

An act relating to seeking a waiver to permit businesses to continue to purchase Exchange plans directly from insurers

Act 67

- Directed DVHA to seek a federal waiver under the Affordable Care Act
  - Waiver would be from requirement to set up Internet-based Small Business Health Options Program (SHOP)
  - Effect of waiver would be to allow qualified employers to continue purchasing Exchange plans directly from health insurers
- Update: waiver was not granted, but new federal guidance allows direct enrollment for 2017 and 2018
  - And new federal regulations may allow state-based Exchanges to continue offering direct enrollment

Act 94

An act relating to an exemption from licensure for visiting team physicians

Act 94

- Exempts from licensure a physician, osteopathic physician, podiatrist, physician assistant, or nurse practitioner who is licensed in another state or Canada if the health care provider:
  - is designated as the team provider by an athletic team visiting Vermont for a specific sporting event; and
  - provider limits practice in Vermont to treating the team's members, coaches, and staff.

Act 111

An act relating to the practice of acupuncture by health care professionals acting within their scope of practice

Act 111

- Allows a health care professional who is not a licensed acupuncturist to perform acupuncture if it is within the scope of his or her professional practice
  - Previously, a person had to be licensed as an acupuncturist or licensed in a profession that specifically allows for the practice of acupuncture
- Requires Director of Office of Professional Regulation to monitor and evaluate whether non-acupuncturists who practice acupuncture are doing so safely, within their scopes of practice, and in a manner consistent with public health, safety, and welfare

Act 112

An act relating to cataloguing and aligning health care performance measures

Act 112

- Requires Green Mountain Care Board, in consultation with Agency of Human Services and Vermont Medical Society, to survey and catalogue existing performance measures required of primary care providers in Vermont
- Requires Board to develop a plan to align performance measures in a way that reduces administrative burden while balancing need to evaluate quality of and access to care
  - Plan due to General Assembly by January 15, 2017.

Act 113

An act relating to implementing an all-payer model and oversight of accountable care organizations

Act 113: All-Payer Model

- All-payer model: A value-based payment model allowing participating health care providers to be paid by Medicaid, Medicare, and commercial insurance using a common methodology that may include population-based payments
- Medicare participation in all-payer model requires the Centers for Medicare and Medicaid Services (CMS) to waive provisions under Title XVIII (Medicare) of the Social Security Act

Act 113: All-Payer Model

- Establishes parameters for a permissible Medicare waiver agreement with the federal government
  - Must be consistent with Act 48 principles
  - Must preserve Medicare consumer protections
  - Must allow providers to choose whether to participate in ACO
  - Must allow Medicare patients to choose their providers
  - Must include outcome measures for population health
  - Must continue to provide Medicare payments directly to providers or ACO without State involvement

Act 113: All-Payer Model

- Establishes criteria for all-payer model, including:
  - Consistent with Act 48 criteria
  - Continue to provide Medicare payments directly to providers or ACO without State involvement
  - Maximizes alignment between Medicaid, Medicare, and commercial payers
  - Strengthens and invests in primary care
  - Incorporates social determinants of health
  - Provides parity of mental health and substance abuse treatment and integrates these treatment systems into overall health care system
  - Includes process to integrate community-based providers
  - Evaluates access to care, quality of care, patient outcomes, and social determinants of health
  - Provides robust patient grievance and appeal protections

Act 113: ACOs

- Accountable care organization (ACO): organization of health care providers with formal legal structure and federal Taxpayer Identification Number that agrees to be accountable for the quality, cost, and overall care of the patients assigned to it
- Act requires ACOS to get and maintain certification from Green Mountain Care Board
  - Requires GMCB to adopt rules by January 1, 2018 establishing standards for certifying ACOs

Act 113: ACOs

- Specifies 16 criteria that GMCB must ensure are met in order to certify an ACO, including that:
  - ACO's governance, leadership, and management structure is transparent, represents its providers and patients, and includes consumer advisory board/consumer input
  - ACO has appropriate mechanisms to provide, manage, and coordinate high-quality health care services for its patients
  - ACO collaborates with providers outside financial model
  - ACO has a financial guarantee sufficient to cover potential losses
- Requires GMCB to adopt rules by January 1, 2018 for reviewing, modifying, and approving ACO budgets

Act 113: Additional Provisions

- GMCB must establish primary care professional advisory group for two years to help GMCB address administrative burden on primary care professionals
- Agency of Human Services must report by January 1, 2017 on its funding and evaluation of contracts with designated agencies, specialized service agencies, and preferred partners

Act 113: Additional Provisions

- "Medicaid pathway" – AHS must create a process for payment and delivery reform for Medicaid-participating providers and Medicaid services
- GMCB must conduct a Medicaid advisory rate case for ACO services by December 31, 2016
- Consideration of multi-year budgets:
  - By GMCB for ACOs
  - By JFO and Dept. of Finance and Management for Medicaid
- Requires Dept. of Health to establish minimum nutrition procurement standards for all food and beverages purchased, sold, or served by or on behalf of the State
  - Nutritional labeling must be displayed for all State-owned or operated vending machines, food/beverage vendors, cafeterias

Act 117

An act relating to extending the moratorium on home health agency certificates of need

Act 117

- Extends moratorium on granting a certificate of need for home health agency services until the earlier of:
  - January 1, 2020; or
  - the General Assembly's lifting of the moratorium after considering a progress report on the Green Mountain Care Board's implementation of its health care reform initiatives and health planning function and how they relate to home health agencies

Act 120

An act relating to health insurance and Medicaid coverage for contraceptives

Act 120

- Requires health insurance plans to provide coverage with no cost-sharing for at least one drug, device, or other product in each contraceptive method for women identified by the U.S. Food and Drug Administration and prescribed by a health care provider
- Plans must provide coverage for voluntary sterilization procedures for men and women with no cost-sharing
  - Except if coverage would disqualify a high-deductible health plan from eligibility for a health savings account under the federal tax code

Act 120

- Requires health insurance plans and Medicaid to provide coverage for a 12-month supply of prescribed contraceptives
  - May be dispensed all at once or over the course of the 12 months at discretion of health care provider
- DVHA must establish and implement value-based payments to health care providers for insertion and removal of long-acting reversible contraceptives
  - Appropriates funds to increase reimbursement rates
- Requires Exchange plans to allow a pregnant woman and her family to enroll at any time after her pregnancy begins, with coverage starting on the first of the month after she selects a health plan.

Act 143

An act relating to notice to patients of new health care provider affiliations

Act 143

- Requires Green Mountain Care Board to have policy for reviewing new physician acquisitions and transfers as part of hospital budget review process
  - Including requiring hospitals to provide notice to physician's patients
- Requires hospitals to notify Attorney General at least 90 days before transaction through which hospital will acquire medical practice
- Prohibits DVHA from using provider-based billing for outpatient medical services provided at off-campus outpatient department of hospital as result of provider's transfer to or acquisition by hospital
  - Requires GMCB to report by February 1, 2017 on whether to expand prohibition to commercial health insurers
- Requires GMCB to provide copies of each health insurer's implementation plan for fair and equitable reimbursement amounts for professional services provided by academic medical centers and by other professionals
  - Also must report by December 1, 2016 on Board's progress toward achieving the fair and equitable reimbursement amounts

Act 151

An act relating to large group insurance

Act 151

- Eliminates the authority for employers with more than 100 employees to purchase health insurance plans through the Vermont Health Benefit Exchange
- Under the prior law, these large groups would have had the option to purchase Exchange plans for coverage beginning on January 1, 2018

Act 152

An act relating to regulation of hospitals, health insurers, and managed care organizations

Act 152

- Requires hospitals to post on their websites information about their community health needs assessment
  - Can meet requirement through compliance with federal standards
- Requires hospitals to provide information on their websites about the membership of their governing body
- Replaces a requirement for individual hospital community reports with a statewide comparative report from the Department of Health
  - Hospitals must provide a link on their own websites
- Provides a role for Office of Health Care Advocate in hospital budget reviews
- Moves authority over health care provider bargaining groups from Department of Financial Regulation (DFR) to Green Mountain Care Board

Act 152

- Directs DFR Commissioner to prepare annual report with number of complaints received during the previous year regarding violations of standards governing managed care organizations
  - Including specifying aggregate number of complaints related to each standard
- Adds to annual reporting requirements for health insurers
- Requires Director of Health Care Reform in Agency of Administration and others to identify opportunities for and make recommendations regarding alignment between:
  - federal requirements for accountable care organizations
  - DVHA in its role as a public managed care organization; and
  - rules applicable to managed care organizations

Act 152

- Imposes certain requirements on DVHA for utilization review determinations beginning on January 1, 2017
- Adds developmental disabilities to the Department of Health's public health surveillance and planning authority
- Authorizes Department of Health to adopt rules regarding screening for chronic diseases and developmental disabilities in newborns
- Requires Department of Health to adopt rules requiring screening for congenital heart defects in all newborns

Act 164

An act relating to the regulation of vision insurance plans

Act 164

- Prohibits vision insurance plans from restricting a vision care provider's choice of sources, suppliers, and optical laboratories if provider determines that the source, supplier, or laboratory he/she has chosen offers products, services, or materials in a way that is more beneficial to consumer, including with respect to cost, quality, timing, or selection, than the one chosen by the plan
- Prohibits a plan from imposing any penalties or fees on a provider for using any supplier, laboratory, product, service, or material
  - Provider must notify consumer of any additional costs consumer may incur because the products, service, or materials are coming from the source, supplier, or laboratory the provider selected rather than the one selected by the plan
- Requires Department of Financial Regulation to enforce the provisions of the bill and provisions of existing law relating to vision care plans

Act 165

An act relating to prescription drugs

Act 165: Rx Cost Transparency

- Green Mountain Care Board, in collaboration with Dept. of Vermont Health Access, must identify annually up to 15 prescription drugs on which the State spends significant health care dollars and for which the wholesale acquisition cost has increased:
  - by 50% or more over the past 5 years or
  - by 15% or more over the past 12 months
- Board must provide list and percentages to the Attorney General's Office and post on website
- AG's Office must require each drug's manufacturer to provide justification for the cost increases

Act 165: Rx Cost Transparency

- AG's Office also must provide an annual report to General Assembly and post report on its website
- Information provided to AG's Office:
  - is exempt from the Public Records Act
  - cannot be released in a manner that:
    - allows for identification of drugs or manufacturers, or
    - is likely to compromise the financial, competitive, or proprietary nature of the information
- AG's Office may bring civil action against a manufacturer that fails to provide required information

Act 165: Rx Formularies

- Requires DFR Commissioner to adopt rules requiring health insurers offering Exchange plans to provide prescription drug formulary information to enrollees, potential enrollees, health care providers
- Formulary must:
  - be posted online in standard format established by DFR
  - be updated frequently
  - be searchable by enrollees, potential enrollees, providers
  - include information about the drugs covered, cost-sharing, drug tiers, prior authorization, step therapy, and utilization management requirements

Act 165: 340B Drug Pricing

- Requires Dept. of Vermont Health Access to use same dispensing fee for 340B prescription drugs as it uses for non-340B drugs in Medicaid
  - Allows DVHA to modify 340B dispensing fee or reimbursement formula for federally qualified health centers (FQHCs) and Title X family planning clinics
- Requires DVHA to report by March 15, 2017 on:
  - 340B reimbursement formulas in other states
  - pros and cons of using same dispensing fee for 340B and non-340B prescription drugs in Medicaid
  - benefits, if any, of using 340B drug pricing to consumers, other payers, overall health care system

Act 165: Bronze plans

- Requires DVHA to convene an advisory group to develop options for 2018 bronze Exchange plans
- Options must include:
  - one or more plans with a higher out-of-pocket limit on Rx coverage than the limit in 8 V.S.A. § 4089i, and
  - two or more plans with an out-of-pocket limit at or below the limit in 8 V.S.A. § 4089i
- 8 V.S.A. § 4089i(c) provides:

  (c) A health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall limit a beneficiary's out-of-pocket expenditures for prescription drugs, including specialty drugs, to no more for self-only and family coverage per year than the minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively.

Act 165: Bronze plans

- Per the I.R.S., for 2015, 2016, and 2017, the minimum to qualify as an HDHP is $1,300 for an individual plan/$2,600 for a family plan
- The federal maximum out-of-pocket limit for 2016 is $6,850 for an individual plan/$13,700 for a family plan
- Bronze plans must have a 60% actuarial value
  - This means that on average, the plan pays 60% of the cost of care and the insured pays 40% (not including premiums)

Act 165: Bronze plans

- For 2018 plan year **only**, DVHA must certify at least two standard bronze-level plans that meet the out-of-pocket Rx limit, and may certify one or more bronze-level plans with modifications to the out-of-pocket Rx limit
- For each individual enrolled in a bronze plan for plan years 2016 and 2017 who had out-of-pocket Rx expenditures that met the limit, health insurers must automatically reenroll in a bronze plan for 2018 that meets the limit, unless the individual chooses a different plan

Act 165: Bronze plans

- Director of Health Care Reform must determine whether the U.S. Department of Health and Human Services has the authority to waive out-of-pocket limits and/or actuarial requirements for bronze plans
  - If so, DVHA must apply for a waiver by March 1, 2017
- By February 15, 2017, DVHA must provide information to the committees of jurisdiction on cost-sharing options and experience in bronze plans and comparisons of bronze plans with and without the statutory out-of-pocket Rx limit


Questions