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- The Committee on Health and Welfare to which was referred Senate Bill

 No. 151 entitled "An act relating to pay parity and transparency in health care"

 respectfully reports that it has considered the same and recommends that the

 bill be amended by striking out all after the enacting clause and inserting in

 lieu thereof the following:
- 7 Sec. 1. 8 V.S.A. § 4062 is amended to read: (was Sec. 12)
- 8 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS
- 9 ***
- 10 (b)(1) In conjunction with a rate filing required by subsection (a) of this 11 section, an insurer shall file a plain language summary of the proposed rate. 12 All summaries shall include a brief justification of any rate increase requested, 13 the information that the Secretary of the U.S. Department of Health and 14 Human Services (HHS) requires for rate increases over 10 percent, the amount 15 of total premium revenue expended on care coordination and management, and 16 any other information required by the Board. The plain language summary 17 shall be in the format required by the Secretary of HHS pursuant to the Patient 18 Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended 19 by the Health Care and Education Reconciliation Act of 2010, Pub. L. No.

111-152, and shall include notification of the public comment period

1	established in subsection (c) of this section. In addition, the insurer shall post
2	the summaries on its website.
3	* * *
4	Sec. 2. 8 V.S.A. § 4100g is amended to read: (was Sec. 9)
5	§ 4100g. COLORECTAL CANCER SCREENING, COVERAGE
6	REQUIRED
7	* * *
8	(b) Insurers shall provide coverage for colorectal cancer screening at a
9	minimum in accordance with U.S. Preventive Services Task Force guidelines,
10	including:
11	(1) Providing providing an insured 50 years of age or older with the
12	option of:
13	(A) annual fecal occult blood testing plus one flexible sigmoidoscopy
14	every five years; or
15	(B) one colonoscopy every 10 years;
16	(2) For for an insured who is at high risk for colorectal cancer,
17	colorectal cancer screening examinations and laboratory tests as recommended
18	by the treating physician.
19	* * *
20	Sec. 3. 18 V.S.A. chapter 13, subchapter 2 is added to read: (was Sec. 16)
21	Subchapter 2. Payment Reform

1	§ 721. INSURER PARTICIPATION IN MULTIPAYER ALTERNATIVE
2	PAYMENT MODELS
3	It is the intent of the General Assembly first to provide commercial health
4	insurers in the State with the opportunity to participate in Vermont's
5	multipayer alternative payment model or models established pursuant to the
6	State's agreement with the Center for Medicare and Medicaid Innovation. In
7	the event that no insurers elect to participate in Vermont's multipayer
8	alternative payment model or models, the Department of Financial Regulation
9	shall require health insurers, as defined in 18 V.S.A. § 9402, to participate in
10	Vermont's multipayer alternative payment model as a condition of doing
11	business in this State.
12	Sec. 4. 18 V.S.A. chapter 21, subchapter 3 is amended to read: (was Sec. 7)
13	Subchapter 3. Venereal Diseases Sexually Transmitted Infections
14	* * *
15	§ 1107. CONSENT TO PREVENTIVE SERVICES AND TREATMENT BY
16	<u>MINORS</u>
17	(a) A minor 12 years of age or older may consent to medical care by a
18	licensed physician related to the prevention of a sexually transmitted infection.
19	(b) Consent under this section shall not be subject to disaffirmance due to
20	minority of the individual consenting. The consent of the parent or legal

1	guardian of a minor consenting under this section shall not be necessary to
2	authorize care as described in this subsection.
3	(c) A minor 12 years of age or older who has or is suspected to have a
4	sexually transmitted infection may consent to treatment in accordance
5	with the provisions of section 4226 of this title.
6	Sec. 5. CONFORMING REVISION (was Sec. 8)
7	When preparing the Vermont Statutes Annotated for publication, the Office
8	of Legislative Counsel shall make the following revisions throughout the
9	statutes as needed for consistency with Sec. 4 of this act, provided the revisions
10	have no effect on the meaning of the affected statutes: replace "venereal
11	disease" with "sexually transmitted infection."
12	Sec. 6. 18 V.S.A. § 9414a is amended to read: (was Sec. 13)
13	§ 9414a. ANNUAL REPORTING BY HEALTH INSURERS
14	* * *
15	(b) Health insurers with a minimum of 2,000 Vermont lives covered at the
16	end of the preceding year or who offer insurance through the Vermont Health
17	Benefit Exchange pursuant to 33 V.S.A. chapter 18, subchapter 1 shall
18	annually report the following information to the Commissioner of Financial
19	Regulation, in plain language, as an addendum to the health insurer's annual
20	statement:
21	* * *

1	(21) the health insurer's legal expenses related to claims or service
2	denials during the preceding year; and
3	(22) the amount and recipient of charitable contributions made by the
4	health insurer during the preceding year-; and
5	(23) risk-based capital reports.
6	* * *
7	Sec. 7. 18 V.S.A. § 9414b is added to read: (was Sec. 4)
8	§ 9414b. INCREASING PRIMARY CARE SPENDING ALLOCATIONS
9	(a)(1) Each of the following entities shall increase the percentage of total
10	health care spending it allocates to primary care, using the baseline percentages
11	determined by the Green Mountain Care Board in accordance with 2020 Acts
12	and Resolves No. 17, by at least one percentage point per year until primary
13	care comprises at least 12 percent of the plan's or payer's overall annual health
14	care spending:
15	(A) each health insurer with 500 or more covered lives for
16	comprehensive, major medical health insurance in this State;
17	(B) the State Employees' Health Benefit Plan; and
18	(C) health benefit plans offered pursuant to 24 V.S.A. § 4947 to
19	entities providing educational services.
20	(2) Upon achieving the 12 percent primary care spending allocation
21	required by subdivision (1) of this subsection, each plan or payer shall

1	maintain or increase the percentage of total health care spending it allocates to
2	primary care at or above 12 percent.
3	(3) A plan's or payer's increased proportional spending on primary care
4	shall not:
5	(A) result in higher health insurance premiums;
6	(B) be achieved through increased fee-for-service payments to
7	providers; or
8	(C) increase the plan's or payer's overall health care expenditures.
9	(b)(1) On or before June 1 of each year, each entity listed in subdivisions
10	(a)(1)(A)–(C) of this section shall report to the Green Mountain Care Board the
11	percentage of its total health care spending that was allocated to primary care
12	during the previous plan year.
13	(2) On or before December 1 of each year from 2024 to 2029, the Green
14	Mountain Care Board shall report to the House Committee on Health Care and
15	the Senate Committees on Health and Welfare and on Finance on progress
16	toward increasing the percentage of health care spending systemwide that is
17	allocated to primary care.
18	Sec. 8. 18 V.S.A. chapter 220 is amended to read: (was Secs. 11 and 15)
19	Chapter 220. GREEN MOUNTAIN CARE BOARD
20	* * *

1	§ 9372. PURPOSE
2	It is the intent of the General Assembly to create an independent board to
3	promote the general good of the State by:
4	(1) improving the health of the population; <u>and</u>
5	(2) reducing the per-capita rate of growth in expenditures for health
6	services in Vermont across all payers, while ensuring that access to care and
7	quality of care are not compromised;, through the review and approval of
8	health insurance rates, hospital and accountable care organization (ACO)
9	budgets and ACO certification, and data analytics.
10	(3) enhancing the patient and health care professional experience of care;
11	(4) recruiting and retaining high-quality health care professionals; and
12	(5) achieving administrative simplification in health care financing and
13	delivery.
14	* * *
15	§ 9374. BOARD MEMBERSHIP; AUTHORITY
16	* * *
17	(b)(1) The initial term of each member of the Board, including the Chair,
18	shall be seven years, and the term of the Chair shall be six years thereafter.
19	(2) The term of each member other than the Chair shall be six years,
20	except that of the members first appointed, one each shall serve a term of three
21	years, four years, five years, and six years. [Repealed.]

1	(3) Subject to the nomination and appointment process, a A member may
2	serve more than one term. A member may be reappointed to an additional
3	term subject to the requirements of section 9391 of this title.
4	* * *
5	§ 9391. NOMINATION AND APPOINTMENT PROCESS
6	(a) Whenever Candidate selection process.
7	(1) Unless a vacancy is filled by reappointment pursuant to subsection
8	(c) of this section, not later than 90 days prior to a known vacancy occurs
9	occurring on the Green Mountain Care Board, or when an incumbent does not
10	declare that he or she will be a candidate to succeed himself or herself, the
11	Green Mountain Care Board Nominating Committee shall commence its
12	nomination application process. The Committee shall select for consideration
13	by the Committee, by majority vote, and provided that a quorum is present,
14	from the applications for membership on the Green Mountain Care Board as
15	many candidates as it deems qualified for the position or positions to be filled.
16	The Committee shall base its determinations on the qualifications set forth in
17	section 9392 of this section title.
18	(2) A Board member who is resigning from the Board prior to the
19	expiration of the member's term shall notify the Committee Chair of the
20	member's anticipated resignation date. Once notified, the Committee Chair
21	shall commence the nomination application process as soon as is practicable in

- light of the anticipated resignation date and shall notify the Governor of the
 anticipated vacancy.
 - (b) Nomination list. The Committee shall submit to the Governor the names of the persons individuals it deems qualified to be appointed to fill the position or positions and the name of any incumbent member who was not reappointed pursuant to subsection (c) of this section and who declares notifies the Committee Chair that he or she the incumbent wishes to be a candidate to succeed himself or herself nominated. An incumbent shall not be required to submit an application for nomination and appointment to the Committee under subsection (a) of this section.
 - (c) Reappointment; notification. To be considered for reappointment to the Green Mountain Care Board, a Board member whose term is expiring shall notify the Governor, not later than 120 days prior to the member's term expiration date, that the member is seeking reappointment. If the Board member is not reappointed by the Governor on or before 30 days after notifying the Governor, the member's term shall end on the expiration date of the member's current term, unless the member is nominated as provided in subsection (b) of this section and subsequently appointed or as otherwise provided by law. A Board member's reappointment shall be subject to the consent of the Senate.

1	(e)(d) Unless the Governor reappointed a Board member pursuant to
2	subsection (c) of this section, The the Governor shall make an appointment to
3	the Green Mountain Care Board from the list of qualified candidates submitted
4	pursuant to subsection (b) of this section not later than 45 days after receipt of
5	the candidate list. The appointment shall be subject to the consent of the
6	Senate. The names of candidates submitted and not selected shall remain
7	confidential.
8	(d)(e) All proceedings of the Committee, including the names of candidates
9	considered by the Committee and information about any candidate submitted
10	by any source, shall be confidential.
11	Sec. 9. 18 V.S.A. § 9456 is amended to read: (was Sec. 14)
12	§ 9456. BUDGET REVIEW
13	* * *
14	(d)(1) Annually, on or before September 15, followed by a written decision
15	by October 1, the Board shall establish a budget for each hospital on or before
16	September 15, followed by a written decision by October 1 that meets the
17	acceptable range of comparison to the national, regional, or in-state peer group
18	norms set forth in the indicators, ratios, and statistics pre-established by the
19	Board as required by subdivision (c)(2) of this section, and is affordable;
20	promotes quality care; promotes access to health care; protects solvency; and is

- not unjust, unfair, inequitable, misleading, or contrary to the laws of this State.
- 2 Each hospital shall operate within the budget established under this section.

3 ***

- 4 Sec. 10. 21 V.S.A. § 640 is amended to read: (was Sec. 5)
- 5 § 640. MEDICAL BENEFITS; ASSISTIVE DEVICES; HOME AND

AUTOMOBILE MODIFICATIONS

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(d) The liability of the employer to pay for medical, surgical, hospital, and nursing services and supplies, prescription drugs, and durable medical equipment provided to the injured employee under this section shall not exceed the maximum fee for a particular service, prescription drug, or durable medical equipment as provided by a schedule of fees and rates prepared by the Commissioner. The Commissioner shall update the schedule of fees and rates on a consistent basis and not less than biennially. The reimbursement rate for services and supplies in the fee schedule shall include consideration of medical necessity, clinical efficacy, cost-effectiveness, and safety, and those services and supplies shall be provided on a nondiscriminatory basis consistent with workers' compensation and health care law. The Commissioner shall authorize reimbursement at a rate higher than the scheduled rate if the employee demonstrates to the Commissioner's satisfaction that reasonable and necessary treatment, prescription drugs, or durable medical equipment is not

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1	available at the scheduled rate. An employer shall establish direct billing and
2	payment procedures and notification procedures as necessary for coverage of
3	medically necessary medically necessary prescription medications for chronic
4	conditions of injured employees, in accordance with rules adopted by the
5	Commissioner.
6	* * *
7	Sec. 11. 33 V.S.A. § 1901a is amended to read: (was Sec. 3)
8	§ 1901a. MEDICAID BUDGET
9	(a) Financial plan. The General Assembly shall approve each year a
10	Medicaid budget. The annual Medicaid budget shall include an annual
11	financial plan, and a five-year financial plan accounting for expenditures and
12	revenues relating to Medicaid and any other health care assistance program
13	administered by the Agency of Human Services.
14	(b) Quarterly information and analysis. The Secretary of Human Services
15	or his or her the Secretary's designee and the Commissioner of Finance and
16	Management shall provide quarterly to the Joint Fiscal Committee such
17	information and analysis as the Committee reasonably determines is necessary
18	to assist the General Assembly in the preparation of the Medicaid budget.

(c) Medicaid provider rates; primary care. It is the intent of the General

Assembly that Vermont's health care system should reimburse all Medicaid

participating providers at rates that are equal to 100 percent of the Medicare

1	rates for the services provided, with first priority for primary care providers. In
2	support of this goal, in its annual budget proposal, the Department of Vermont
3	Health Access shall either provide reimbursement rates for Medicaid
4	participating providers for primary care services at rates that are equal to 100
5	percent of the Medicare rates for the services in effect in calendar year 2022,
6	with positive Consumer Price Index inflation adjustment rates in subsequent
7	years, or, in accordance with 32 V.S.A. § 307(d)(6), provide information on
8	the additional amounts that would be necessary to achieve full reimbursement
9	parity for primary care services with the Medicare rates.
10	Sec. 12. GREEN MOUNTAIN CARE BOARD; HEALTH CARE
11	CONTRACTS; FEE SCHEDULES; REPORT (was Sec. 1)
12	(a) The Green Mountain Care Board shall collect and review a
13	representative sample of health care contracts and fee schedules from health
14	insurers, including contracts and fee schedules with hospital-affiliated, non-
15	hospital-affiliated, and independent health care providers to inform the Board's
16	development of a methodology for increasing the transparency around health
17	care contracts.
18	(b) On or before January 15, 2025, the Board shall provide information to
19	the House Committee on Health Care and the Senate Committees on Health
20	and Welfare and on Finance regarding the Board's proposed methodology for
21	increasing the transparency around health care contracts, including the

1	standards and criteria that the Board intends to use for its reviews of health
2	care contracts and fee schedules, and any recommendations for legislative
3	action.
4	(c) Confidential business information and trade secrets received from an
5	insurer pursuant to subsection (a) of this section shall be exempt from public
6	inspection and copying under 1 V.S.A. § 317(c)(9) and shall be kept
7	confidential, except that the Board may disclose or release information
8	publicly in summary or aggregate form if doing so would not disclose
9	confidential business information or trade secrets.
10	Sec. 13. EFFECTIVE DATES
11	This act shall take effect on July 1, 2024.
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16	
17	(Committee vote:)
18	
19	Senator
20	FOR THE COMMITTEE