Successful Bills the HCA Worked on in 2016

H. 812 All-Payer Model and Accountable Care Organization oversight, regulation and consumer protections

This bill was one of our highest priorities this session. The HCA proposed it and the first version was based on our white paper on consumer protections in ACOs. Legislators added a lot more to the bill, but the final version included almost all of the protections we originally requested. H.812 allows the state to go forward with the All-Payer Model only if certain criteria are met. It requires the Green Mountain Care Board to certify all ACOs and review their budgets, and gives the HCA a role in the budget review process. The bill requires ACOs to have a robust grievance and appeal process and to provide information about complaints to the HCA. It also includes language about integrating home and community based services into the ACO model.

S. 255 Regulation of hospitals, health insurers, and Managed Care Organizations

The culmination of many hours of stakeholder work over the past year, S. 255 streamlines and updates reporting by hospitals, insurers and MCOs. It also retains the consumer protections in the Department of Financial Regulation Rule 09-03 (the former Rule 10). We fought for, and won, the inclusion of a requirement that DFR report the number of complaints it receives about violations of consumer protection standards, broken out by standard. This was a must-pass bill for us, the insurers, the hospitals and the administration.

S. 216 Prescription drug formularies

This bill has four sections related to the dramatic increases in prescription drugs:

- a "first in the nation" requirement that pharmaceutical manufacturers provide information justifying cost increases on 15 drugs to be selected by the Green Mountain Care Board;
- a requirement that insurers selling exchange plans post their formularies online;
- a change in the dispensing fee in the 340B program, which is supposed to save DVHA money;
- creation of a one-year pilot program which will allow one or more bronze plans to have prescription drug maximum out of pocket (MOOP) limits which exceed the state statutory limit. This was the section of the bill we worked on the most. Due to the actuarial constraints placed on exchange plans by the Affordable Care Act, without a change in the law there was a real danger that Vermont would have no bronze plans in 2018. S. 216 gives legislators a chance to more thoughtfully amend Vermont's MOOP Rx limit law next year to try to avoid being caught in the ACA actuarial box again.

S. 20 Dental therapists

This bill creates a new mid-level dental provider option in Vermont to improve access to dental care.

H. 620 Required coverage for contraceptives

H. 620 requires all insurance plans to cover outpatient contraceptive services including sterilizations and all prescription contraceptives and devices. The bill prohibits insurers from establishing rates, terms or conditions that place a greater financial burden on beneficiaries for access to contraceptives than for access to treatment, prescriptions or devices for any other health condition. The bill also creates a **Special Enrollment Period for pregnancy** to allow the purchase of plans through Vermont Health Connect outside of the Open Enrollment Period.

H. 873 Miscellaneous tax

Legislators agreed to continue a major source of funding for the HCA: the Green Mountain Care Board's billback authority on hospitals and insurers. Previous authorization sunsets June 30th, so it was imperative that we get this law amended. A reporting requirement was tacked on which requires the HCA to make recommendations on how the law and HCA structure could be changed to allow us to do more systemic work.

H. 875 Appropriations

Legislators back-filled for the expiration of two federal grants ($160,000) thereby level funding the HCA for SFY 2017 using the billback authority in H. 873. H. 875 also renews but tweaks the **emergency rulemaking authority** for AHS to quickly promulgate rules related to Vermont Health Connect. This authority expires June 30, 2017. The appropriations bill included $250K for an independent study of VHC's viability and sustainability.

S. 245 Notice to patients of new health care provider affiliations

This bill requires hospitals to notify patients of provider acquisitions, including disclosure of any resulting new charges. The bill prohibits DVHA from using provider-based billing for outpatient medical services provided at an off-campus (>250 yards from the main hospital campus) outpatient department of a hospital as a result of the provider's transfer to or acquisition by the hospital. S. 245 also requires the GMCB to report on the advisability of expanding these requirements to commercial insurers.

S. 62 Surrogate decision making for Do-Not-Resuscitate Orders and Clinician Orders for Life-Sustaining Treatment

This bill establishes a process for designating a surrogate to consent to DNRs and COLSTs when an individual does not have an advance directive or medical guardian.

Initiatives the HCA Did Not Work On

The HCA did not support or oppose the Dr. Dynasaur 2.0 proposal (which would expand Dr. D to all Vermonters regardless of income up to age 26), the Universal Primary Care proposal (which would have the state pay for all primary care), the reorganization of AHS to create a new state health care agency (S. 107), or the creation of a new health care research commission for legislators. The Dr. D proposal got some funding for a study; UPC got no money for further

studies, but did get a literature review by the administration on whether it is worthwhile to pursue this step towards single payer; S. 107 died; the research commission got no money.