

# THE LEGISLATIVE BULLETIN

A PUBLICATION OF THE VERMONT MEDICAL SOCIETY

Week of April 4, 2011

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## Working for Vermont Physicians at the State House

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## FOUR MAJOR BILLS OF INTEREST TO PHYSICIANS PASS THE HOUSE OF THE REPRESENTATIVES

This has been an extremely busy time at the Vermont State House with four major bills of interest to physicians being recently passed by the House of Representatives and referred to the Senate. With a possible adjournment date of May 7th, the Senate will have to quickly act on the bills and then joint House/Senate conference committees will be appointed to develop the final legislation.

### H. 202 - Health Care Reform Bill

H.202 would establish three new organizations within state government to help control health care costs and increase health insurance coverage: a new Green Mountain Care Board to oversee cost containment strategies; the Vermont Health Benefit Exchange as required under the federal Accountable Care Act (ACA) for helping to achieve universal insurance coverage; and, the possible evolution of the Health Benefit Exchange into Green Mountain Care as the state's single-payer plan.

### Green Mountain Care Board

The bill creates the Green Mountain Care Board with a full time chair and four part-time members. Beginning on July 1, 2011 the Board's duties will include:

- Development, implementation and evaluation of payment reform pilots;
- Develop, by rule, payment reform and costs containment methodologies (health insurers are required to participate in the development of payment reform pilots);
- Review and approve Vermont's statewide HIT plan; and,
- Develop and maintain a health care workforce development strategic plan (including reviewing the adequacy of health care professional reimbursement rates).

No later than July 1, 2013, the Board's duties will also include:

- Ensure that health care professionals receive reasonable rates in order to have consistent reimbursement amounts accepted by these persons;
- Review and approve recommendations from BISHCA on insurance rate increases, hospital budgets and CONs;
- Review and approve, with recommendations from DVHA, the benefit package for qualified health benefit plans offered by the health benefit exchange;
- Develop and maintain a method for evaluating system-wide performance and quality by Oct. 15, 2012; and,
- Develop and approve the Green Mountain Care benefit package and recommend a three-year Green Mountain Care budget to the governor and General Assembly.

### Vermont Health Benefit Exchange

The bill also establishes the Vermont Health Benefit Exchange as a division of DVHA headed by a deputy commissioner. Beginning on Jan. 1, 2014, the exchange will provide qualified health benefit plans to eligible individuals and small businesses. If the exchange is required by the federal government to contract with more than one health insurer, the exchange will mandate a unified, simplified administration system for health insurers that may include claims administration, benefit management, billing, and other functions.

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(Con'td. from pg. 1) Federal premium credits and cost-sharing subsidies will be available to individuals who enroll in health benefit exchange plans – provided that their income is generally above 133 percent and no more than 400 percent of the Federal Poverty Level and they meet other requirements. Dr. Hsiao's report estimates that under the ACA \$240 million in new federal funds will flow into the exchange in the form of premium subsidies for individuals in 2015 and \$420 million in new federal funds in 2019. It is also anticipated that the individuals currently covered under VHAP would receive their insurance through the exchange beginning Jan. 1, 2014.

The duties and responsibilities of the exchange are drafted to comply with the ACA and these include: offering coverage for health services through qualified health benefit plans; enrolling individuals in a qualified health benefit plan; collecting premium payments made for qualified health benefit plans from employers and individuals on a pretax basis, and, informing enrollees of their eligibility for premiums and subsidies. The section also establishes broad “quality and wellness” standards for qualified plans that include participation in the Blueprint for Health.

### **Green Mountain Care**

The purpose of Green Mountain Care – the bill's conditional single-payer plan – is to provide, as a public good, comprehensive, affordable, high-quality health care coverage for all Vermont residents. The bill authorizes the agency of human services to solicit bids from private insurers for the administration of Green Mountain Care with preference being given to Vermont-based businesses. Individuals would be allowed to maintain coverage they may have other than Green Mountain Care or elect supplemental coverage. The Agency of Human Services is directed to seek permission from CMS to administer the Medicare and SCHIP programs in Vermont.

The implementation date of Green Mountain Care would be 90 days following the last to occur of the following conditions:

- Enactment of a law by the General Assembly establishing the public financing for Green Mountain Care;
- The Green Mountain Care Board's approval of an initial benefit package;
- Enactment of an appropriation by the General Assembly for the benefit package; and,
- The passage of legislation by Congress authorizing a waiver to allow the health benefit exchange to receive federal fund contributions in lieu of the individual and small business tax credits

provided by the ACA (under current law, the state cannot apply for these waivers until 2017).

### **Workforce Issues:**

The bill acknowledges Vermont's shortage of primary care professionals, periodic geographic shortages of specialty care professionals and the fact that that many physician practices are closed to new patients. The Green Mountain Care board in consultation with hospitals and VMS is required to identify physician specialties that face shortages and develop strategies for ensuring access to these services. Beginning in July of 2011, the Green Mountain Care Board will be charged with reviewing the adequacy of health care professional reimbursement rates to determine their impact on recruitment and retention. Payment rates and methods to be established by the Board after July 1, 2013 must be sufficient to recruit and retain enough professionals to ensure that services are available to all Vermonters and are distributed equitably.

### **Administrative Simplification:**

The health benefit exchange is authorized to determine a method to provide a unified, simplified administration system for insurers offering qualified health benefit plans through the exchange. The exchange may contract with a single entity for administration, may license and require the use of particular software, or may require insurers to conform to a standard set of systems and rules. The Green Mountain Care Board is required to consider compensating health care professionals for the completing requests for prior authorization.

### **Single Formulary:**

The bill defers creation of a single formulary and requires the Department of Vermont Health Access (DVHA) to conduct a study and report to the legislature on or before Jan. 1, 2012. The study will address the following issues:

- The creation of a single formulary to be used by all payers of health services, allowing exceptions for Medicaid rebates, and for 340B formularies;
- The feasibility of requesting a waiver from Medicare Part D to ensure Medicare participation in the formulary;
- The feasibility of enabling all prescription drugs to be purchased through the Medicaid program or through the 340B program; and,
- A uniform set of drug management rules to minimize administrative burdens addressing timely decisions, access to clinical peers, access to evidence-based rationales, an exemption process, and reporting data on prescriber satisfaction.

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(Con'td. from pg. 2) Much of VMS's testimony on H.202 has focused on the need to attract and retain physicians in order to provide the increased health services related to an aging population. These include a reduction of administrative costs and burdens on physicians, addressing the practice of defensive medicine, providing adequate reimbursement and encouraging individuals to take greater responsibility for their own health status.

#### **H. 441 – State Fiscal Year 2012 Budget** **Catamount Health Plans**

Governor Peter Shumlin's Medicaid budget for State Fiscal Year 2012 proposed to allow all Vermonters eligible for Catamount Health Plans to enroll in Medicaid under a new VHAP Expanded program and to end the current Catamount health insurance program. Since there are no personal income limits for Catamount, the proposal would have allowed high-income Vermonters to enroll in Medicaid. In addition, the transfer of the Catamount health insurance program from BCBSVT and MVP to the Medicaid program would have resulted in a 32.8-percent cut in physician reimbursement for the Catamount population.

In its advocacy efforts against the Governor's proposal, VMS indicated that expanding enrollment in Medicaid with its below cost physician reimbursement without any limits on enrollee's income would have put physicians' ability to provide care to their patients at risk and it would added to the cost-shift.

H.441, the Appropriations bill for state fiscal year 2012, does not include the Governor's proposal to merge Catamount Health into Medicaid. Instead, the bill helps to address the budget shortfall by including a new Catamount compromise that was developed by VMS, VAHHS and BCBSVT and has been accepted by the administration. Under the compromise, the current Catamount program would continue to be offered by BCBSVT and MVP and the program's reimbursement levels and administrative cost would be reduced as follows:

- Physician reimbursement would be reduced by seven percent from the current level of 118 percent of 2006 Medicare to 110 percent of 2006 Medicare;
- Hospital reimbursement would be reduced by nine percent from the current level of 100 percent of actual cost plus ten percent to 100 percent of the actual cost; and
- BCBSVT's and MVP's administrative costs would be reduced by 15 percent from the current level of seven percent of overall premiums to six percent of overall premium.
- In addition, the Catamount deductible would increase from the current level of \$500 to \$1,200 for

an individual policy with a \$700 rebate being made available for those enrollees with incomes less than 300 percent of the Federal Poverty Level (FPL)

These reductions will result in an overall lower premium under Catamount and therefore reduce the state's subsidy costs for those enrollees with incomes less than 300 percent of FPL. It is anticipated that the Catamount program will end on Dec. 31, 2013 and the current enrollees would receive their health insurance from plans offered through the Health Benefit Exchange mandated under the federal Accountable Care Act.

#### **Over-the Counter Drugs, Multi-source Prescription Drugs and Specialty Drugs**

Section E.301.1 authorizes Medicaid to create a preferred list for over-the-counter drugs similar to the preferred drug list for prescription drugs. Of potential concern to VMS, it also requires justification for prescribing multi-source prescription drugs.

Finally, this section authorizes DVHA to establish lower reimbursements for specialty drugs, high-cost drugs used to treat complex or rare conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia.

#### **H.201 – Palliative Care**

A House Human Services Committee bill that includes a number of provisions addressing hospice and palliative care passed the House in late March. The bill encourages health insurers in Vermont to cover "enhanced hospice care" that does not require patients to forego curative care in order to obtain hospice benefits, covers patients with a longer life expectancy (12 months) and includes access to nurses who can assist patients with terminal illness. The bill directs the Department of Vermont Health Access (DVHA) to apply for a waiver from the Centers for Medicare and Medicaid Services (CMS) that would allow DVHA to obtain federal match for a similar enhanced hospice benefit program for Medicaid patients.

The bill would also allow patients who have enrolled in hospice to apply for benefits from the *Choices for Care* program, a state long-term care program that assists people with everyday activities at home or in a long-term care facility. Support available through *Choices for Care* can include assistance with activities of daily living, medication management, and assistance with things like meal preparation and household chores. Currently patients who participate in the *Choices for Care* program can elect hospice benefits, but patients receiving hospice benefits cannot apply for assistance from the *Choices for Care* program.

(*Con'td. from pg. 3*) H.201 also will standardize the statewide use of the do not resuscitate/clinician order for life sustaining treatment (DNR/COLST) form developed by the Department of Health. The form is designed to ensure continuity of care and patient wishes, particularly when patients transfer from one setting to another. While the DNR portion of the order addresses only cardio-pulmonary resuscitation (CPR), the remainder of the COLST order form may be used to specify other types of treatment such as intubation and mechanical ventilation, artificially administered nutrition, comfort measures, and transfer to hospital.

Finally the bill makes the Vermont Board of Medical Practice responsible for continuing medical education (CME) for physicians beginning with a requirement for ten hours of CME during the 2012-2014 license renewal period. The CME provision addresses palliative care and pain management services by authorizing the board to determine how physicians can demonstrate competence in recognizing the need for consultation or referral in these areas, affording the board with flexibility to ensure that continuing education requirements are meaningful and realistic.

The CME language was a compromise reached by the House Human Services Committee, Representative George Till., M.D., and VMS, and replaced a section of the bill that would have created an ongoing legislative mandate for almost all physicians to take four hours of continuing medical education every two years in palliative care, hospice or pain management. VMS opposed legislatively mandating specific content for continuing education for professionals. H. 201 will now be considered by the Senate.

Language of the CME amendment to H. 201 as passed by the House:

(b) A licensee for renewal of an active license to practice medicine and surgery shall have completed a minimum of ten hours of continuing medical education which shall meet minimum criteria as established by rule, by the board, by August 31, 2012 and shall be in effect for the renewal of licenses to practice medicine and surgery expiring after August 31, 2014. The training provided by the continuing medical education shall be designed to assure that the licensee has updated his or her knowledge and skills in his or her own specialties and also has kept abreast of advances in other fields to which patient referrals may be appropriate. The board shall require

evidence of current professional competence in recognizing the need for timely appropriate consultations and referrals to assure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

#### **H.436 – Miscellaneous Tax Bill**

As passed by the House, the miscellaneous tax bill increases a number of health care related taxes in order to provide additional revenue to fund the state fiscal year 2012 budget. In addition to increasing the current tax on hospitals from the current rate of 5.5 percent of net patient revenue to a new rate of six percent, the Governor proposed adding a new three-percent tax on the net revenue of dentists within the state. As the House Health and Welfare Committee considered the proposed tax on dentists, a number of committee members raised the possibility of also creating a new tax of up to six percent on the net revenues of physicians.

In addition to supporting VAHHS in opposition to the increased tax on hospitals, VMS testified strongly in opposition to the creation of a new tax on physicians and cited a number of reasons why a tax would have a deleterious impact on Vermont's health-care system. These included the fact that Vermont is currently facing a shortage of primary care and specialty physicians and a physician-provider tax on physicians would make it more difficult to attract and retain physicians and therefore increase access problems for patients; and, since physicians cannot "balance bill," a physician provider tax would directly reduce physicians' net income. In addition, small, independent physician practices would be hardest hit since they do not have the market power to successfully negotiate increased fee schedules to offset any new tax.

The bill that passed the House did not include the tax on dentists, however, it does include a requirement directing the secretary of administration to develop systems to identify and collect data necessary to administer any health-care related tax that is permitted by federal law but that Vermont does not currently levy. VMS will continue to work next year to oppose the creation of a new provider tax on physicians.

If you have any questions on any of these bills, please feel free to contact VMS.

In order to read the text of bills, please go to:  
<http://www.leg.state.vt.us/database/status/status.cfm>.