TO THE HONORABLE SENATE:

The Committee on Finance to which was referred House Bill No. 29 entitled "An act relating to permitting Medicare supplemental plans to offer expense discounts" respectfully reports that it has considered the same and recommends that the Senate propose to the House that the bill be amended 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 rates for persons eligible for Medicare by reason of age and persons eligible for Medicare by reason of disability.

(2)(A) A health insurance company, hospital or medical service corporation, or health maintenance organization that issues Medicare supplemental insurance policies may offer expense discounts to encourage timely, full payment of premiums. Expense discounts may include premium reductions for advance payment of a full year's premiums, for paperless billing, for electronic funds transfer, and for other activities directly related to premium payment. The availability of one or more expense discounts shall not be considered a deviation from community rating.

(B) A health insurance company, hospital or medical service corporation, or health maintenance organization that issues Medicare supplemental insurance policies shall not offer reduced premiums or other discounts related to a person's age, gender, marital status, or other demographic criteria.

* * *

Sec. 2. MEDICARE SUPPLEMENTAL INSURANCE PLANS; REPORT

(a) The Green Mountain Care Board, in consultation with the Department of Financial Regulation, shall consider the advantages and disadvantages of:

(1) the Board assuming responsibility for reviewing the premium rates for Medicare supplemental insurance plans using the process set forth in 8 V.S.A. § 4062b;

(2) requiring increased standardization among Medicare supplemental plans;

(3) reviewing and regulating the amounts that Medicare supplemental plans reimburse health care providers for their services; and

(4) specifying the allowable amounts that Medicare supplemental plans may include in their rates for nonclaim expenses such as administrative costs, marketing expenses, and commissions for agents and brokers.

(b) On or before November 1, 2017, the Board shall report its findings and recommendations to the Health Reform Oversight Committee, the House Committee on Health Care, and the Senate Committees on Health and Welfare and on Finance.

* * * Health Care Professional Payment Parity * * *

Sec. 3. FINDINGS

The General Assembly finds:

(1) Serious disparities exist between the amounts commercial health insurers in Vermont reimburse health care professionals for the same services in different settings. The differences are particularly significant for the amounts paid for the services of a health care professional practicing at an

academic medical center and those of a health care professional in an independent medical practice or community hospital setting. For example, in January 2015, BlueCross BlueShield of Vermont provided the following reimbursement amounts for physician services:

(A) for an office consultation visit for an established patient, CPT code 99213, $78.00 for a physician in an independent practice and $177.00, or 2.3 times that amount, for a physician employed by the University of Vermont Medical Center (UVMMC);

(B) for a diagnostic, screening colonoscopy, CPT code 45378, $584.00 for a physician in an independent practice and $1,356.00, or 2.3 times that amount, for a physician employed by UVMMC; and

(C) for removal of a single skin lesion for biopsy, CPT code 11000, $109.00 for a physician in an independent practice and $349.00, or 3.2 times that amount, for a physician employed by UVMMC.

(2) Community hospitals in Vermont face disparities in their physician reimbursement rates that are similar to those of independent practices.

(3) Low reimbursement rates from commercial health insurers and Medicaid have placed burdens on health care professionals in independent practices, causing many of them to close their practices or affiliate with academic medical centers or other hospitals.

(4) The General Assembly asked the Green Mountain Care Board, the commercial insurers, and others to address the issue of the disparity in reimbursement amounts to health care professionals in 2014 Acts and Resolves No. 144, Sec. 19; 2015 Acts and Resolves No. 54, Sec 23; and 2016 Acts and Resolves No. 143, Sec. 5, but little progress has been made to date.

Sec. 4. GREEN MOUNTAIN CARE BOARD; HEALTH CARE PROFESSIONAL PAYMENT PARITY WORK GROUP

(a) The Green Mountain Care Board shall convene the Health Care Professional Payment Parity Work Group to determine how best to ensure fair and equitable reimbursement amounts to health care professionals for providing the same services in different settings.

(b) The Work Group shall be composed of the following members:

(1) the Chair of the Green Mountain Care Board or designee;

(2) the Commissioner of Vermont Health Access or designee;

(3) a representative of each commercial health insurer with 5,000 or more covered lives in Vermont;

(4) a representative of independent physician practices, appointed by Health First;

(5) a representative of the University of Vermont Medical Center;

(6) a representative of Vermont's community hospitals, appointed by the Vermont Association of Hospitals and Health Systems;

(7) a representative of Vermont's critical access hospitals, appointed by the Vermont Association of Hospitals and Health Systems;

(8) a representative of Vermont's federally qualified health centers and rural health clinics, appointed by the Bi-State Primary Care Association;

(9) a representative of naturopathic physicians, appointed by the Vermont Association of Naturopathic Physicians;

(10) a representative of chiropractors, appointed by the Vermont Chiropractic Association; and

(11) the Chief Health Care Advocate or designee from the Office of the Health Care Advocate.

(c) The Green Mountain Care Board, in consultation with the other members of the Work Group, shall develop a plan for reimbursing health care professionals in a fair and equitable manner, including the following:

(1) proposing a process for reducing existing disparities in reimbursement amounts for health care professionals across all settings by the maximum achievable amount over three years, beginning on or before January 1, 2018, which shall include:

(A) establishing a process for and evaluating the potential impacts of increasing the reimbursement amounts for lower paid providers and reducing the reimbursement amounts for the highest paid providers;

(B) evaluating the potential impact of requiring health insurers to modify their reimbursement amounts to health care professionals across all settings for nonemergency evaluation and management office visits codes to the amount of the insurer's average payment for that code across all settings in Vermont on January 1, 2017 or on another specified date;

(C) ensuring that there will be no negative net impact on reimbursement amounts for providers in independent practices and community hospitals;

(D) ensuring that there will be no increase in medical costs or health insurance premiums as a result of the adjusted reimbursement amounts;

(E) considering the impact of the adjusted reimbursement amounts on the implementation of value-based reimbursement models, including the all-payer model; and

(F) developing an oversight and enforcement mechanism through which the Green Mountain Care Board shall evaluate the alignment between reimbursement amounts to providers, hospital budget revenues, and health insurance premiums;

(2) identifying the time frame for adjusting the reimbursement amounts for each category of health care services; and

(3) enforcement and accountability provisions to ensure measurable results.

(d)(1) The Green Mountain Care Board shall provide an update on its progress toward achieving provider payment parity at each meeting of the Health Reform Oversight Committee during the final adjournment of the 2017 legislative session.

(2) On or before November 1, 2017, the Green Mountain Care Board shall submit a final timeline and implementation plan, and propose any necessary legislative changes, to the Health Reform Oversight Committee, the House Committee on Health Care, and the Senate Committees on Health and Welfare and on Finance.

Sec. 5. REIMBURSEMENT AMOUNTS FOR NEWLY ACQUIRED OR NEWLY AFFILIATED PRACTICES

(a) Health care professionals employed by practices newly acquired by or newly affiliated with hospitals on or after November 1, 2017 shall continue to be reimbursed the same professional fees as they were prior to the date of the acquisition or affiliation, subject to any modifications resulting from implementation of the provider payment parity plan required by Sec. 4 of this act.

(b) The Green Mountain Care Board shall ensure compliance with subsection (a) of this section through its review of hospital budgets pursuant to 18 V.S.A. chapter 221, subchapter 7.

* * * Health Insurer Bill Back * * *

Sec. 6. 18 V.S.A. § 9374(h) is amended to read:

(h)(1) Except as otherwise provided in subdivision (2) of this subsection, expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the Board shall be borne as follows:

(A) 40 percent by the State from State monies;

(B) 15 percent by the hospitals; and

(C) ~~15~~ 45 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125~~;~~

~~(D) 15 percent by,~~ health insurance companies licensed under 8 V.S.A. chapter 101~~;~~, and

~~(E) 15 percent by~~ health maintenance organizations licensed under 8 V.S.A. chapter 139.

(2) The Board may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subdivision (1) of this subsection if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

(3) Expenses under subdivision (1)(C) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical,

comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

* * * Effective Dates * * *

Sec. 7. EFFECTIVE DATES

(a) Secs. 1 (Medicare supplemental plans) and 6 (health insurer bill back) shall take effect on July 1, 2017.

(b) Secs. 2 (report on Medicare supplemental plans), 3–5 (payment parity) and this section shall take effect on passage.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE