



Highlights from 2016 health care legislation

Jennifer Carbee, Legislative Counsel
Office of Legislative Council
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Acts to be discussed

- ▶ Act 165 (S.216): An act relating to prescription drugs
 - ▶ Act 173 (S.243): An act relating to combating opioid abuse in Vermont
 - ▶ Act 113 (H.812): An act relating to implementing an all-payer model and oversight of accountable care organizations
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Other health care bills passed during 2016 legislative session

- ▶ H.171 – restrictions on the use of e-cigarettes
 - ▶ H.524 – SHOP Exchange waiver
 - ▶ H.559 – licensure exemption for visiting team physicians
 - ▶ H.620 – insurance coverage for contraceptives
 - ▶ H.690 – allowing practice of acupuncture by other health care professionals if it is within their scope of practice
 - ▶ H.761 – cataloguing and aligning health care performance measures
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More health care bills passed in 2016

- ▶ S.62 – surrogate decision making for DNR/COLST
- ▶ S.132 – prohibiting conversion therapy on minors
- ▶ S.157 – breast density notification and education
- ▶ S.190 – allowing prescriptions to be maintained outside original container
- ▶ S.214 – no large groups in the Exchange
- ▶ S.215 – regulating vision insurance plans
- ▶ S.245 – notice of new health care provider affiliations
- ▶ S.255 – regulation of hospitals and health insurers
- ▶ S.256 – extending home health agency CON moratorium

Act 165 (S.216)

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

Act 173 (S.243)

An act relating to combating opioid abuse in Vermont



Act 173: Vermont Prescription Monitoring System (VPMS)

- ▶ Requires dispensers to report to VPMS within 24 hours/one business day after dispensing
- ▶ Requires dispensers to query VPMS:
 - before dispensing opioids to a patient who is new to the pharmacy
 - when someone pays cash for opioids despite having prescription drug coverage on file
 - when a patient asks to refill an opioid prescription substantially earlier than would be typical
 - when the dispenser knows the patient is being prescribed opioids by more than one prescriber

Act 173: Opioid prescribing limits

- ▶ Directs Commissioner of Health to adopt rules on prescribing opioids after consulting Controlled Substances and Pain Management Advisory Council
- ▶ Rules may include:
 - numeric and temporal limits on pills prescribed
 - including maximum number of pills to be prescribed following minor medical procedures
 - contemporaneous prescription of naloxone in some cases
- ▶ Rules must include:
 - informed consent that explains risks of taking opioids
 - prescribers providing information to patients about safe storage and disposal of controlled substances

Act 173: Medical education

- ▶ Requires all health care providers who can prescribe or dispense controlled substances to complete a total of at least two hours of continuing education per licensing period on topics related to appropriate prescribing, use of the VPMS, and prevention of controlled substance misuse, abuse, and diversion
- ▶ Department of Health must report by January 15, 2017 on appropriate safe prescribing and disposal of controlled substances prescribed by veterinarians for animals, dispensed to owners

Act 173: Medical education

- ▶ Requires Commissioner of Health and medical educators to develop curricular materials to ensure students in health professional programs learn safe prescribing practices and screening, prevention, and intervention for cases of prescription drug misuse and abuse

Act 173: Acupuncture

- ▶ Requires BlueCross BlueShield of Vermont to:
 - evaluate the evidence supporting the use of acupuncture to treat pain
 - determine whether its health insurance plans should provide coverage for acupuncture services
- ▶ Creates a DVHA pilot project to offer acupuncture services to Medicaid-eligible Vermonters with a diagnosis of chronic pain
 - progress report due January 15, 2017
 - must also consider if acupuncture has a role in treating substance use disorder

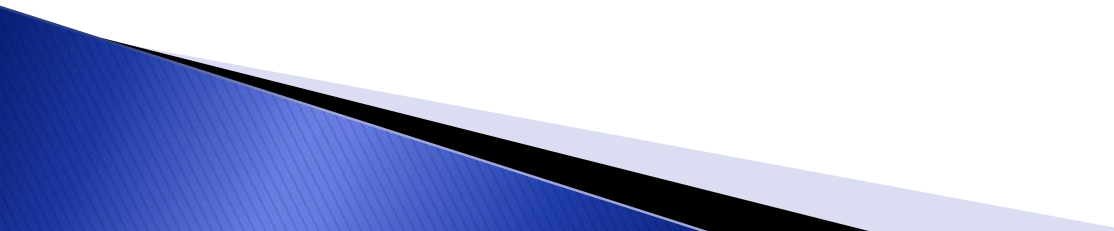
Act 173: Funding

- ▶ Increases fee on pharmaceutical manufacturers whose drugs are paid for by DVHA from 0.5% to 1.5% of annual DVHA drug spending
 - Money goes into Evidence-Based Education and Advertising Fund
 - Act increases permissible uses of Fund
- ▶ Appropriates \$1.275 million to Department of Health for academic detailing, unused prescription drug disposal initiatives, opioid antagonist rescue kits, hospital antimicrobial program
- ▶ Appropriates \$200,000 to DVHA for acupuncture pilot project

Act 113 (H.812): 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
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Act 113: All-payer model

- ▶ Act 113 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 an 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 also establishes numerous criteria that the all-payer model must meet

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 113 requires ACOS to obtain and maintain certification from the 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 a primary care professional advisory group for two years to help the 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
 - Report must include a plan for implementing value-based Medicaid payments for service providers that improves access and quality, and must describe interaction with Medicaid payments to same providers from ACOs

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

