H.559: Final Section-by-Section Summary as Passed by House and Senate
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May 16, 2012

Secs. 1 and 2 – Employers in the Vermont Health Benefit Exchange

- Defines "qualified employer" for the Exchange as an employer with 50 or fewer employees for 2014 and 2015
- Defines "qualified employer" for the Exchange as an employer with 100 or fewer employees for 2016
- Employer can stay in the Exchange even if expands beyond 50 (or 100 in 2016) as long as it continues to make Exchange coverage available to its employees
- All employers eligible to purchase in the Exchange starting in 2017

Sec. 2a – Dental plans; bronze level of coverage

- Dental plans offered in conjunction with qualified health benefit plans can be offered in the Exchange
- Health plans offered in the Exchange must include at least bronze level of coverage

Sec. 2b – Navigators

- Navigators must provide information about Sec. 125 plans and help employers set them up

Sec. 2c – Range of plans in the Exchange

- Green Mountain Care (GMC) Board must approve a full range of cost-sharing structures in the Exchange for each actuarial value
- GMC Board must allow insurers to offer wellness rewards and discounts

Sec. 2d – Brokers in the Exchange

- Exchange must establish procedures allowing agents and brokers to be appropriately compensated for:
    - Facilitating enrollment of individuals and employers in Exchange plans
    - Assisting qualified individuals to apply for premium tax credits and cost-sharing subsidies

Sec. 2e – Prohibition on brokers' fees in insurance rates

- Prohibits inclusion of agents' and brokers' fees in insurance rates in the individual and small group markets starting in 2014
- Allows Exchange to create mechanism for paying agents and brokers outside of insurance rates

Sec. 2f and 2g – Disclosure of brokers' fees

- Requires disclosure of agents' and brokers' fees in the large group market beginning July 1, 2012

- Requires disclosure of agents' and brokers' fees in the individual and small group markets beginning July 1, 2012 and ending when the insurer no longer pays any such fees

Sec. 2h – Bronze plan notice

- The Exchange must clearly indicate to the purchaser of a bronze plan, and of other plans as appropriate, that the plan has the potential for significant out-of-pocket costs in addition to the premium

Sec. 3 – Merger of individual and small group markets

- Merges the individual and small group health insurance markets into one market
- Plans available for individuals and employers up to 50 employees in 2014 and 2015 and up to 100 employees starting in 2016
- Plans must be sold through the Exchange
- Takes effect January 1, 2014

Sec. 4 – Grandfathered health plans

- Preserves existing individual and small group market provisions for grandfathered plans starting January 1, 2014 unless/until plan loses grandfathered status
- Same provisions as in current law with a few exceptions – no preexisting condition exclusion allowed for small group plans (per ACA), deletes some outdated provisions

Sec. 5 – Green Mountain Care Board's authority

- Allows chair of GMC Board to apply for grant funding
- Creates "bill-back" provision to fund certain GMC Board expenses
- Allows chair of GMC Board to issue subpoenas, examine persons, administer oaths, and require production of papers and records

Sec. 5a – Bill-back report

- Requires Dept of Financial Regulation (DFR) and GMC Board to recommend by February 1, 2013 how best to allocate expenses for regulatory duties among hospitals and health insurers

Secs. 6 – 11 – Unified health care budget

- Moves the unified health care budget from DFR to the GMC Board
- Sec. 6 – adds a definition of unified health care budget to GMC Board chapter
- Sec. 7 – [Deleted]
- Sec. 8. – deletes reference to unified health care budget from HCA's duties
- Sec. 9 – deletes reference to unified health care budget from components of DFR's health resource allocation plan
- Sec. 10 – deletes provision on unified health care budget and expenditure analysis from HCA chapter

- Sec. 11 – enacts same provision on unified health care budget and expenditure analysis in GMC Board chapter as was deleted in Sec. 10, changing references from DFR to GMC Board

Sec. 11a – Claims edit standards

- Minor modifications to statutes on claim edits standards
- Shifts responsibility for convening work group, requires annual progress report

Sec. 11b – Mental health and substance abuse quality assurance

- Requires DFR to develop quality indicators to evaluate and ensure health insurer compliance with mental health parity laws
- Requires Dept. of Health and Dept. of Mental Health to evaluate and ensure health care professionals and facilities provide high quality mental health and substance abuse treatment services
- Requires GMC Board to consider results of managed care organizations' quality improvement projects

Sec. 11c – Parity for primary mental health care; recommendations

- Requires DFR to recommend by January 15, 2013 guidelines for distinguishing between primary and specialty mental health services and estimate related premium impacts

Secs. 11d and 11e – Parity for primary mental health care; rulemaking

- Specifies that insurance co-pays for primary mental health care and services cannot exceed co-pays for care and services from a primary care provider and that co-pays for specialty mental health care and services cannot exceed co-pays for care and services from a specialist provider (takes effect January 1, 2014)
- Requires DFR to adopt rules by October 1, 2013 distinguishing between primary and specialty mental health services

Sec. 11f – Mental Health Care Ombudsman

- Directs Department of Mental Health to establish an Office of the Mental Health Care Ombudsman in the state's designated protection and advocacy agency
- Specifies that the agency is not required to undertake any additional duties beyond those required under federal law

Sec. 11g – Definition of "prior authorization"

- Defines "prior authorization" as process for determining medical necessity and/or appropriateness of drugs, medical procedures, medical tests, health care services

Sec. 11h – Uniform prior authorization forms

- Starting March 1, 2014, health plans must accept either the national standard transaction information for electronic authorization or DFR's uniform forms for prior authorization of prescription drugs, medical procedures, and medical tests; health plans must have the capability to accept both

- By September 1, 2013, requires DFR to develop clear, uniform, readily accessible prior authorization forms – as many as appropriate for prescription drugs and one for medical procedures/tests
- Specifies criteria for uniform prior authorization forms
- Health plan must respond to prior authorization request within 48 hours for urgent requests and 120 hours for non-urgent requests

Secs. 12 – 22 – Certificates of Need

- Sec. 12 – extends from 10 days to 30 days the amount of time the GMC Board has to approve, modify, or disapprove insurance rate requests, gives GMC Board authority over hospital budgets and certificates of need (CON), delays GMC authority over CONs from July 1, 2012 to January 1, 2013, gives GMC Board responsibility for unified health care budget, requires GMC Board to review mental health and substance abuse treatment data and discuss with its mental health technical advisory group
- Sec. 13 – updates cross-references, adds GMC Board definition to CON chapter
- Sec. 14 – provides GMC Board with same general enforcement powers as DFR commissioner has over health insurers, health care providers, health care facilities, health plans, and others
- Secs. 14a and 15 – replaces DFR authority over CONs with GMC Board
- Sec. 16 – expands circumstances in which health care facility other than a hospital must get a CON to include transfer of more than 50% ownership in the facility, replaces DFR authority over CONs with GMC Board
- Secs. 16a–22 - replaces DFR authority over CONs with GMC Board

Sec. 23 – Hospital budget review

- Replaces role of DFR commissioner with GMC Board in hospital budget review process

Sec. 24 – Provider bargaining groups

- Expands list of officials with whom health care provider bargaining groups may negotiate to include the Secretary of Administration and the GMC Board; expands the topics on which they may negotiate to include administrative simplification, information technology, and workforce planning

Sec. 24a – Certificate of Merit

- Requires a party filing a claim to recover damages from personal injury or wrongful death occurring on or after February 1, 2013 to file a certificate of merit along with the complaint
- Certificate of merit certifies that attorney or plaintiff has consulted with a qualified health care provider, and that the health care provider has described the applicable standard of care and indicated that there is a reasonable likelihood the plaintiff will be able to show the defendant failed to meet the standard of care and so caused the plaintiff's injury

Sec. 24b – [Deleted]

Secs. 24c and 24d – Pre-suit mediation; sunset

- Allows potential medical malpractice plaintiff to request that each potential defendant participate in pre-suit mediation
- Details pre-suit mediation process
- Begins February 1, 2013 and sunsets February 1, 2015

Sec. 24e – Medical malpractice reform report

- By September 1, 2014, Secretary of Administration or designee to report on the impacts of the certificate of merit and pre-suit mediation enacted by this act

Sec. 24f – Hospital data reports

- Beginning in 2013, hospital community reports to include data from all Vermont hospitals of reportable adverse events, along with analysis and explanatory comments

Sec. 25 – Insurance rate reviews

- Amends health insurance rate review process to require DFR commissioner to make a recommendation to the GMC Board on a rate request within 30 days or he or she will be deemed to have recommended approval
- Requires GMC Board to approve, modify, or disapprove a rate request within 30 days or it will be deemed to have approved the rate
- Requires DFR to apply the GMC Board's decision within five business days
- Exempts vision and long-term care policies from certain rates and forms requirements, to which many other limited benefit policies are already exempt
- Exempts Medicare supplemental policies from GMC Board approval requirement

Sec. 25a – HMO rates and forms

- Makes conforming changes to HMO rates and forms statute to reflect GMC Board's role in rate review

Sec. 26 – Appeals

- Specifies that only GMC Board decisions are appealable and that the DFR commissioner's recommendations to the Board on rate requests are not appealable

Sec. 26a – Consumer protection report

- Requires report from DFR, in collaboration with HCO and AHS, regarding:
    - Recommendations on how best to represent the public interest before GMC Board and others
    - Recommendations on coordinating, consolidating, or both the consumer protection activities of DFR, HCO, and AHS
    - Ombudsman's current and projected funding needs and recommended funding mechanisms

Sec. 27 – Payment reform pilots

- Moves responsibility for payment reform pilot projects from the Director of Payment Reform in the Department of Vermont Health Access (DVHA) to the GMC Board, which must collaborate with the DVHA commissioner
- Delays dates payment reform pilot projects start from one by Jan. 1, 2012 and two or more by July 1, 2012, to one by July 1, 2012 and two or more by Oct. 1, 2012
- Moves health insurer involvement language from 18 V.S.A. chapter 13 to Board
- After implementation of pilots, health insurers can appeal GMC Board's decisions

Sec. 28 – Blueprint for Health

- Requires Blueprint director to collaborate with Commissioners of Mental Health and of DAIL, in addition to Commissioners of Health and of DVHA
- Requires Blueprint director to collaborate with chair of GMC Board, in addition to DFR commissioner, whenever health insurance issues involved
- Replaces representative from DFR with representative from the GMC Board on the Blueprint Executive Committee; also adds a licensed mental health professional with clinical experience in Vermont and a representative from the Vermont Council of Developmental and Mental Health Services

Sec. 28a – Blueprint participation, legislative intent

- Expresses legislative intent that:
    - Access to and payments for community health teams should begin at least six months before the practice is scheduled to be scored for Blueprint recognition
    - Blueprint director increase payments to medical homes in recognition of updated NCQA scoring requirements
    - All health insurance plans, including multistate plans, participate in Blueprint

Sec. 29 – HMO reporting requirements

- Reduces from 120 days to 90 days after the close of the fiscal year the time within which HMOs must file their annual report with DFR

Sec. 30 – VPQHC

- Moves VPQHC contract from DFR to Health Department, adds DVHA oversight for health information technology (HIT) integration into state HIT plan

Sec. 31 – Discretionary clause ban

- Prohibits any insurer from including a discretionary clause in a contract for health insurance, life insurance, or disability income protection coverage
- Renders any such provision "null and void" as of July 1, 2012

Sec. 32 – Prescription drugs

- Prohibits health insurers and pharmacy benefit managers from imposing an annual limit on prescription drug benefits

- Requires health plans to limit annual out-of-pocket expenses for prescription drugs, including specialty drugs, to no more for self-only and family coverage than the minimum dollar amounts in effect for self-only and family coverage for a high deductible health plan (HDHP)
- For prescription drugs offered in conjunction with a HDHP, prohibits plan from coverage prescription drugs until the expenditures applicable to the deductible under the HDHP have met the mount of the minimum annual deductibles in effect for self-only and family coverage under federal law; then coverage for prescription benefits will begin and the out-of-pocket limits will apply

Secs. 32a and 32b – Prescribed product manufacturers

- Excludes prescription eyeglasses, sunglasses, and other eyewear from definition of prescribed product
- Includes combination products in the definition of a prescribed product
- Exempts samples of medical foods from the gift ban
- Allows free combination products, medical food, and infant formula to be given to free clinics in addition to what they may already receive
- Gives the Attorney General's office the same authority to investigate violations of the gift ban and disclosure requirements as under the Consumer Fraud Act
- Prohibits any public reporting of free products provided to free clinics from identifying the recipients or connecting them with a monetary value
- Requires disclosure of samples and donations to free clinics of medical food and infant formula to be made in aggregate form

Secs. 33-35a – Medicaid Waivers

- Sec. 33 – allows Agency of Human Services (AHS) to seek federal waivers to serve individuals eligible for both Medicare and Medicaid ("dual eligibles")
- Sec. 34 – allows AHS to seek new or renewed federal waivers to implement Medicaid, Choices for Care, and SCHIP programs on terms and conditions similar to Global Commitment, including:
    - maintaining and expanding the public managed care entity model
    - obtaining federal matching funds for state Exchange subsidies
    - ensuring a streamlined transition between Medicaid and the Exchange
- Sec. 34a – expands authority of AHS secretary to apply to federal Secretary of Health and Human Services to allow Medicare and Medicaid participation in payment reform activities in addition to the Blueprint
- Sec. 35 – Waiver updates
    - Requires AHS secretary or designee to provide a waiver update to the committees of jurisdiction by January 30, 2013, with monthly information and updates to the Health Care Oversight Committee (HCOC) or to a telephone call of interested stakeholders if HCOC is not meeting that month
    - Requires AHS secretary or designee to provide updates at each Medicaid and Exchange advisory committee meeting
    - Requires AHS secretary or designee to present transition plan for VHAP, ESIA, and CHAP to the committees of jurisdiction by January 15, 2013

- Sec. 35a – Waiver and transition planning
    - Expresses legislative intent that transition from Catamount and VHAP to the Exchange with subsidies should minimize the financial exposure of low-income Vermonters and of the state and should ensure sufficient compensation for providers
    - Expresses legislative intent to ensure continued oversight of transition after adjournment through HCOC and committees of jurisdiction
    - Expresses legislative intent that administration not implement basic health program without legislative approval
    - Expresses legislative intent that General Assembly continue overseeing development of transition plan during 2013 session
    - Requires DVHA, in consultation with Medicaid and Exchange Advisory Committee, to evaluate options for affordable coverage for people over 133% FPL

Sec. 35b – Medicaid/Exchange advisory committee

- Allows Medicaid and Exchange Advisory Committee to exceed 22 members and adds members representing brokers and agents

Sec. 35c – Exchange implementation and transition planning; updates

- Allows House Health Care (HHC), Senate Health & Welfare (SH&W), and Senate Finance committees to meet when Legislature not in session during 2012 to get updates on health care reform, including waivers, transition planning, HIT, VITL, and Exchange implementation
- Meetings to be called by the chairs, with approval from Speaker and Pro Tem
- If AHS gets results of federal review of Vermont's Exchange implementation plan when legislature is not in session, the Administration to present results to HCOC and joint meeting of HHC, SH&W, and S. Finance
- If AHS gets results of federal review when legislature is in session, Administration to present results to standing committees
- By February 1, 2013, Administration to present to standing committees the Exchange certification application AHS submitted to federal government

Sec. 36 – Health Access Eligibility Unit

- Deletes reference to health care eligibility unit (HAEU) being part of DVHA

Secs. 36a and 36b – Preconditions for Green Mountain Care; JFO review

- Amends preconditions that must be met for Green Mountain Care implementation
- Requires JFO to review GMC Board's findings that preconditions for Green Mountain Care have been met within 90 days after GMC Board makes its determination

Secs. 37 – 39 – Technical/clarifying changes

- Sec. 37 – corrects cross-references in Blueprint/payment reform definitions

- Sec. 38 - allows member of GMC Board to submit his/her name for consideration for reappointment to GMC Board; specifies that names of candidates submitted to Governor but not selected remain confidential
- Sec. 39 – clarifies that members of GMC Board will continue to serve until their replacements are appointed

Sec. 39a – Sports injuries

- Prohibits coaches from allowing a youth athlete to go back into a school athletic team practice or game if the coach has reason to believe that the athlete has a concussion or other head injury
- A coach cannot allow youth athletes to train or compete again until they have been examined by and received permission from appropriate health care provider

Secs. 40 and 40a – Rules

- Allows GMC Board to use DFR's hospital budget review rules until earlier of March 1, 2013 or the Board's adoption of its own rules
- Requires GMC Board to adopt rules by January 1, 2013 on insurance rate reviews, hospital budget reviews, and certificates of need

Sec. 40b – Position transfer

- Transfers a position from DFR to GMC Board by January 1, 2013

Sec. 40c – Maximizing federal funds

- Requires Secretary of Administration or designee to report to committees of jurisdiction by January 15, 2013 on strategies for maximizing the number of Vermonters eligible to receive federal premium tax credits and cost-sharing subsidies and for maximizing the amount they will receive

Sec. 40d – Health Care Oversight Committee

- Renames the Health Access Oversight Committee to be the Health Care Oversight Committee
- Revises House membership from two members from House Human Services (HHS), two members from HHC, and one member from House Appropriations (HAC) to one member each from HHS, HHC, and HAC, and two at-large House members
- Revises Senate membership from three members from SH&W, one member from Finance, and one member from Senate Appropriations (SAC) to one member each from SH&W, Finance, and SAC, and two at-large Senate members
- Charge is oversight of all health care and human services programs when legislature not in session, including mental health, substance abuse, health care reform

Sec. 41 – Repeals

- Repeals laws on insurance quality task force, provider reimbursement survey, safety net, HAEU transfer, payment reform pilots, DVHA prescribed product report, I-SaveRx, Vermont health access plan (VHAP) and employer-sponsored

insurance assistance (ESIA), small group and nongroup markets, market security trust, industrial health insurance policies, and franchise plan policies
- Specifies that VHAP and ESIA enrollees may continue to receive transitional coverage
- Specifies that small group and nongroup market plans issued or renewed in 2013 can remain in effect until their anniversary date in 2014, if allowed by federal law

Sec. 41a – Transitional provisions, implementation
- Allows small employers to enroll in plans through the Exchange as early as October 1, 2013 and no later than the renewal date of a plan that took effect before January 1, 2014
- Allows individuals to enroll in plans through the Exchange between October 1, 2013 and March 31, 2014, pursuant to ACA regulations
- Allows Commissioner of Fin Reg to allow small group and association plans to extend beyond renewal date to ensure smooth transition to Exchange
- Allows DFR and GMC Board to continue to approve rates and forms for nongroup/small group market plans, or extend coverage under existing plans, if Exchange not operational by Jan. 1, 2014 and people cannot enroll any other way
- Allows DVHA to continue VHAP and ESIA coverage if the Exchange is not operational by January 1, 2014 and people cannot enroll any other way
- Does not require insurers to apply guaranteed issue for nongroup and small group plans issued under current market laws after January 1, 2014
- Expresses legislative intent not to impair collective bargaining agreements entered into before January 1, 2013 and in effect on January 1, 2014 for the duration of the agreement

Sec. 41b – Medicare supplemental plans; Exchange web portal
- Specifies that the act does not prohibit DVHA from allowing Medicare Supplemental policies to be offered on Exchange web portal in the future after seeking input of consumers, insurers, and other stakeholders

Sec. 41c – Statutory Revision
- Directs Legislative Council to change references to Health Access Oversight Committee to Health Care Oversight Committee

Sec. 42 – Effective Dates