CONFIDENTIAL
LEGISLATIVE BILL REVIEW FORM: 2014

Bill Number: H. 596—H. 596, an act relating to the conversion of assets of a nonprofit hospital was struck and replaced with S. 252.

Title of Bill: An act relating to miscellaneous amendments to health care laws

Agency/ Dept: DVHA **Author of Bill Review:** Devon Green (modified for DVHA by Ashley Berliner)

Date of Bill Review: 5/13/14 **Status of Bill: (check one):**

_____Upon Introduction _____ As passed by 1st body _X_As passed by both bodies

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Recommended Position:

X Support ___Oppose ___Remain Neutral ___Support with modifications identified in #8 below

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Analysis of Bill

1. Summary of bill and issue it addresses. *Describe what the bill is intended to accomplish and why.*

Sections 2-4, VHC Small Employer Direct Enrollment

- Allows small employers to enroll directly (along with by phone, navigator, website) into a Vermont Health Connect qualified health plan through an insurer that is under contract with VHC as provided for by the feds.

Section 10, Standardized Health Insurance Claims and Edits

- Moves date for private insurance from 2015 to 2016. Keeps date for Medicaid at 2017.
  - NOTE: we will likely need to address this again in 2016 session.

Section 12-15, Pharmacy Benefit Managers; Required Practices with Respect to Health Insurers

- Removes PBMs' ability to impose contract terms that limit disclosure of financial information to a health insurer.
- Requires PBMs to disclose annually to health insurers, DFR, and GMC Board the aggregate amount the PBM kept on all prescription drug claims for which PBM charged the insurer during the previous calendar year in excess of the amount the PBM paid to pharmacies.
- Requires PBMs to pay pharmacy claims or notify the pharmacy that a claim is contested or denied within 14 calendar days of receipt of the claim.
- Except for the annual disclosure requirement, PBM provisions take effect on July 1, 2014 and apply to contracts entered into or renewed on or after that date.

Reports:

Section 7, Contract for administration of certain elements of GMC; Report

- By 1/1/15, AHS shall report to the General Assembly the elements of GMC that it will be contracting out to an administrator

Section 9, GMCB requested change on cost-shift report (DVHA contributes to cost-shift report)

- Cost shift report can be included in annual report

Section 16, Adverse Childhood Experiences; Report

- By 1/15/15, Blueprint and GMCB shall review evidence-based materials on the relationship between adverse childhood experiences and population health and recommend to the Gen. Assembly whether and how ACE should be integrated into Blueprint and how much it will cost.
- Blueprint and GMCB shall also evaluate emerging health care delivery quality initiatives and determine whether and how they should be integrated into Blueprint

Section 17, Chronic care management in Blueprint report

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- By 10/1/14, AoA shall recommend:
  - Whether to increase payments to Blueprint providers
  - Whether to expand Blueprint to include additional chronic conditions, such as obesity, mental conditions, and oral health

Section 20, Increasing Medicaid Rates; Report

- By 1/15/15, AoA, in consultation with GMCB, shall report the impact of increasing Medicaid reimbursement rates to provider to match Medicare rates and address the following issues:
  - Amount of state funds to do the increase
  - Impact on health insurance premiums
  - How much premium reductions would affect federal subsidies in Vermont Health Connect and impact on pass-through funds with State Innovation Waiver for GMC.

Section 25, Effective Dates

- Takes effect upon passage, except:
  - Sec. 24 repeal of offer of state health insurance to legislators and session-only employees take effect retroactively to 1/1/14, except for people who were on the plan.
  - Sec. 14 PBM prompt payment shall take effect 7/1/14 and apply to contracts entered into or renewed on or after 7/1/14.

Impacting Other departments:

Section 6, Administration; Enrollment

- Repeals Act 48 provision requiring GMC to try to be the administrator for the Medicare program in Vermont—Medicare administrator is currently regional and contract is not up until 2019.
- States that GMC is payer of last resort as opposed to secondary payer. This means if someone has Medicare and a supplemental policy, GMC pays after the supplemental policy, not before.

Section 11, Non-Emergency Walk-In Centers

- Urgent care centers shall not discriminate against patients based on insurance status or lack of insurance

2. Is there a need for this bill? *Please explain why or why not.*

- Shows that we are continuing to move forward on health care reform
- Solves DFR ambiguity around rate review at GMCB
- Pushes back claim edits date to a more reasonable timeframe (although will likely have to be adjusted further next year)

3. What are likely to be the fiscal and programmatic implications of this bill for this Department?

Sec. 12-15: State auditor can get information on PBM of state employee plan; DVHA PBM will have to comply with transparency effective immediately. Prompt payment won't apply to the contract DVHA is currently negotiating, assuming it is signed before July 1, 2014.

DVAH will need to contribute to 6-7 new reports/studies involving complex programs, analysis and multiple departments.

4. What might be the fiscal and programmatic implications of this bill for other departments in state government, and what is likely to be their perspective on it?

- Sec. 5: DFR positive impact with clarification around rate review
- Sec. 10: GMCB extension on claim edits positive outcome
- Sec. 19 requires a study that AOA does not have the expertise to do or funding to hire a consultant to do. AOA will need to ask other departments to assist with it.
- Sec. 21: Potential financial impact on AG's office for HIT IP report—no funding in this bill for the report.

5. What might be the fiscal and programmatic implications of this bill for others, and what is likely to be their perspective on it? (f*or example, public, municipalities, organizations, business, regulated entities, etc)*

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- Sec. 2-4: Businesses have option for direct enrollment for 2015 plan year. This was already happening.
- Sec. 11: Nondiscrimination provision for urgent care centers. Does not actually force all urgent care centers to take all patients, but urgent care centers might see it that way.
- Sec. 12-15: New requirements will affect PBMs and those who contract with them

6. Other Stakeholders:

6.1 Who else is likely to support the proposal and why?

DFR/GMCB on 2 provisions – needed technical changes. Some health care advocates may see it as a positive step forward in terms of momentum.

6.2 Who else is likely to oppose the proposal and why?

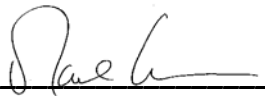
PBMs – would prefer confidentiality in reporting to health plans, DFR and GMCB.

Ugent Care Provider (Kevin Ellis) – worried about nondiscrimination provision

7. Rationale for recommendation: *Justify recommendation stated above.*

- Shows that we are continuing to move forward on health care reform
- Solves DFR ambiguity around rate review at GMCB
- Pushes back claim edits date to a more reasonable timeframe (although will likely have to be adjusted further next year)

8. Specific modifications that would be needed to recommend support of this bill*: None.*

Secretary/Commissioner has reviewed this document:  ***Date: _5/20/14_____***

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