

1 TO THE HONORABLE SENATE:

2 The Committee on Health and Welfare to which was referred House Bill No.

3 202 entitled “An act relating to a universal and unified health system”

4 respectfully reports that it has considered the same and recommends that the

5 Senate propose to the House that the bill be amended by striking out all after

6 the enacting clause and inserting in lieu thereof the following:

7 Sec. 1. INTENT

8 (a) It is the intent of the general assembly to create Green Mountain Care to
9 contain costs and to provide, as a public good, comprehensive, affordable,
10 high-quality, publicly financed health care coverage for all Vermont residents
11 in a seamless manner regardless of income, assets, health status, or availability
12 of other health coverage. It is the intent of the general assembly to achieve
13 health care reform through the coordinated efforts of an independent board,
14 state government, and the citizens of Vermont, with input from health care
15 professionals, businesses, and members of the public.

16 (b) It is also the intent of the general assembly to maximize the receipt of
17 federal funds, including those available pursuant to the Patient Protection and
18 Affordable Care Act (Public Law 111-148), as amended by the federal Health
19 Care and Education Reconciliation Act of 2010 (Public Law 111-152), and to
20 create a reasonable plan to implement Green Mountain Care as set forth in this
21 act.

1 Sec. 1a. PRINCIPLES FOR HEALTH CARE REFORM

2 The general assembly adopts the following principles as a framework for
3 reforming health care in Vermont:

4 (1) The state of Vermont must ensure universal access to and coverage
5 for high-quality, medically necessary health services for all Vermonters.
6 Systemic barriers, such as cost, must not prevent people from accessing
7 necessary health care. All Vermonters must receive appropriate health care at
8 the appropriate time in the appropriate setting.

9 (2) Overall health care costs must be contained and growth in health
10 care spending in Vermont must balance the health care needs of the population
11 with the ability to pay for such care. Growth in Vermont's per-capita health
12 care spending must not outpace growth in per-capita health care spending
13 nationally.

14 (3) The health care system must be transparent in design, efficient in
15 operation, and accountable to the people it serves. The state must ensure
16 public participation in the design, implementation, evaluation, and
17 accountability mechanisms of the health care system.

18 (4) Primary care must be preserved and enhanced so that Vermonters
19 have care available to them, preferably within their own communities. Other
20 aspects of Vermont's health care infrastructure, including the educational and
21 research missions of the state's academic medical center and other

1 postsecondary educational institutions, the nonprofit missions of the
2 community hospitals, and the critical access designation of rural hospitals,
3 must be supported in such a way that all Vermonters, including those in rural
4 areas, have access to necessary health services and that these health services
5 are sustainable.

6 (5) Every Vermonter should be able to choose his or her health care
7 providers.

8 (6) Vermonters should be aware of the costs of the health services they
9 receive. Costs should be transparent and easy to understand.

10 (7) Individuals have a personal responsibility to maintain their own
11 health and to use health resources wisely, and all individuals should have a
12 financial stake in the health services they receive.

13 (8) The health care system must recognize the primacy of the
14 relationship between patients and their health care practitioners, respecting the
15 professional judgment of health care practitioners and the informed decisions
16 of patients.

17 (9) Vermont's health delivery system must seek continuous
18 improvement of health care quality and safety and of the health of the
19 population and promote and incent healthy lifestyles. The system therefore
20 must be evaluated regularly for improvements in access, quality, and cost
21 containment, and it must recognize that additional evaluation tools may be

1 required to ensure access to and quality of mental health care.

2 (10) Vermont's health care system must include mechanisms for
3 containing all system costs and eliminating unnecessary expenditures,
4 including by reducing administrative costs and by reducing costs that do not
5 contribute to efficient, high-quality health services or improve health
6 outcomes. Efforts to reduce overall health care costs should identify sources of
7 excess cost growth.

8 (11) The financing of health care in Vermont must be sufficient, fair,
9 predictable, transparent, sustainable, and shared equitably.

10 (12) The system must consider the effects of payment reform on
11 individuals and on health care professionals and suppliers. It must enable
12 health care professionals to provide, on a solvent basis, effective and efficient
13 health services that are in the public interest.

14 (13) Vermont's health care system must operate as a partnership
15 between consumers, employers, health care professionals, hospitals, and the
16 state and federal government.

17 (14) State government must ensure that the health care system satisfies
18 the principles expressed in this section.

1 Sec 1b. 3 V.S.A. § 2222a is amended to read:

2 § 2222a. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY
3 AND AFFORDABILITY

4 (a) The ~~secretary~~ director of health care reform in the agency of
5 administration shall be responsible for the coordination of health care system
6 reform ~~initiatives~~ efforts among executive branch agencies, departments, and
7 offices, and for coordinating with the Green Mountain Care board established
8 in 18 V.S.A. chapter 220.

9 (b) The ~~secretary~~ director shall ensure that those executive branch agencies,
10 departments, and offices responsible for the development, improvement, and
11 implementation of Vermont's health care system reform do so in a manner that
12 is coordinated, timely, equitable, patient-centered, and evidence-based, ~~and~~
13 seeks to inform and improve the quality and affordability of patient care and
14 public health, contain costs, and attract and retain well-paying jobs in this state.

15 (c) Vermont's health care system reform ~~initiatives~~ efforts include:

16 (1) The state's chronic care infrastructure, disease prevention, and
17 management program contained in the blueprint for health established by
18 ~~chapter 13 of Title 18 V.S.A. chapter 13,~~ the goal of which is to achieve a
19 unified, comprehensive, statewide system of care that improves the lives of all
20 Vermonters with or at risk for a chronic condition or disease.

1 (2) The Vermont health information technology project pursuant to
2 ~~chapter 219 of Title 18 V.S.A. chapter 219.~~

3 (3) The multi-payer data collection project pursuant to 18 V.S.A.
4 § 9410.

5 (4) The common claims administration project pursuant to 18 V.S.A.
6 § 9408.

7 (5) The consumer price and quality information system pursuant to
8 18 V.S.A. § 9410.

9 (6) ~~Any~~ The information technology work done by the quality assurance
10 system pursuant to 18 V.S.A. § 9416.

11 (7) The public health promotion programs of the agency of human
12 services, including primary prevention for chronic disease, community
13 assessments, school wellness programs, public health information technology,
14 data and surveillance systems, healthy retailers, healthy community design,
15 and alcohol and substance abuse treatment and prevention programs.

16 (8) ~~Medicaid, the Vermont health access plan, Dr. Dynasaur, premium~~
17 ~~assistance programs for employer-sponsored insurance, VPharm, and Vermont~~
18 ~~Rx, which are established in chapter 19 of Title 33 and provide health care~~
19 ~~coverage to elderly, disabled, and low to middle income Vermonters. The~~
20 creation of a universal health care system to provide affordable, high-quality

1 health care coverage to all Vermonters and to include federal funds to the
2 maximum extent allowable under federal law and waivers from federal law.

3 (9) ~~Catamount Health, established in 8 V.S.A. § 4080f, which provides a~~
4 ~~comprehensive benefit plan with a sliding scale premium based on income to~~
5 ~~uninsured Vermonters.~~ A reformation of the payment system for health
6 services to encourage quality and efficiency in the delivery of health care as set
7 forth in 18 V.S.A. chapter 220.

8 (10) ~~The uniform hospital uncompensated care policies.~~ A strategic
9 approach to workforce needs set forth in 18 V.S.A. chapter 222, including
10 retraining programs for workers displaced through increased efficiency and
11 reduced administration in the health care system and ensuring an adequate
12 health care workforce to provide access to health care for all Vermonters.

13 (11) A plan for public financing of health care coverage for all
14 Vermonters.

15 (d) ~~The secretary shall report to the commission on health care reform, the~~
16 ~~health access oversight committee, the house committee on health care, the~~
17 ~~senate committee on health and welfare, and the governor on or before~~
18 ~~December 1, 2006, with a five year strategic plan for implementing Vermont's~~
19 ~~health care system reform initiatives, together with any recommendations for~~
20 ~~administration or legislation. Annually, beginning January 15, 2007, the~~

1 ~~secretary shall report to the general assembly on the progress of the reform~~
2 ~~initiatives.~~

3 (e) ~~The secretary of administration~~ director of health care reform or
4 designee shall provide information and testimony on the activities included in
5 this section to the health access oversight committee, ~~the commission on health~~
6 ~~care reform~~, and to any legislative committee upon request.

7 * * * Road Map to a Universal and a Unified Health System * * *

8 Sec. 2. STRATEGIC PLAN; UNIVERSAL AND UNIFIED HEALTH
9 SYSTEM

10 (a) Vermont must begin to plan now for health care reform, including
11 simplified administration processes, payment reform, and delivery reform, in
12 order to have a publicly financed program of universal and unified health care
13 operational after the occurrence of specific events, including the receipt of a
14 waiver from the federal Exchange requirement from the U.S. Department of
15 Health and Human Services. A waiver will be available in 2017 under the
16 provisions of existing law in the Patient Protection and Affordable Care Act
17 (Public Law 111-148) (“Affordable Care Act”), as amended by the federal
18 Health Care and Education Reconciliation Act of 2010 (Public Law 111-152),
19 and may be available in 2014 under the provisions of two bills, H.R. 844 and
20 S.248, introduced in the 112th Congress. In order to begin the planning efforts,
21 the director of health care reform in the agency of administration shall

1 establish a strategic plan, which shall include timelines and allocations of the
2 responsibilities associated with health care system reform, to further the
3 containment of health care costs, to further Vermont's existing health care
4 system reform efforts as described in 3 V.S.A. § 2222a and to further the
5 following:

6 (1) As provided in Sec. 4 of this act, all Vermont residents shall be
7 eligible for Green Mountain Care, a universal health care program that will
8 provide health benefits through a single payment system. To the maximum
9 extent allowable under federal law and waivers from federal law, Green
10 Mountain Care shall include health coverage provided under the health benefit
11 exchange established under 33 V.S.A. chapter 18, subchapter 1; under
12 Medicaid; under Medicare; by employers that choose to participate; and to
13 state employees and municipal employees, including teachers. In the event of
14 a modification to the Affordable Care Act by congressional, judicial, or federal
15 administrative action which prohibits implementation of the health benefit
16 exchange; eliminates federal funds available to individuals, employees, or
17 employers; or eliminates the waiver under Section 1332 of the Affordable Care
18 Act, the director of health care reform shall continue, and adjust as appropriate,
19 the planning and cost-containment activities provided in this act related to
20 Green Mountain Care and to creation of a unified, simplified administration
21 system for health insurers offering health benefit plans, including identifying

1 the financing impacts of such a modification on the state and its effects on the
2 activities proposed in this act.

3 (2)(A) As provided in Sec. 4 of this act, no later than November 1,
4 2013, the Vermont health benefit exchange established in 33 V.S.A. chapter
5 18, subchapter 1 shall begin enrolling individuals and small employers for
6 coverage beginning January 1, 2014. The intent of the general assembly is to
7 establish the Vermont health benefit exchange in a manner such that it may
8 become the foundation for Green Mountain Care.

9 (B) No later than February 15, 2012, the director of health care
10 reform or designee shall provide the house committee on health care and the
11 senate committee on finance and on health and welfare the following
12 information related to the Vermont health benefit exchange, to the extent
13 available:

14 (i) a list of the federal health benefits required under the
15 Affordable Care Act as defined in chapter 18, subchapter 1 of Title 33,
16 including covered services and cost-sharing;

17 (ii) a comparison of the federal health benefits with the Vermont
18 health insurance benefit requirements provided for in 8 V.S.A. chapter 108;

19 (iii) information relating to the silver, gold, and platinum benefit
20 levels of qualified health benefit plans that may be available in the Vermont
21 health benefit exchange;

1 (iv) a draft of qualified health benefit plan choices that may be
2 available in the Vermont health benefit exchange;

3 (v) in collaboration with the three insurers with the largest number
4 of lives, premium estimates for draft plan choices described in subdivision (iv)
5 of this subdivision (B); and

6 (vi) the status of related tax credits, including small employer tax
7 credits, and of cost-sharing subsidies.

8 (C) The director shall deliver to the general assembly by January 15,
9 2015 a report including:

10 (i) the qualified health benefit plans available in and outside the
11 exchange, current and projected premiums, and enrollment data;

12 (ii) recommendations for any statutory changes needed to improve
13 the functioning of the exchange, including those needed to reduce premiums
14 and administrative costs for qualified health benefit plans and others the
15 director determines are necessary to achieve cost-effectiveness; and

16 (iii) Vermont's efforts to obtain a waiver from the exchange
17 requirement under Section 1332 of the Affordable Care Act.

18 (3) As provided in Sec. 4 of this act, no later than November 1, 2016,
19 the Vermont health benefit exchange established in 33 V.S.A. chapter 18,
20 subchapter 1 shall begin enrolling large employers for coverage beginning
21 January 1, 2017.

1 (4) No later than January 1, 2014, the commissioner of banking,
2 insurance, securities, and health care administration may require that all
3 individual and small group health insurance products be sold only through the
4 Vermont health benefit exchange and may require all large group insurance
5 products to be aligned with the administrative requirements and essential
6 benefits required in the Vermont health benefit exchange. The commissioner
7 shall provide recommendations necessary to effect the intent of this
8 subdivision as part of the integration plan established in Sec. 8 of this act.

9 (5) The director shall supervise the planning efforts, reports of which are
10 due on January 15, 2012, as provided in Secs. 8 and 10 through 13 of this act,
11 including integration of multiple payers into the Vermont health benefit
12 exchange; a continuation of the planning necessary to ensure an adequate,
13 well-trained primary care workforce; necessary retraining for any employees
14 dislocated from health care professionals or from health insurers due to the
15 simplification in the administration of health care; and unification of health
16 system planning, regulation, and public health.

17 (6) The director shall supervise the planning efforts, reports of which are
18 due January 15, 2013, as provided in Sec. 9 of this act, to establish the
19 financing necessary for Green Mountain Care, for recruitment and retention
20 programs for health care professionals, and for covering the uninsured and
21 underinsured through Medicaid and the Vermont health benefit exchange.

1 (7) The director, in collaboration with the agency of human services,
2 shall obtain waivers, exemptions, agreements, legislation, or a combination
3 thereof to ensure that, to the extent possible under federal law, all federal
4 payments provided within the state for health services are paid directly to
5 Green Mountain Care. Green Mountain Care shall assume responsibility for
6 the benefits and services previously paid for by the federal programs, including
7 Medicaid, Medicare, and, after implementation, the Vermont health benefit
8 exchange. In obtaining the waivers, exemptions, agreements, legislation, or
9 combination thereof, the secretary shall negotiate with the federal government
10 a federal contribution for health care services in Vermont that reflects medical
11 inflation, the state gross domestic product, the size and age of the population,
12 the number of residents living below the poverty level, the number of
13 Medicare-eligible individuals, and other factors that may be advantageous to
14 Vermont and that do not decrease in relation to the federal contribution to other
15 states as a result of the waivers, exemptions, agreements, or savings from
16 implementation of Green Mountain Care.

17 (8) No later than January 15, 2012, the secretary of administration or
18 designee shall submit to the house committees on health care and on judiciary
19 and the senate committees on health and welfare and on judiciary a proposal
20 for potential improvement or reforms to the medical malpractice system for
21 Vermont. The proposal shall be designed to address any findings of defensive

1 medicine, reduce health care costs and medical errors, and protect patients'
2 rights, and shall include the secretary's or designee's consideration of a no-
3 fault system and of confidential pre-suit mediation.

4 (b) The chair of the Green Mountain Care board established in 18 V.S.A.
5 chapter 220, in collaboration with the director of health care reform in the
6 agency of administration, shall develop a work plan for the board, which may
7 include any necessary processes for implementation of the board's duties, a
8 timeline for implementation of the board's duties, and a plan for ensuring
9 sufficient staff to implement the board's duties. The work plan shall be
10 provided to the house committee on health care and the senate committee on
11 health and welfare no later than January 15, 2012.

12 * * * Cost Containment, Budgeting, and Payment Reform * * *

13 Sec. 3. 18 V.S.A. chapter 220 is added to read:

14 CHAPTER 220. GREEN MOUNTAIN CARE BOARD

15 Subchapter 1. Green Mountain Care Board

16 § 9371. PRINCIPLES FOR HEALTH CARE REFORM

17 The general assembly adopts the following principles as a framework for
18 reforming health care in Vermont:

19 (1) The state of Vermont must ensure universal access to and coverage
20 for high-quality, medically necessary health services for all Vermonters.
21 Systemic barriers, such as cost, must not prevent people from accessing

1 necessary health care. All Vermonters must receive appropriate health care at
2 the appropriate time in the appropriate setting.

3 (2) Overall health care costs must be contained and growth in health
4 care spending in Vermont must balance the health care needs of the population
5 with the ability to pay for such care. Growth in Vermont's per-capita health
6 care spending must not outpace growth in per-capita health care spending
7 nationally.

8 (3) The health care system must be transparent in design, efficient in
9 operation, and accountable to the people it serves. The state must ensure
10 public participation in the design, implementation, evaluation, and
11 accountability mechanisms of the health care system.

12 (4) Primary care must be preserved and enhanced so that Vermonters
13 have care available to them, preferably within their own communities. Other
14 aspects of Vermont's health care infrastructure, including the educational and
15 research missions of the state's academic medical center and other
16 postsecondary educational institutions, the nonprofit missions of the
17 community hospitals, and the critical access designation of rural hospitals,
18 must be supported in such a way that all Vermonters, including those in rural
19 areas, have access to necessary health services and that these health services
20 are sustainable.

1 (5) Every Vermonter should be able to choose his or her health care
2 providers.

3 (6) Vermonters should be aware of the costs of the health services they
4 receive. Costs should be transparent and easy to understand.

5 (7) Individuals have a personal responsibility to maintain their own
6 health and to use health resources wisely, and all individuals should have a
7 financial stake in the health services they receive.

8 (8) The health care system must recognize the primacy of the
9 relationship between patients and their health care practitioners, respecting the
10 professional judgment of health care practitioners and the informed decisions
11 of patients.

12 (9) Vermont's health delivery system must seek continuous
13 improvement of health care quality and safety and of the health of the
14 population and promote and incent healthy lifestyles. The system therefore
15 must be evaluated regularly for improvements in access, quality, and cost
16 containment, and it must recognize that additional evaluation tools may be
17 required to ensure access to and quality of mental health care.

18 (10) Vermont's health care system must include mechanisms for
19 containing all system costs and eliminating unnecessary expenditures,
20 including by reducing administrative costs and by reducing costs that do not
21 contribute to efficient, high-quality health services or improve health

1 outcomes. Efforts to reduce overall health care costs should identify sources of
2 excess cost growth.

3 (11) The financing of health care in Vermont must be sufficient, fair,
4 predictable, transparent, sustainable, and shared equitably.

5 (12) The system must consider the effects of payment reform on
6 individuals and on health care professionals and suppliers. It must enable
7 health care professionals to provide, on a solvent basis, effective and efficient
8 health services that are in the public interest.

9 (13) Vermont's health care system must operate as a partnership
10 between consumers, employers, health care professionals, hospitals, and the
11 state and federal government.

12 (14) State government must ensure that the health care system satisfies
13 the principles expressed in this section.

14 § 9372. PURPOSE

15 It is the intent of the general assembly to create an independent board to
16 promote the general good of the state by:

17 (1) improving the health of the population;

18 (2) reducing the per-capita rate of growth in expenditures for health
19 services in Vermont across all payers while ensuring that access to care and
20 quality of care are not compromised.

1 (3) enhancing the patient and health care professional experience of
2 care;

3 (4) recruiting and retaining high-quality health care professionals; and

4 (5) achieving administrative simplification in health care financing and
5 delivery.

6 § 9373. DEFINITIONS

7 As used in this chapter:

8 (1) “Board” means the Green Mountain Care board established in this
9 chapter.

10 (2) “Chronic care” means health services provided by a health care
11 professional for an established clinical condition that is expected to last one
12 year or more; that requires ongoing clinical management; and that requires
13 health services that attempt to restore the individual to highest function,
14 minimize the negative effects of the condition, and prevent complications
15 related to chronic conditions.

16 (3) “Chronic care management” means a system of coordinated health
17 care interventions and communications for individuals with chronic conditions,
18 including significant patient self-care efforts, systemic supports for licensed
19 health care practitioners and their patients, and a plan of care emphasizing
20 prevention of complications, utilizing evidence-based practice guidelines,
21 patient empowerment strategies, and evaluation of clinical, humanistic, and

1 economic outcomes on an ongoing basis with the goal of improving overall
2 health.

3 (4) “Global payment” means a payment from a health insurer, Medicaid,
4 Medicare, or other payer for the health services of a defined population of
5 patients for a defined period of time. Such payments may be adjusted to
6 account for the population’s underlying risk factors, including severity of
7 illness and socioeconomic factors that may influence the cost of health care for
8 the population.

9 (5) “Green Mountain Care” means the public–private universal health
10 care program designed to provide health benefits through a simplified,
11 uniform, single administrative system pursuant to 33 V.S.A. chapter 18,
12 subchapter 2.

13 (6) “Health care professional” means an individual, partnership,
14 corporation, facility, or institution licensed or certified or otherwise authorized
15 by Vermont law to provide professional health services.

16 (7) “Health care system” means the local, state, regional, or national
17 system of delivering health services, including administrative costs, capital
18 expenditures, preventive care and wellness services.

19 (8) “Health insurer” means any health insurance company, nonprofit
20 hospital and medical service corporation, managed care organization, and, to
21 the extent permitted under federal law, any administrator of a health benefit

1 plan offered by a public or a private entity. The term does not include
2 Medicaid, the Vermont health access plan, or any other state health care
3 assistance program financed in whole or in part through a federal program.

4 (9) “Health service” means any treatment or procedure delivered by a
5 health care professional to maintain an individual’s physical or mental health
6 or to diagnose or treat an individual’s physical or mental health condition,
7 including services ordered by a health care professional, chronic care
8 management, preventive care, wellness services, and medically necessary
9 services to assist in activities of daily living.

10 (10) “Integrated delivery system” means a group of health care
11 professionals, associated either through employment by a single entity or
12 through a contractual arrangement, that provides health services for a defined
13 population of patients and is compensated through a global payment.

14 (11) “Manufacturers of prescribed products” shall have the same
15 meaning as “manufacturers” in section 4631a of this title.

16 (12) “Payment reform” means modifying the method of payment from a
17 fee-for-service basis to one or more alternative methods for compensating
18 health care professionals, health care provider bargaining groups created
19 pursuant to section 9409 of this title, integrated delivery systems, and other
20 health care professional arrangements, manufacturers of prescribed products,
21 medical supply companies, and other companies providing health services or

1 health supplies for the provision of high-quality and efficient health services,
2 products, and supplies while measuring quality and efficiency. The term may
3 include shared savings agreements, bundled payments, episode-based
4 payments, and global payments.

5 (13) “Preventive care” means health services provided by health care
6 professionals to identify and treat asymptomatic individuals who have risk
7 factors or preclinical disease, but in whom the disease is not clinically
8 apparent, including immunizations and screening, counseling, treatment, and
9 medication determined by scientific evidence to be effective in preventing or
10 detecting a condition.

11 (14) “Wellness services” means health services, programs, or activities
12 that focus on the promotion or maintenance of good health.

13 § 9374. BOARD MEMBERSHIP; AUTHORITY

14 (a)(1) On July 1, 2011, the Green Mountain Care board is created and shall
15 consist of a chair and four members. The chair and all of the members shall be
16 state employees and shall be exempt from the state classified system.

17 (2) The chair and the members of the board shall be nominated by the
18 Green Mountain Care board nominating committee established in subchapter 2
19 of this chapter using the qualifications described in section 9392 of this chapter
20 and shall be otherwise appointed and confirmed in the manner of a superior

1 judge. The governor shall not appoint a nominee who was denied confirmation
2 by the senate within the past six years.

3 (b)(1) The initial term of the chair shall be seven years, and the term of the
4 chair shall be six years thereafter.

5 (2) The term of each member other than the chair shall be six years,
6 except that of the members first appointed, one each shall serve a term of three
7 years, four years, five years, and six years.

8 (3) Subject to the nomination and appointment process, a member may
9 serve more than one term.

10 (4) Members of the board may be removed only for cause. The board
11 shall adopt rules pursuant to 3 V.S.A. chapter 25 to define the basis and
12 process for removal.

13 (c)(1) No board member shall, during his or her term or terms on the board,
14 be an officer of, director of, organizer of, employee of, consultant to, or
15 attorney for any person subject to supervision or regulation by the board; nor
16 receive directly or indirectly any payment or gratuity from any person subject
17 to supervision or regulation by the board; nor have a direct or indirect financial
18 relationship with any person or interest in any entity subject to supervision or
19 regulation by the board.

20 (2) The prohibitions contained in subdivision (1) this subsection shall
21 not be construed to prohibit a board member from:

1 (A) being an insurance policyholder or from receiving health services
2 on the same terms as are available to the public generally;

3 (B) owning a stock, bond, or other security in an entity subject to
4 supervision or regulation by the board that is purchased by or through a mutual
5 fund, blind trust, or other mechanism where a person other than the board
6 member chooses the stock, bond, or security; or

7 (C) receiving retirement benefits through a defined benefit plan from
8 an entity subject to supervision or regulation by the board.

9 (d) The chair shall have general charge of the offices and employees of the
10 board but may hire a director to oversee the administration and operation.

11 (e)(1) The board shall establish a consumer, patient, business, and health
12 care professional advisory group to provide input and recommendations to the
13 board. Members of such advisory group who are not state employees or whose
14 participation is not supported through their employment or association shall
15 receive per diem compensation and reimbursement of expenses pursuant to
16 32 V.S.A. § 1010, including costs of travel, child care, personal assistance
17 services, and any other service necessary for participation in the advisory
18 group and approved by the board.

19 (2) The board may establish additional advisory groups and
20 subcommittees as needed to carry out its duties. The board shall appoint

1 diverse health care professionals to the additional advisory groups and
2 subcommittees as appropriate.

3 (f) In carrying out its duties pursuant to this chapter, the board shall seek
4 the advice of the state health care ombudsman established in 8 V.S.A.
5 § 4089w. The state health care ombudsman shall advise the board regarding
6 the policies, procedures, and rules established pursuant to this chapter. The
7 ombudsman shall represent the interests of Vermont patients and Vermont
8 consumers of health insurance and may suggest policies, procedures, or rules
9 to the board in order to protect patients' and consumers' interests.

10 § 9375. DUTIES

11 (a) The board shall execute its duties consistent with the principles
12 expressed in 18 V.S.A. § 9371.

13 (b) The board shall have the following duties:

14 (1) Oversee the development and implementation, and evaluate the
15 effectiveness, of health care payment and delivery system reforms designed to
16 control the rate of growth in health care costs and maintain health care quality
17 in Vermont, including ensuring that the payment reform pilot projects set forth
18 in chapter 13, subchapter 2 of this title are consistent with such reforms.

19 (A) Implement by rule, pursuant to 3 V.S.A. chapter 25,
20 methodologies for achieving payment reform and containing costs, which may
21 include the creation of health care professional cost-containment targets, global

1 payments, bundled payments, global budgets, risk-adjusted capitated
2 payments, or other uniform payment methods and amounts for integrated
3 delivery systems, health care professionals, or other provider arrangements.

4 (B) Prior to the initial adoption of the rules described in subdivision
5 (A) of this subdivision (1), report the board's proposed methodologies to the
6 house committee on health care and the senate committee on health and
7 welfare.

8 (C) In developing methodologies pursuant to subdivision (A) of this
9 subdivision (1), engage Vermonters in seeking ways to equitably distribute
10 health services while acknowledging the connection between fair and
11 sustainable payment and access to health care.

12 (D) Nothing in this subdivision (1) shall be construed to limit the
13 authority of other agencies or departments of state government to engage in
14 additional cost-containment activities to the extent permitted by state and
15 federal law.

16 (3) Review and approve Vermont's statewide health information
17 technology plan pursuant to section 9351 of this title to ensure that the
18 necessary infrastructure is in place to enable the state to achieve the principles
19 expressed in section 9371 of this title.

20 (4) Review the health care workforce development strategic plan created
21 in chapter 222 of this title.

1 (5) Review the health resource allocation plan created in chapter 221 of
2 this title.

3 (6) Set rates for health care professionals pursuant to section 9376 of
4 this title, to be implemented over time, and make adjustments to the rules on
5 reimbursement methodologies as needed.

6 (7) Review and approve recommendations from the commissioner of
7 banking, insurance, securities, and health care administration, within 10
8 business days of receipt of such recommendations and taking into
9 consideration the requirements in the underlying statutes, changes in health
10 care delivery, changes in payment methods and amounts, and other issues at
11 the discretion of the board, on:

12 (A) any insurance rate increases pursuant to 8 V.S.A. chapter 107,
13 beginning January 1, 2012;

14 (B) hospital budgets pursuant to chapter 221, subchapter 7 of this
15 title, beginning July 1, 2012; and

16 (C) certificates of need pursuant to chapter 221, subchapter 5 of this
17 title, beginning July 1, 2012.

18 (8) Prior to the adoption of rules, review and approve, with
19 recommendations from the commissioner of Vermont health access, the benefit
20 package or packages for qualified health benefit plans pursuant to 33 V.S.A.
21 chapter 18, subchapter 1 no later than January 1, 2013. The board shall report

1 to the house committee on health care and the senate committee on health and
2 welfare within 15 days following its approval of the initial benefit package and
3 any subsequent substantive changes to the benefit package.

4 (9)(A) Develop and maintain a method for evaluating systemwide
5 performance and quality, including identification of the appropriate process
6 and outcome measures:

7 (i) for determining public and health care professional satisfaction
8 with the health system;

9 (ii) for utilization of health services;

10 (iii) in consultation with the department of health and the director
11 of the Blueprint for Health, for quality of health services and the effectiveness
12 of prevention and health promotion programs;

13 (iv) for cost-containment and limiting the growth in health care
14 expenditures;

15 (v) for determining the adequacy of the supply and distribution of
16 health care resources in this state; and

17 (vi) for other measures as determined by the board.

18 (B) The board shall adopt evaluation criteria pursuant to subdivision
19 (A) of this subdivision (5) by October 15, 2013 and, beginning in 2014, shall
20 present testimony each year during the legislative session to the house
21 committees on appropriations and on health care and the senate committees on

1 appropriations and on health and welfare regarding the criteria or
2 modifications to such criteria, an assessment of the health care system's
3 performance and any resulting recommendations, and the process and outcome
4 measures used.

5 (c) The board shall have the following duties related to Green Mountain
6 Care:

7 (1) Prior to implementing Green Mountain Care, review and approve,
8 upon recommendation from the agency of human services, the Green Mountain
9 Care benefit package within the parameters established in 33 V.S.A. chapter
10 18, subchapter 2.

11 (2) When providing its recommendations for the benefit package
12 pursuant to subdivision (1) of this subsection, the agency of human services
13 shall present a report on the benefit package proposal to the house committee
14 on health care and the senate committee on health and welfare. The report
15 shall describe the covered services to be included in the Green Mountain Care
16 benefit package and any cost-sharing requirements. If the general assembly is
17 not in session at the time that the agency makes its recommendations, the
18 agency shall send its report by first class mail to each member of the house
19 committee on health care and the senate committee on health and welfare.

20 (3) Prior to implementing Green Mountain Care and annually after
21 implementation, recommend to the general assembly and the governor a

1 three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be
2 adjusted annually in response to realized revenues and expenditures, that
3 reflects any modifications to the benefit package and includes recommended
4 appropriations, revenue estimates, and necessary modifications to tax rates and
5 other assessments.

6 (d) Annually on or before January 15, the board shall submit a report of its
7 activities for the preceding state fiscal year to the house committee on health
8 care and the senate committee on health and welfare. The report shall include
9 any changes to the payment rates for health care professionals pursuant to
10 section 9376 of this title, any new developments with respect to health
11 information technology, the results of the systemwide performance and quality
12 evaluations required by subdivision (b)(9) of this section, any
13 recommendations for modifications to Vermont statutes, and any actual or
14 anticipated impacts on the work of the board as a result of modifications to
15 federal laws, regulations, or programs. The report shall identify how the work
16 of the board comports with the principles expressed in section 9371 of this
17 title.

18 (f) All reports prepared by the board shall be available to the public and
19 shall be posted on the board's website.

20 § 9376. PAYMENT AMOUNTS; METHODS

1 (a) It is the intent of the general assembly to ensure payments to health care
2 professionals that are consistent with efficiency, economy, and quality of care
3 and will permit them to provide, on a solvent basis, effective and efficient
4 health services that are in the public interest. It is also the intent of the general
5 assembly to eliminate the shift of costs between the payers of health services to
6 ensure that the amount paid to health care professionals is sufficient to enlist
7 enough providers to ensure that health services are available to all Vermonters
8 and are distributed equitably.

9 (b)(1) The board shall set reasonable rates for health care professionals,
10 health care provider bargaining groups created pursuant to section 9409 of this
11 title, manufacturers of prescribed products, medical supply companies, and
12 other companies providing health services or health supplies based on
13 methodologies pursuant to section 9375 of this title, in order to have a
14 consistent reimbursement amount accepted by these persons. In its discretion,
15 the board may implement rate-setting for different groups of health care
16 professionals over time and need not set rates for all types of health care
17 professionals. In establishing rates, the board may consider legitimate
18 differences in costs among health care professionals, such as the cost of
19 providing a specific necessary service or services that may not be available
20 elsewhere in the state, and the need for health care professionals in particular

1 areas of the state, particularly in underserved geographic or practice shortage
2 areas.

3 (2) Nothing in this subsection shall be construed to limit the ability of a
4 health care professional to accept less than the rate established in subdivision
5 (1) of this subsection from a patient without health insurance or other coverage
6 for the service or services received.

7 (c) The board shall approve payment methodologies that encourage
8 cost-containment; provision of high-quality, evidence-based health services in
9 an integrated setting; patient self-management; access to primary care health
10 services for underserved individuals, populations, and areas; and healthy
11 lifestyles. Such methodologies shall be consistent with payment reform and
12 with evidence-based practices, and may include fee-for-service payments if the
13 board determines such payments to be appropriate.

14 (d) To the extent required to avoid federal antitrust violations and in
15 furtherance of the policy identified in subsection (a) of this section, the board
16 shall facilitate and supervise the participation of health care professionals and
17 health care provider bargaining groups in the process described in subsection
18 (b) of this section.

19 § 9377. PAYMENT REFORM; PILOTS

20 (a) It is the intent of the general assembly to achieve the principles stated in
21 section 9371 of this title. In order to achieve this goal and to ensure the

1 success of health care reform, it is the intent of the general assembly that
2 payment reform be implemented and that payment reform be carried out as
3 described in this section. It is also the intent of the general assembly to ensure
4 sufficient state involvement and action in the design and implementation of the
5 payment reform pilot projects described in this section to comply with federal
6 and state antitrust provisions by replacing competition between payers and
7 others with state-supervised cooperation and regulation.

8 (b)(1) The board shall be responsible for payment and delivery system
9 reform, including setting the overall policy goals for the pilot projects
10 established in chapter 13, subchapter 2 of this title. The director of payment
11 reform in the department of Vermont health access shall develop and
12 implement the payment reform pilot projects in accordance with policies
13 established by the board, and the board shall evaluate the effectiveness of such
14 pilot projects in order to inform the payment and delivery system reform.

15 (2) Payment reform pilot projects shall be developed and implemented
16 to manage the costs of the health care delivery system, improve health
17 outcomes for Vermonters, provide a positive health care experience for
18 patients and health care professionals, and further the following objectives:

19 (A) payment reform pilot projects should align with the Blueprint for
20 Health strategic plan and the statewide health information technology plan;

1 (B) health care professionals should coordinate patient care through a
2 local entity or organization facilitating this coordination or another structure
3 which results in the coordination of patient care and a sustained focus on
4 disease prevention and promotion of wellness that includes individuals,
5 employers, and communities;

6 (C) health insurers, Medicaid, Medicare, and all other payers should
7 reimburse health care professionals for coordinating patient care through
8 consistent payment methodologies, which may include a global budget; a
9 system of cost containment limits, health outcome measures, and patient
10 consumer satisfaction targets which may include risk-sharing or other
11 incentives designed to reduce costs while maintaining or improving health
12 outcomes and patient consumer satisfaction; or another payment method
13 providing an incentive to coordinate care and control cost growth;

14 (D) the scope of services in any capitated payment should be broad
15 and comprehensive, including prescription drugs, diagnostic services, acute
16 and sub-acute home health services, services received in a hospital, mental
17 health and substance abuse services, and services from a licensed health care
18 practitioner; and

19 (E) health insurers, Medicaid, Medicare, and all other payers should
20 reimburse health care professionals for providing the full spectrum of
21 evidence-based health services.

1 (3) In addition to the objectives identified in subdivision (a)(3) of this
2 section, the design and implementation of payment reform pilot projects may
3 consider:

4 (A) alignment with the requirements of federal law to ensure the full
5 participation of Medicare in multipayer payment reform; and

6 (B) with input from long-term care providers, the inclusion of home
7 health services and long-term care services as part of capitated payments.

8 (c) To the extent required to avoid federal antitrust violations, the board
9 shall facilitate and supervise the participation of health care professionals,
10 health care facilities, and insurers in the planning and implementation of the
11 payment reform pilot projects, including by creating a shared incentive pool if
12 appropriate. The board shall ensure that the process and implementation
13 include sufficient state supervision over these entities to comply with federal
14 antitrust provisions and shall refer to the attorney general for appropriate action
15 the activities of any individual or entity that the board determines, after notice
16 and an opportunity to be heard, violate state or federal antitrust laws without a
17 countervailing benefit of improving patient care, improving access to health
18 care, increasing efficiency, or reducing costs by modifying payment methods.

19 (d) The board or designee shall apply for grant funding, if available, for the
20 evaluation of the pilot projects described in this section.

21 § 9378. PUBLIC PROCESS

1 The Green Mountain Care board shall provide a process for soliciting public
2 input. The process may include receiving written comments on proposed new
3 or amended rules or holding public hearings or both.

4 § 9379. AGENCY COOPERATION

5 The secretary of administration shall ensure that, in accordance with state
6 and federal privacy laws, the Green Mountain Care board has access to data
7 and analysis held by any executive branch agency which is necessary to carry
8 out the board’s duties as described in this chapter.

9 § 9380. RULES

10 The board may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to
11 carry out the provisions of this chapter.

12 § 9381. APPEALS

13 (a) The Green Mountain Care board shall adopt procedures for
14 administrative appeals of its actions, orders, or other determinations. Such
15 procedures shall provide for the issuance of a final order and the creation of a
16 record sufficient to serve as the basis for judicial review pursuant to subsection
17 (b) of this section.

18 (b) Any person aggrieved by a final action, order, or other determination of
19 the Green Mountain Care board may, upon exhaustion of all administrative
20 appeals available pursuant to subsection (a) of this section, appeal to the
21 supreme court pursuant to the Vermont Rules of Appellate Procedure.

1 Subchapter 2. Green Mountain Care Board Nominating Committee

2 § 9390. GREEN MOUNTAIN CARE BOARD NOMINATING

3 COMMITTEE CREATED; COMPOSITION

4 (a) A Green Mountain Care board nominating committee is created for the
5 nomination of the chair and members of the Green Mountain Care board.

6 (b)(1) The committee shall consist of nine members who shall be selected
7 as follows:

8 (A) Two members appointed by the governor.

9 (B) Two members of the senate, not all of whom shall be members of
10 the same party, to be appointed by the committee on committees.

11 (C) Two members of the house of representatives, not all of whom
12 shall be members of the same party, to be appointed by the speaker of the
13 house of representatives.

14 (D) One member each to be appointed by the governor, the president
15 pro tempore of the senate, and the speaker of the house, with knowledge of or
16 expertise in health care policy, health care delivery, or health care financing, to
17 complement that of the remaining members of the committee.

18 (2) The members of the committee shall serve for terms of two years
19 and may serve for no more than three consecutive terms. All appointments
20 shall be made between January 1 and February 1 of each odd-numbered year.

1 except to fill a vacancy. Members shall serve until their successors are
2 appointed.

3 (3) The members shall elect their own chair who shall serve for a term
4 of two years.

5 (c) For committee meetings held when the general assembly is not in
6 session, the legislative members of the Green Mountain Care board nominating
7 committee shall be entitled to per diem compensation and reimbursement of
8 expenses in accordance with the provisions of 2 V.S.A. § 406. Committee
9 members who are not legislators shall be entitled to per diem compensation
10 and reimbursement of expenses on the same basis as that applicable to the
11 legislative members, and their compensation and reimbursements shall be paid
12 out of the budget of the Green Mountain Care board.

13 (d) The Green Mountain Care board nominating committee shall use the
14 qualifications described in section 9392 of this title for the nomination of
15 candidates for the chair and members of the Green Mountain Care board. The
16 nominating committee shall adopt procedures for a nomination process based
17 on the rules adopted by the judicial nominating board, and shall make such
18 procedures available to the public.

19 (e) A quorum of the committee shall consist of five members.

20 (f) The board is authorized to use the staff and services of appropriate state
21 agencies and departments as necessary to conduct investigations of applicants.

1 § 9391. NOMINATION AND APPOINTMENT PROCESS

2 (a) Whenever a vacancy occurs on the Green Mountain Care board, or
3 when an incumbent does not declare that he or she will be a candidate to
4 succeed himself or herself, the Green Mountain Care board nominating
5 committee shall select by majority vote, provided that a quorum is present,
6 from the list of persons interested in serving on the Green Mountain Care
7 board as many candidates as it deems qualified for the position or positions to
8 be filled. The committee shall base its determinations on the qualifications set
9 forth in section 9392 of this section.

10 (b) The committee shall submit to the governor the names of the persons it
11 deems qualified to be appointed to fill the position or positions.

12 (c) The governor shall make an appointment to the Green Mountain Care
13 board from the list of qualified candidates submitted pursuant to subsection (b)
14 of this section. The appointment shall be subject to the consent of the senate.

15 (d) All proceedings of the committee, including the names of candidates
16 considered by the committee and information about any candidate submitted
17 by any source, shall be confidential.

18 § 9392. QUALIFICATIONS FOR NOMINEES

19 The Green Mountain Care board nominating committee shall assess
20 candidates using the following criteria:

21 (1) commitment to the principles expressed in section 9371 of this title.

1 CHAPTER 13. CHRONIC CARE INFRASTRUCTURE
2 AND PREVENTION MEASURES

3 § 701. DEFINITIONS

4 For the purposes of this chapter:

5 (1) “Blueprint for Health” or “Blueprint” means the state’s program for
6 integrating a system of health care for patients, improving the health of the
7 overall population, and improving control over health care costs by promoting
8 health maintenance, prevention, and care coordination and management.

9 (2) “Board” means the Green Mountain Care board established in
10 chapter 220 of this title.

11 (3) “Chronic care” means health services provided by a health care
12 professional for an established clinical condition that is expected to last a year
13 or more and that requires ongoing clinical management attempting to restore
14 the individual to highest function, minimize the negative effects of the
15 condition, prevent complications related to chronic conditions, engage in
16 advanced care planning, and promote appropriate access to palliative care.
17 Examples of chronic conditions include diabetes, hypertension, cardiovascular
18 disease, cancer, asthma, pulmonary disease, substance abuse, mental illness,
19 spinal cord injury, hyperlipidemia, and chronic pain.

20 ~~(3)~~(4) “Chronic care information system” means the electronic database
21 developed under the Blueprint for Health that shall include information on all

1 cases of a particular disease or health condition in a defined population of
2 individuals.

3 ~~(4)~~(5) “Chronic care management” means a system of coordinated
4 health care interventions and communications for individuals with chronic
5 conditions, including significant patient self-care efforts, systemic supports for
6 licensed health care practitioners and their patients, and a plan of care
7 emphasizing prevention of complications utilizing evidence-based practice
8 guidelines, patient empowerment strategies, and evaluation of clinical,
9 humanistic, and economic outcomes on an ongoing basis with the goal of
10 improving overall health.

11 (6) “Global payment” means a payment from a health insurer, Medicaid,
12 Medicare, or other payer for the health services of a defined population of
13 patients for a defined period of time. Such payments may be adjusted to
14 account for the population’s underlying risk factors, including severity of
15 illness and socioeconomic factors that may influence the cost of health care for
16 the population.

17 ~~(5)~~(7) “Health care professional” means an individual, partnership,
18 corporation, facility, or institution licensed or certified or authorized by law to
19 provide professional health care services.

20 ~~(6)~~(8) “Health benefit plan” shall have the same meaning as in 8 V.S.A.
21 § 4088h.

1 ~~(7)~~(9) “Health insurer” shall have the same meaning as in section 9402
2 of this title.

3 (10) “Health service” means any treatment or procedure delivered by a
4 health care professional to maintain an individual’s physical or mental health
5 or to diagnose or treat an individual’s physical or mental health condition,
6 including services ordered by a health care professional, chronic care
7 management, preventive care, wellness services, and medically necessary
8 services to assist in activities of daily living.

9 ~~(8)~~(11) “Hospital” shall have the same meaning as in section 9456 of
10 this title.

11 (12) “Integrated delivery system” means a group of health care
12 professionals, associated either through employment by a single entity or
13 through a contractual arrangement, that provides health services for a defined
14 population of patients and is compensated through a global payment.

15 (13) “Payment reform” means modifying the method of payment from a
16 fee for-service basis to one or more alternative methods for compensating
17 health care professionals, health care provider bargaining groups created
18 pursuant to section 9409 of this title, integrated delivery systems and other
19 health care professional arrangements, manufacturers of prescribed products,
20 medical supply companies, and other companies providing health services or
21 health supplies, for the provision of high-quality and efficient health services,

1 products, and supplies while measuring quality and efficiency. The term may
2 include shared savings agreements, bundled payments, episode-based
3 payments, and global payments.

4 (14) “Preventive care” means health services provided by health care
5 professionals to identify and treat asymptomatic individuals who have risk
6 factors or preclinical disease, but in whom the disease is not clinically
7 apparent, including immunizations and screening, counseling, treatment, and
8 medication determined by scientific evidence to be effective in preventing or
9 detecting a condition.

10 (15) “Wellness services” means health services, programs, or activities
11 that focus on the promotion or maintenance of good health.

12 Subchapter 1. Blueprint for Health

13 § 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

14 * * *

15 Subchapter 2. Payment Reform

16 § 721. PURPOSE

17 It is the intent of the general assembly to achieve the principles stated in
18 section 9371 of this title. In order to achieve this goal and to ensure the
19 success of health care reform, it is the intent of the general assembly that
20 payment reform be implemented and that payment reform be carried out as
21 described in this section. It is also the intent of the general assembly to ensure

1 sufficient state involvement and action in the design and implementation of the
2 payment reform pilot projects described in this section to comply with federal
3 and state antitrust provisions by replacing competition between payers and
4 others with state-supervised cooperation and regulation.

5 § 722. PILOT PROJECTS

6 (a) The Green Mountain Care board shall be responsible for payment
7 reform and delivery system reform, including setting the overall policy goals
8 for the pilot projects as provided in this subchapter. The director of payment
9 reform in the department of Vermont health access shall develop and
10 implement the payment reform pilot projects consistent with policies
11 established by the board and the board shall evaluate the effectiveness of the
12 pilot projects in order to inform the payment and delivery system reform.
13 Whenever health insurers are involved, the director and the Green Mountain
14 Care board shall collaborate with the commissioner of banking, insurance,
15 securities, and health care administration.

16 (b) The director of payment reform shall convene a broad-based group of
17 stakeholders, including health care professionals who provide health services,
18 health insurers, professional organizations, community and nonprofit groups,
19 consumers, businesses, school districts, the state health care ombudsman, and
20 state and local governments to advise the director in developing and

1 implementing the pilot projects and the Green Mountain Care board in setting
2 overall policy goals.

3 (c) Payment reform pilot projects shall be developed and implemented to
4 manage the costs of the health care delivery system, improve health outcomes
5 for Vermonters, provide a positive health care experience for patients and
6 health care professionals, and further the following objectives:

7 (1) payment reform pilot projects should align with the Blueprint for
8 Health strategic plan and the statewide health information technology plan;

9 (2) health care professionals should coordinate patient care through a
10 local entity or organization facilitating this coordination or another structure
11 which results in the coordination of patient care and a sustained focus on
12 disease prevention and promotion of wellness that includes individuals,
13 employers, and communities;

14 (3) health insurers, Medicaid, Medicare, and all other payers should
15 reimburse health care professionals for coordinating patient care through
16 consistent payment methodologies, which may include a global budget; a
17 system of cost containment limits, health outcome measures, and patient
18 consumer satisfaction targets which may include risk-sharing or other
19 incentives designed to reduce costs while maintaining or improving health
20 outcomes and patient consumer satisfaction; or another payment method
21 providing an incentive to coordinate care and control cost growth; and

1 (4) the scope of services in any capitated payment should be broad and
2 comprehensive, including prescription drugs, diagnostic services, acute and
3 sub-acute home health services, services received in a hospital, mental health
4 and substance abuse services, and services from a licensed health care
5 practitioner; and

6 (5) health insurers, Medicaid, Medicare, and all other payers should
7 reimburse health care professionals for providing the full spectrum of
8 evidence-based health services.

9 (d) In addition to the objectives identified in subsection (c) of this section,
10 the design and implementation of payment reform pilot projects may consider:

11 (1) alignment with the requirements of federal law to ensure the full
12 participation of Medicare in multipayer payment reform; and

13 (2) with input from long-term care providers, the inclusion of home
14 health services and long-term care services as part of capitated payments.

15 (e) The first pilot project shall become operational no later than January 1,
16 2012, and two or more additional pilot projects shall become operational no
17 later than July 1, 2012.

18 (f) The Green Mountain Care board shall ensure that payment reform pilot
19 projects are consistent with the board's overall efforts to control the rate of
20 growth in health care costs while maintaining or improving health care quality.

21 § 723. HEALTH INSURER PARTICIPATION

1 (a)(1) Health insurers shall participate in the development of the payment
2 reform strategic plan for the pilot projects and in the implementation of the
3 pilot projects, including providing incentives, fees, or payment methods, as
4 required in this section. This requirement may be enforced by the department
5 of banking, insurance, securities, and health care administration to the same
6 extent as the requirement to participate in the Blueprint for Health pursuant to
7 8 V.S.A. § 4088h.

8 (2) The board may establish procedures to exempt or limit the
9 participation of health insurers offering a stand-alone dental plan or specific
10 disease or other limited-benefit coverage or participation by insurers with a
11 minimal number of covered lives as defined by the board, in consultation with
12 the commissioner of banking, insurance, securities, and health care
13 administration. Health insurers shall be exempt from participation if the
14 insurer offers only benefit plans which are paid directly to the individual
15 insured or the insured's assigned beneficiaries and for which the amount of the
16 benefit is not based upon potential medical costs or actual costs incurred.

17 (b) In the event that the secretary of human services is denied permission
18 from the Centers for Medicare and Medicaid Services to include financial
19 participation by Medicare in the pilot projects, health insurers shall not be
20 required to cover the costs associated with individuals covered by Medicare.

21 § 724. ANTITRUST PROTECTION

1 To the extent required to avoid federal antitrust violations, the director shall
2 facilitate and supervise the participation of health care professionals, health
3 care facilities, and insurers in the planning and implementation of the payment
4 reform pilot projects, including by creating a shared incentive pool if
5 appropriate. The director shall ensure that the process and implementation
6 include sufficient state supervision over these entities to comply with federal
7 antitrust provisions and shall refer to the attorney general for appropriate action
8 the activities of any individual or entity that the director determines, after
9 notice and an opportunity to be heard, violate state or federal antitrust laws
10 without a countervailing benefit of improving patient care, improving access to
11 health care, increasing efficiency, or reducing costs by modifying payment
12 methods.

13 § 725. ADMINISTRATION; RULES

14 (a) The director of payment reform shall apply for grant funding, if
15 available, for the design and implementation evaluation of the pilot projects
16 described in this section.

17 (b) The agency of human services may adopt rules pursuant to 3 V.S.A.
18 chapter 25 as needed to carry out the provisions of this chapter.

19 (c) After implementation of the pilot projects described in this subchapter,
20 health insurers shall have appeal rights pursuant to section 9381 of this title.

21 Sec. 3d. 18 V.S.A. § 4631a is amended to read:

1 § 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED
2 PRODUCTS

3 (a) As used in this section:

4 * * *

5 (5) “Gift” means:

6 (A) Anything of value provided for free to a health care provider ~~for~~
7 free or to a member of the Green Mountain Care board established in chapter
8 220 of this title; or

9 (B) Except as otherwise provided in subdivision (a)(1)(A)(ii) of this
10 section, any payment, food, entertainment, travel, subscription, advance,
11 service, or anything else of value provided to a health care provider or to a
12 member of the Green Mountain Care board established in chapter 220 of this
13 title, unless:

14 (i) it is an allowable expenditure as defined in subdivision (a)(1)
15 of this section; or

16 (ii) the health care provider or board member reimburses the cost
17 at fair market value.

18 * * *

19 (b)(1) It is unlawful for any manufacturer of a prescribed product or any
20 wholesale distributor of medical devices, or any agent thereof, to offer or give

1 any gift to a health care provider or to a member of the Green Mountain Care
2 board established in chapter 220 of this title.

3 * * *

4 Sec. 3e. 18 V.S.A. § 4632 is amended to read:

5 § 4632. DISCLOSURE OF ALLOWABLE EXPENDITURES AND GIFTS
6 BY MANUFACTURERS OF PRESCRIBED PRODUCTS

7 (a)(1) Annually on or before October 1 of each year, every manufacturer of
8 prescribed products shall disclose to the office of the attorney general for the
9 fiscal year ending the previous June 30th the value, nature, purpose, and
10 recipient information of:

11 (A) any allowable expenditure or gift permitted under subdivision
12 4631a(b)(2) of this title to any health care provider or to a member of the
13 Green Mountain Care board established in chapter 220 of this title, except:

14 (i) royalties and licensing fees as described in subdivision
15 4631a(a)(1)(F) of this title;

16 (ii) rebates and discounts for prescribed products provided in the
17 normal course of business as described in subdivision 4631a(b)(2)(F) of this
18 title;

19 (iii) payments for clinical trials as described in subdivision
20 4631a(a)(1)(C) of this title, which shall be disclosed after the earlier of the date
21 of the approval or clearance of the prescribed product by the Food and Drug

1 Administration or two calendar years after the date the payment was made.

2 For a clinical trial for which disclosure is delayed under this subdivision (iii),
3 the manufacturer shall identify to the attorney general the clinical trial, the start
4 date, and the web link to the clinical trial registration on the national clinical
5 trials registry;

6 (iv) interview expenses as described in subdivision 4631a(a)(1)(G)
7 of this title; and

8 (v) coffee or other snacks or refreshments at a booth at a
9 conference or seminar.

10 * * *

11 (5) The office of the attorney general shall report annually on the
12 disclosures made under this section to the general assembly and the governor
13 on or before April 1. The report shall include:

14 (A) Information on allowable expenditures and gifts required to be
15 disclosed under this section, which shall ~~be presented in both~~ present
16 information in aggregate form; ~~and~~ by selected types of health care providers
17 or individual health care providers, as prioritized each year by the office; and
18 showing the amounts expended on the Green Mountain Care board established
19 in chapter 220 of this title.

20 (B) Information on violations and enforcement actions brought
21 pursuant to this section and section 4631a of this title.

1 costs; to promote health, prevention, and healthy lifestyles by individuals; and
2 to improve quality of health care.

3 (c) Nothing in this chapter shall be construed to reduce, diminish, or
4 otherwise infringe upon the benefits provided to eligible individuals under
5 Medicare.

6 § 1802. DEFINITIONS

7 For purposes of this subchapter:

8 (1) “Affordable Care Act” means the federal Patient Protection and
9 Affordable Care Act (Public Law 111-148), as amended by the federal Health
10 Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as
11 further amended.

12 (2) “Commissioner” means the commissioner of the department of
13 Vermont health access.

14 (3) “Health benefit plan” means a policy, contract, certificate, or
15 agreement offered or issued by a health insurer to provide, deliver, arrange for,
16 pay for, or reimburse any of the costs of health services. This term does not
17 include coverage only for accident or disability income insurance, liability
18 insurance, coverage issued as a supplement to liability insurance, workers’
19 compensation or similar insurance, automobile medical payment insurance,
20 credit-only insurance, coverage for on-site medical clinics, or other similar
21 insurance coverage where benefits for health services are secondary or

1 incidental to other insurance benefits as provided under the Affordable Care
2 Act. The term also does not include stand-alone dental or vision benefits;
3 long-term care insurance; specific disease or other limited benefit coverage,
4 Medicare supplemental health benefits, Medicare Advantage plans, and other
5 similar benefits excluded under the Affordable Care Act.

6 (4) “Health insurer” shall have the same meaning as in 18 V.S.A.
7 § 9402.

8 (5) “Qualified employer” means an employer that:

9 (A) has its principal place of business in this state and elects to
10 provide coverage for its eligible employees through the Vermont health benefit
11 exchange, regardless of where an employee resides; or

12 (B) elects to provide coverage through the Vermont health benefit
13 exchange for all of its eligible employees who are principally employed in this
14 state.

15 (6) “Qualified entity” means an entity with experience in individual and
16 group health insurance, benefit administration, or other experience relevant to
17 health benefit program eligibility, enrollment, or support.

18 (7) “Qualified health benefit plan” means a health benefit plan which
19 meets the requirements set forth in section 1806 of this title.

20 (8) “Qualified individual” means an individual, including a minor, who
21 is a Vermont resident and, at the time of enrollment:

1 (A) is not incarcerated, or is only incarcerated awaiting disposition of
2 charges; and

3 (B) is, or is reasonably expected to be during the time of enrollment,
4 a citizen or national of the United States or an immigrant lawfully present in
5 the United States as defined by federal law.

6 § 1803. VERMONT HEALTH BENEFIT EXCHANGE

7 (a)(1) The department of Vermont health access shall establish the
8 Vermont health benefit exchange, which shall be administered by the
9 department in consultation with the advisory committee established in
10 section 402 of this title.

11 (2) The Vermont health benefit exchange shall be considered a division
12 within the department of Vermont health access and shall be headed by a
13 deputy commissioner as provided in 3 V.S.A. chapter 53.

14 (b)(1)(A) The Vermont health benefit exchange shall provide qualified
15 individuals and qualified employers with qualified health benefit plans,
16 including the multistate plans required by the Affordable Care Act, with
17 effective dates beginning on or before January 1, 2014. The Vermont health
18 benefit exchange may contract with qualified entities or enter into
19 intergovernmental agreements to facilitate the functions provided by the
20 Vermont health benefit exchange.

1 (B) Prior to contracting with any health insurer, the Vermont health
2 benefit exchange shall consider the insurer's historic rate increase information
3 required under section 1806 of this title, along with the information and the
4 recommendations provided to the Vermont health benefit exchange by the
5 commissioner of banking, insurance, securities, and health care administration
6 under Section 2794(b)(1)(B) of the federal Public Health Service Act.

7 (2) To the extent allowable under federal law, the Vermont health
8 benefit exchange may offer health benefits to populations in addition to those
9 eligible under Subtitle D of Title I of the Affordable Care Act, including:

10 (A) to individuals and employers who are not qualified individuals or
11 qualified employers as defined by this subchapter and by the Affordable Care
12 Act;

13 (B) Medicaid benefits to individuals who are eligible, upon approval
14 by the Centers for Medicare and Medicaid Services and provided that
15 including these individuals in the health benefit exchange would not reduce
16 their Medicaid benefits;

17 (C) Medicare benefits to individuals who are eligible, upon approval
18 by the Centers for Medicare and Medicaid Services and provided that
19 including these individuals in the health benefit exchange would not reduce
20 their Medicare benefits; and

21 (D) state employees and municipal employees, including teachers.

1 (3) To the extent allowable under federal law, the Vermont health
2 benefit exchange may offer health benefits to employees for injuries arising out
3 of or in the course of employment in lieu of medical benefits provided pursuant
4 to chapter 9 of Title 21 (workers' compensation).

5 (c)(1) The Vermont health benefit exchange may determine an appropriate
6 method to provide a unified, simplified administration system for health
7 insurers offering qualified health benefit plans. The exchange may include
8 claims administration, benefit management, billing, or other components in the
9 unified system and may achieve simplification by contracting with a single
10 entity for administration and management of all qualified health benefit plans,
11 by licensing or requiring the use of particular software, by requiring health
12 insurers to conform to a standard set of systems and rules, or by another
13 method determined by the commissioner.

14 (2) The Vermont health benefit exchange may offer certain services,
15 such as wellness programs and services designed to simplify administrative
16 processes, to health insurers offering plans outside the exchange, to workers'
17 compensation insurers, to employers, and to other entities.

18 (d) The Vermont health benefit exchange may enter into
19 information-sharing agreements with federal and state agencies and other state
20 exchanges to carry out its responsibilities under this subchapter provided such
21 agreements include adequate protections with respect to the confidentiality of

1 the information to be shared and provided such agreements comply with all
2 applicable state and federal laws and regulations.

3 § 1804. QUALIFIED EMPLOYERS

4 [Reserved.]

5 § 1805. DUTIES AND RESPONSIBILITIES

6 The Vermont health benefit exchange shall have the following duties and
7 responsibilities consistent with the Affordable Care Act:

8 (1) Offering coverage for health services through qualified health
9 benefit plans, including by creating a process for:

10 (A) the certification, decertification, and recertification of qualified
11 health benefit plans as described in section 1806 of this title;

12 (B) enrolling qualified individuals in qualified health benefit plans,
13 including through open enrollment periods as provided in the Affordable Care
14 Act, and ensuring that individuals may transfer coverage between qualified
15 health benefit plans and other sources of coverage as seamlessly as possible;

16 (C) collecting premium payments made for qualified health benefit
17 plans from employers and individuals on a pretax basis, including collecting
18 premium payments from multiple employers of one individual for a single plan
19 covering that individual; and

20 (D) creating a simplified and uniform system for the administration
21 of health benefits.

1 (2) Determining eligibility for and enrolling individuals in Medicaid,
2 Dr. Dynasaur, VPharm, and VermontRx pursuant to chapter 19 of this title, as
3 well as any other public health benefit program.

4 (3) Creating and maintaining consumer assistance tools, including a
5 website through which enrollees and prospective enrollees of qualified health
6 benefit plans may obtain standardized comparative information on such plans,
7 a toll-free telephone hotline to respond to requests for assistance, and
8 interactive online communication tools, in a manner that complies with the
9 Americans with Disabilities Act.

10 (4) Creating standardized forms and formats for presenting health
11 benefit options in the Vermont health benefit exchange, including the use of
12 the uniform outline of coverage established under Section 2715 of the federal
13 Public Health Services Act.

14 (5) Assigning a quality and wellness rating to each qualified health
15 benefit plan offered through the Vermont health benefit exchange and
16 determining each qualified health benefit plan's level of coverage in
17 accordance with regulations issued by the U.S. Department of Health and
18 Human Services.

19 (6) Determining enrollee premiums and subsidies as required by the
20 secretary of the U.S. Treasury or of the U.S. Department of Health and Human
21 Services and informing consumers of eligibility for premiums and subsidies,

1 including by providing an electronic calculator to determine the actual cost of
2 coverage after application of any premium tax credit under Section 36B of the
3 Internal Revenue Code of 1986 and any cost-sharing reduction under Section
4 1402 of the Affordable Care Act.

5 (7) Transferring to the secretary of the U.S. Department of the Treasury
6 the name and taxpayer identification number of each individual who was an
7 employee of an employer but who was determined to be eligible for the
8 premium tax credit under Section 36B of the Internal Revenue Code of 1986
9 for the following reasons:

10 (A) The employer did not provide minimum essential coverage; or

11 (B) The employer provided the minimum essential coverage, but it
12 was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to
13 be either unaffordable to the employee or not to provide the required minimum
14 actuarial value.

15 (8) Performing duties required by the secretary of the U.S. Department
16 of Health and Human Services or the secretary of the U.S. Department of the
17 Treasury related to determining eligibility for the individual responsibility
18 requirement exemptions, including:

19 (A) Granting a certification attesting that an individual is exempt
20 from the individual responsibility requirement or from the penalty for violating
21 that requirement, if there is no affordable qualified health benefit plan

1 available through the Vermont health benefit exchange or the individual's
2 employer for that individual or if the individual meets the requirements for any
3 exemption from the individual responsibility requirement or from the penalty
4 pursuant to Section 5000A of the Internal Revenue Code of 1986; and

5 (B) transferring to the secretary of the U.S. Department of the
6 Treasury a list of the individuals who are issued a certification under
7 subdivision (8)(A) of this section, including the name and taxpayer
8 identification number of each individual.

9 (9)(A) Transferring to the secretary of the U.S. Department of the
10 Treasury the name and taxpayer identification number of each individual who
11 notifies the Vermont health benefit exchange that he or she has changed
12 employers and of each individual who ceases coverage under a qualified health
13 benefit plan during a plan year and the effective date of that cessation; and

14 (B) Communicating to each employer the name of each of its
15 employees and the effective date of the cessation reported to the U.S.
16 Department of the Treasury under this subdivision.

17 (10) Establishing a navigator program as described in section 1807 of
18 this title.

19 (11) Reviewing the rate of premium growth within and outside the
20 Vermont health benefit exchange.

1 (12) Crediting the amount of any free choice voucher provided pursuant
2 to Section 10108 of the Affordable Care Act to the monthly premium of the
3 plan in which a qualified employee is enrolled and collecting the amount
4 credited from the offering employer.

5 (13) Providing consumers and health care professionals with satisfaction
6 surveys and other mechanisms for evaluating the performance of qualified
7 health benefit plans and informing the commissioner of Vermont health access
8 and the commissioner of banking, insurance, securities, and health care
9 administration of such performance.

10 (14) Ensuring consumers have easy and simple access to the relevant
11 grievance and appeals processes pursuant to 8 V.S.A. chapter 107 and 3 V.S.A.
12 § 3090 (human services board).

13 (15) Consulting with the advisory committee established in section 402
14 of this title to obtain information and advice as necessary to fulfill the duties
15 outlined in this subchapter.

16 (16) Referring consumers to the office of health care ombudsman for
17 assistance with grievances, appeals, and other issues involving the Vermont
18 health benefit exchange.

19 § 1806. QUALIFIED HEALTH BENEFIT PLANS

20 (a) Prior to contracting with a health insurer to offer a qualified health
21 benefit plan, the commissioner shall determine that making the plan available

1 through the Vermont health benefit exchange is in the best interest of
2 individuals and qualified employers in this state. In determining the best
3 interest, the commissioner shall consider affordability; promotion of
4 high-quality care, prevention, and wellness; promotion of access to health care;
5 participation in the state's health care reform efforts; and such other criteria as
6 the commissioner, in his or her discretion, deems appropriate.

7 (b) A qualified health benefit plan shall provide the following benefits:

8 (1)(A) The essential benefits package required by Section 1302(a) of the
9 Affordable Care Act and any additional benefits required by the secretary of
10 human services by rule after consultation with the advisory committee
11 established in section 402 of this title and after approval from the Green
12 Mountain Care board established in 18 V.S.A. chapter 220.

13 (B) Notwithstanding subdivision (1)(A) of this subsection, a health
14 insurer may offer a plan that provides more limited dental benefits if such plan
15 meets the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code
16 and provides pediatric dental benefits meeting the requirements of Section
17 1302(b)(1)(J) of the Affordable Care Act either separately or in conjunction
18 with a qualified health benefit plan.

19 (2) At least the silver level of coverage as defined by Section 1302 of
20 the Affordable Care Act and the cost-sharing limitations for individuals
21 provided in Section 1302 of the Affordable Care Act, as well as any more

1 restrictive cost-sharing requirements specified by the secretary of human
2 services by rule after consultation with the advisory committee established in
3 section 402 of this title and after approval from the Green Mountain Care
4 board established in 18 V.S.A. chapter 220.

5 (3) For qualified health benefit plans offered to employers, a deductible
6 which meets the limitations provided in Section 1302 of the Affordable Care
7 Act and any more restrictive deductible requirements specified by the secretary
8 of human services by rule after consultation with the advisory committee
9 established in section 402 of this title and after approval from the Green
10 Mountain Care board established in 18 V.S.A. chapter 220.

11 (c) A qualified health benefit plan shall meet the following minimum
12 prevention, quality, and wellness requirements:

13 (1) standards for marketing practices, network adequacy, essential
14 community providers in underserved areas, appropriate services to enable
15 access for underserved individuals or populations, accreditation, quality
16 improvement, and information on quality measures for health benefit plan
17 performance, as provided in Section 1311 of the Affordable Care Act and any
18 more restrictive requirements provided by 8 V.S.A. chapter 107;

19 (2) quality and wellness standards as specified in rule by the secretary of
20 human services, after consultation with the commissioners of health and of

1 banking, insurance, securities, and health care administration and with the
2 advisory committee established in section 402 of this title; and

3 (3) standards for participation in the Blueprint for Health as provided in
4 18 V.S.A. chapter 13.

5 (d) A health insurer offering a qualified health benefit plan shall use the
6 uniform enrollment forms and descriptions of coverage provided by the
7 commissioner of Vermont health access and the commissioner of banking,
8 insurance, securities, and health care administration.

9 (e)(1) A health insurer offering a qualified health benefit plan shall comply
10 with the following insurance and consumer information requirements:

11 (A)(i) Obtain premium approval through the rate review process
12 provided in 8 V.S.A. chapter 107; and

13 (ii) Submit to the commissioner of banking, insurance, securities,
14 and health care administration a justification for any premium increase before
15 implementation of that increase and prominently post this information on the
16 health insurer's website.

17 (B) Offer at least one qualified health benefit plan at the silver level
18 and at least one qualified health benefit plan at the gold level that meet the
19 requirements of Section 1302 of the Affordable Care Act and any additional
20 requirements specified by the secretary of human services by rule. In addition,
21 a health insurer may choose to offer one or more qualified health benefit plans

1 at the platinum level that meet the requirements of Section 1302 of the
2 Affordable Care Act and any additional requirements specified by the secretary
3 of human services by rule.

4 (C) Charge the same premium rate for a health benefit plan without
5 regard to whether the plan is offered through the Vermont health benefit
6 exchange and without regard to whether the plan is offered directly from the
7 carrier or through an insurance agent.

8 (D) Provide accurate and timely disclosure of information to the
9 public and to the Vermont health benefit exchange relating to claims denials,
10 enrollment data, rating practices, out-of-network coverage, enrollee and
11 participant rights provided by Title I of the Affordable Care Act, and other
12 information as required by the commissioner of Vermont health access or by
13 the commissioner of banking, insurance, securities, and health care
14 administration. The commissioner of banking, insurance, securities, and health
15 care administration shall define, by rule, the acceptable time frame for
16 provision of information in accordance with this subdivision.

17 (E) Provide information in a timely manner to an individual, upon
18 request, regarding the cost-sharing amounts for that individual's health benefit
19 plan.

20 (2) A health insurer offering a qualified health benefit plan shall comply
21 with all other insurance requirements for health insurers as provided in

1 8 V.S.A. chapter 107 and as specified by rule by the commissioner of banking,
2 insurance, securities, and health care administration.

3 (f) Consistent with Section 1311(e)(1)(B) of the Affordable Care Act, the
4 Vermont health benefit exchange shall not exclude a health benefit plan:

5 (1) on the basis that the plan is a fee-for-service plan;

6 (2) through the imposition of premium price controls by the Vermont
7 health benefit exchange; or

8 (3) on the basis that the health benefit plan provides for treatments
9 necessary to prevent patients' deaths in circumstances the Vermont health
10 benefit exchange determines are inappropriate or too costly.

11 § 1807. NAVIGATORS

12 (a)(1) The Vermont health benefit exchange shall establish a navigator
13 program to assist individuals and employers in enrolling in a qualified health
14 benefit plan offered under the Vermont health benefit exchange. The Vermont
15 health benefit exchange shall select individuals and entities qualified to serve
16 as navigators and shall award grants to navigators for the performance of their
17 duties.

18 (2) The Vermont health benefit exchange shall ensure that navigators
19 are available to provide assistance in person or through interactive technology
20 to individuals in all regions of the state in a manner that complies with the
21 Americans with Disabilities Act.

1 (3) Consistent with Section 1311(i)(4) of the Affordable Care Act,
2 health insurers shall not serve as navigators, and no navigator shall receive any
3 compensation from a health insurer in connection with enrolling individuals or
4 employees in qualified health benefit plans.

5 (b) Navigators shall have the following duties:

6 (1) Conduct public education activities to raise awareness of the
7 availability of qualified health benefit plans;

8 (2) Distribute fair and impartial information concerning enrollment in
9 qualified health benefit plans and concerning the availability of premium tax
10 credits and cost-sharing reductions;

11 (3) Facilitate enrollment in qualified health benefit plans, Medicaid,
12 Dr. Dynasaur, VPharm, VermontRx, and other public health benefit programs;

13 (4) Provide referrals to the office of health care ombudsman and any
14 other appropriate agency for any enrollee with a grievance, complaint, or
15 question regarding his or her health benefit plan, coverage, or a determination
16 under that plan or coverage;

17 (5) Provide information in a manner that is culturally and linguistically
18 appropriate to the needs of the population being served by the Vermont health
19 benefit exchange; and

20 (6) Distribute information to health care professionals, community
21 organizations, and others to facilitate the enrollment of individuals who are

1 eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRx, other public health
2 benefit programs, or the Vermont health benefit exchange in order to ensure
3 that all eligible individuals are enrolled.

4 § 1808. FINANCIAL INTEGRITY

5 (a) The Vermont health benefit exchange shall:

6 (1) Keep an accurate accounting of all activities, receipts, and
7 expenditures and submit this information annually as required by federal law;

8 (2) Cooperate with the secretary of the U.S. Department of Health and
9 Human Services or the inspector general of the U.S. Department of Health and
10 Human Services in any investigation into the affairs of the Vermont health
11 benefit exchange, any examination of the properties and records of the
12 Vermont health benefit exchange, or any requirement for periodic reports in
13 relation to the activities undertaken by the Vermont health benefit exchange.

14 (b) In carrying out its activities under this subchapter, the Vermont health
15 benefit exchange shall not use any funds intended for the administrative and
16 operational expenses of the Vermont health benefit exchange for staff retreats,
17 promotional giveaways, excessive executive compensation, or promotion of
18 federal or state legislative or regulatory modifications.

19 § 1809. PUBLICATION OF COSTS AND SATISFACTION SURVEYS

20 (a) The Vermont health benefit exchange shall publish the average costs of
21 licensing, regulatory fees, and any other payments required by the exchange, as

1 well as the administrative costs of the exchange on a website intended to
2 educate consumers about such costs. This information shall include
3 information on monies lost to waste, fraud, and abuse.

4 (b) The Vermont health benefit exchange shall publish the deidentified
5 results of the satisfaction surveys and other evaluation mechanisms required
6 pursuant to subdivision 1805(13) of this title on a website intended to enable
7 consumers to compare the qualified health benefit plans offered through the
8 exchange.

9 § 1810. RULES

10 The secretary of human services may adopt rules pursuant to 3 V.S.A.
11 chapter 25 as needed to carry out the duties and functions established in this
12 subchapter.

13 Subchapter 2. Green Mountain Care

14 § 1821. PURPOSE

15 The purpose of Green Mountain Care is to provide, as a public good,
16 comprehensive, affordable, high-quality, publicly financed health care
17 coverage for all Vermont residents in a seamless and equitable manner
18 regardless of income, assets, health status, or availability of other health
19 coverage. Green Mountain Care shall contain costs by:

20 (1) providing incentives to residents to avoid preventable health
21 conditions, promote health, and avoid unnecessary emergency room visits;

- 1 (2) establishing innovative payment mechanisms to health care
2 professionals, such as global payments;
3 (3) encouraging the management of health services through the
4 Blueprint for Health; and
5 (4) reducing unnecessary administrative expenditures.

6 § 1822. IMPLEMENTATION; WAIVER

- 7 (a) Green Mountain Care shall not be implemented unless the Green
8 Mountain Care Board has determined that each of the following conditions will
9 be met:

10 (1) Each Vermont resident covered by Green Mountain Care will
11 receive benefits with an actuarial value of 80 percent or greater.

12 (2) Implementation of Green Mountain Care will not have a negative
13 aggregate impact on Vermont's economy.

14 (3) The financing for Green Mountain Care is fair, equitable, and
15 sustainable.

16 (4) Administrative expenses will be reduced.

17 (5) Cost-containment efforts will result in a reduction in Vermont's
18 per-capita health care spending below the rate of growth in per-capita health
19 care spending nationally, adjusted to account for demographic differences.

20 (6) Health care professionals will be reimbursed at levels sufficient to
21 allow Vermont to recruit and retain high-quality health care professionals.

1 (b) Green Mountain Care shall be implemented 90 days following the last
2 to occur of:

3 (1) Receipt of a waiver under Section 1332 of the Affordable Care Act
4 pursuant to subsection (c) of this section.

5 (2) Enactment of a law establishing the financing for Green Mountain
6 Care.

7 (3) Approval by the Green Mountain Care board of the initial Green
8 Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

9 (4) Enactment of the appropriations for the initial Green Mountain Care
10 benefit package proposed by the Green Mountain Care board pursuant to
11 18 V.S.A. § 9375.

12 (5) The board's determinations pursuant to subsection (a) of this section.

13 (c) As soon as allowed under federal law, the secretary of administration
14 shall seek a waiver to allow the state to suspend operation of the Vermont
15 health benefit exchange and to enable Vermont to receive the appropriate
16 federal fund contribution in lieu of the federal premium tax credits,
17 cost-sharing subsidies, and small business tax credits provided in the
18 Affordable Care Act. The secretary may seek a waiver from other provisions
19 of the Affordable Care Act as necessary to ensure the operation of Green
20 Mountain Care.

1 § 1823. DEFINITIONS

2 For purposes of this subchapter:

3 (1) “Agency” means the agency of human services.

4 (2) “Board” means the Green Mountain Care board established in
5 18 V.S.A. chapter 220.

6 (3) “CHIP funds” means federal funds available under Title XXI of the
7 Social Security Act.

8 (4) “Chronic care” means health services provided by a health care
9 professional for an established clinical condition that is expected to last one
10 year or more; that requires ongoing clinical management; and that requires
11 health services that attempt to restore the individual to highest function,
12 minimize the negative effects of the condition, and prevent complications
13 related to chronic conditions. Examples of chronic conditions include
14 diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary
15 disease, substance abuse, mental illness, spinal cord injury, and
16 hyperlipidemia.

17 (5) “Chronic care management” means a system of coordinated health
18 care interventions and communications for individuals with chronic conditions,
19 including significant patient self-care efforts, systemic supports for licensed
20 health care practitioners and their patients, and a plan of care emphasizing
21 prevention of complications utilizing evidence-based practice guidelines,

1 patient empowerment strategies, and evaluation of clinical, humanistic, and
2 economic outcomes on an ongoing basis with the goal of improving overall
3 health.

4 (6) “Health care professional” means an individual, partnership,
5 corporation, facility, or institution licensed or certified or otherwise authorized
6 by Vermont law to provide professional health services.

7 (7) “Health service” means any treatment or procedure delivered by a
8 health care professional to maintain an individual’s physical or mental health
9 or to diagnose or treat an individual’s physical or mental health condition,
10 including services ordered by a health care professional, chronic care
11 management, preventive care, wellness services, and medically necessary
12 services to assist in activities of daily living.

13 (8) “Hospital” shall have the same meaning as in 18 V.S.A. § 1902 and
14 may include hospitals located outside the state.

15 (9) “Preventive care” means health services provided by health care
16 professionals to identify and treat asymptomatic individuals who have risk
17 factors or preclinical disease, but in whom the disease is not clinically
18 apparent, including immunizations and screening, counseling, treatment, and
19 medication determined by scientific evidence to be effective in preventing or
20 detecting a condition.

1 (10) “Primary care” means health services provided by health care
2 professionals specifically trained for and skilled in first-contact and continuing
3 care for individuals with signs, symptoms, or health concerns, not limited by
4 problem origin, organ system, or diagnosis, and shall include family planning,
5 prenatal care, and mental health and substance abuse treatment.

6 (11) “Secretary” means the secretary of human services.

7 (12) “Vermont resident” means an individual domiciled in Vermont as
8 evidenced by an intent to maintain a principal dwelling place in Vermont
9 indefinitely and to return to Vermont if temporarily absent, coupled with an act
10 or acts consistent with that intent. An individual shall not be considered to be
11 a Vermont resident if he or she is 18 years of age or older and is claimed as a
12 dependent on the tax return of a resident of another state.

13 (13) “Wellness services” means health services, programs, or activities
14 that focus on the promotion or maintenance of good health.

15 § 1824. ELIGIBILITY

16 (a)(1) Upon implementation, all Vermont residents shall be eligible for
17 Green Mountain Care, regardless of whether an employer offers health
18 insurance for which they are eligible. The agency shall establish standards by
19 rule for proof and verification of residency.

20 (2)(A) Except as otherwise provided in subdivision (C) of this
21 subdivision (2), if an individual is determined to be eligible for Green

1 Mountain Care based on information later found to be false, the agency shall
2 make reasonable efforts to recover from the individual the amounts expended
3 for his or her care. In addition, if the individual knowingly provided the false
4 information, he or she shall be assessed an administrative penalty of not more
5 than \$5,000.00.

6 (B) The agency shall include information on the Green Mountain
7 Care application to provide notice to applicants of the penalty for knowingly
8 providing false information as established in subdivision (2)(A) of this
9 subsection.

10 (C) An individual determined to be eligible for Green Mountain Care
11 whose health services are paid in whole or in part by Medicaid funds who
12 commits fraud shall be subject to the provisions of chapter 1, subchapter V of
13 this title in lieu of the administrative penalty described in subdivision (A) of
14 this subdivision (2).

15 (3)(A) Except as otherwise provided in this section, a person who is not
16 a Vermont resident shall not be eligible for Green Mountain Care.

17 (B) Except as otherwise provided in subdivision (C) of this
18 subdivision (3), an individual covered under Green Mountain Care shall inform
19 the agency within 60 days of becoming a resident of another state.

20 An individual who obtains or attempts to obtain health services through Green
21 Mountain Care more than 60 days after becoming a resident of another state

1 shall reimburse the agency for the amounts expended for his or her care and
2 shall be assessed an administrative penalty of not more than \$1,000.00 for a
3 first violation and not more than \$2,000.00 for any subsequent violation.

4 (C) An individual whose health services are paid in whole or in part
5 by Medicaid funds who obtains or attempts to obtain health services through
6 Green Mountain Care more than 60 days after becoming a resident of another
7 state shall be subject to the provisions of chapter 1, subchapter V of this title in
8 lieu of the administrative penalty described in subdivision (B) of this
9 subdivision (3).

10 (b) The agency shall establish a procedure to enroll residents in Green
11 Mountain Care.

12 (c)(1) The agency shall establish by rule a process to allow health care
13 professionals to presume an individual is eligible based on the information
14 provided on a simplified application.

15 (2) After submission of the application, the agency shall collect
16 additional information as necessary to determine whether Medicaid, Medicare,
17 CHIP, or other federal funds may be applied toward the cost of the health
18 services provided, but shall provide payment for any health services received
19 by the individual from the time the application is submitted.

20 (3) If an individual presumed eligible for Green Mountain Care pursuant
21 to subdivision (1) of this subsection is later determined not to be eligible for

1 the program, the agency shall make reasonable efforts to recover from the
2 individual the amounts expended for his or her care.

3 (d) The agency shall adopt rules pursuant to 3 V.S.A. chapter 25 to ensure
4 that Vermont residents who are temporarily out of the state and who intend to
5 return and reside in Vermont remain eligible for Green Mountain Care while
6 outside Vermont. The agency shall consider imposing a supplemental
7 financial contribution requirement and, if such a requirement is to be imposed,
8 shall define the circumstances in which it will be applied.

9 (e) A nonresident visiting Vermont, or his or her insurer, shall be billed for
10 all services received. The agency may enter into intergovernmental
11 arrangements or contracts with other states and countries to provide reciprocal
12 coverage for temporary visitors and shall adopt rules pursuant to 3 V.S.A.
13 chapter 25 to carry out the purposes of this subsection.

14 § 1825. HEALTH BENEFITS

15 (a)(1) Green Mountain Care shall include primary care, preventive care,
16 chronic care, acute episodic care, and hospital services and shall include at
17 least the same covered services as those included in the benefit package in
18 effect for the lowest cost Catamount Health plan offered on January 1, 2011.

19 (2) It is the intent of the general assembly that Green Mountain Care
20 provide a level of coverage that includes benefits that are actuarially equivalent
21 to at least 87 percent of the full actuarial value of the covered health services.

1 (3) The Green Mountain Care board shall consider whether to impose
2 cost-sharing requirements; if so, whether to vary the cost-sharing requirements
3 based on an individual’s ability to pay; and the impact of any cost-sharing
4 requirements on an individual’s ability to access care. The board shall
5 consider waiving any cost-sharing requirement for chronic care for evidence-
6 based primary and preventive care; for palliative care; and for individuals
7 participating in chronic care management and, where circumstances warrant,
8 for individuals with chronic conditions who are not participating in a chronic
9 care management program.

10 (4)(A) The Green Mountain Care board established in 18 V.S.A. chapter
11 220 shall consider whether to include dental, vision, and hearing benefits in the
12 Green Mountain Care benefit package.

13 (B) The Green Mountain Care board shall consider whether to
14 include long-term care benefits in the Green Mountain Care benefit package.

15 (5) Green Mountain Care shall not limit coverage of preexisting
16 conditions.

17 (6) The Green Mountain Care board shall approve the benefit package
18 and present it to the general assembly as part of its recommendations for the
19 Green Mountain Care budget.

20 (b)(1)(A) For individuals eligible for Medicaid or CHIP, the benefit
21 package shall include the benefits required by federal law, as well as any

1 additional benefits provided as part of the Green Mountain Care benefit
2 package.

3 (B) Upon implementation of Green Mountain Care, the benefit
4 package for individuals eligible for Medicaid or CHIP shall also include any
5 optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services
6 covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc for
7 which these individuals are eligible on January 1, 2014. Beginning with the
8 second year of Green Mountain Care and going forward, the Green Mountain
9 Care board may, consistent with federal law, modify these optional benefits, as
10 long as at all times the benefit package for these individuals contains at least
11 the benefits described in subdivision (A) of this subdivision (b)(1).

12 (2) For children eligible for benefits paid for with Medicaid funds, the
13 benefit package shall include early and periodic screening, diagnosis, and
14 treatment services as defined under federal law.

15 (3) For individuals eligible for Medicare, the benefit package shall
16 include the benefits provided to these individuals under federal law, as well as
17 any additional benefits provided as part of the Green Mountain Care benefit
18 package.

19 § 1826. BLUEPRINT FOR HEALTH

20 (a) It is the intent of the general assembly that within five years following
21 the implementation of Green Mountain Care, each individual enrolled in Green

1 Mountain Care will have a primary health care professional who is involved
2 with the Blueprint for Health established in 18 V.S.A. chapter 13.

3 (b) Consistent with the provisions of 18 V.S.A. chapter 13, if an individual
4 enrolled in Green Mountain Care does not have a medical home through the
5 Blueprint for Health, the individual may choose a primary health care
6 professional who is not participating in the Blueprint to serve as the
7 individual's primary care point of contact.

8 (c) The agency shall determine a method to approve a specialist as a
9 patient's primary health care professional for the purposes of establishing a
10 medical home or primary care point of contact for the patient. The agency
11 shall approve a specialist as a patient's medical home or primary care point of
12 contact on a case-by-case basis and only for a patient who receives the
13 majority of his or her health care from that specialist.

14 (d) Green Mountain Care shall be integrated with the Blueprint for Health
15 established in 18 V.S.A. chapter 13.

16 § 1827. ADMINISTRATION; ENROLLMENT

17 (a)(1) The agency shall, under an open bidding process, solicit bids from
18 and award contracts to public or private entities for administration of certain
19 elements of Green Mountain Care, such as claims administration and provider
20 relations.

1 (2) The agency shall ensure that entities awarded contracts pursuant to
2 this subsection do not have a financial incentive to restrict individuals' access
3 to health services. The agency may establish performance measures that
4 provide incentives for contractors to provide timely, accurate, transparent, and
5 courteous services to individuals enrolled in Green Mountain Care and to
6 health care professionals.

7 (3) When considering contract bids pursuant to this subsection, the
8 agency shall consider the interests of the state relating to the economy, the
9 location of the entity, and the need to maintain and create jobs in Vermont.
10 The agency may utilize an econometric model to evaluate the net costs of each
11 contract bid.

12 (b) Nothing in this subchapter shall require an individual with health
13 coverage other than Green Mountain Care to terminate that coverage.

14 (c) An individual enrolled in Green Mountain Care may elect to maintain
15 supplemental health insurance if the individual so chooses.

16 (d) Except for cost-sharing, Vermonters shall not be billed any additional
17 amount for health services covered by Green Mountain Care.

18 (e) The agency shall seek permission from the Centers for Medicare and
19 Medicaid Services to be the administrator for the Medicare program in
20 Vermont. If the agency is unsuccessful in obtaining such permission, Green
21 Mountain Care shall be the secondary payer with respect to any health service

1 that may be covered in whole or in part by Title XVIII of the Social Security
2 Act (Medicare).

3 (f) Green Mountain Care shall be the secondary payer with respect to any
4 health service that may be covered in whole or in part by any other health
5 benefit plan, including private health insurance, retiree health benefits, or
6 federal health benefit plans offered by the Veterans' Administration, by the
7 military, or to federal employees.

8 (g) The agency may seek a waiver under Section 1115 of the Social
9 Security Act to include Medicaid and under Section 2107(e)(2)(A) of the
10 Social Security Act to include SCHIP in Green Mountain Care. If the agency
11 is unsuccessful in obtaining one or both of these waivers, Green Mountain
12 Care shall be the secondary payer with respect to any health service that may
13 be covered in whole or in part by Title XIX of the Social Security Act
14 (Medicaid) or Title XXI of the Social Security Act (CHIP), as applicable.

15 (h) Any prescription drug coverage offered by Green Mountain Care shall
16 be consistent with the standards and procedures applicable to the pharmacy
17 best practices and cost control program established in sections 1996 and 1998
18 of this title.

19 (i) Green Mountain Care shall maintain a robust and adequate network of
20 health care professionals located in Vermont or regularly serving Vermont
21 residents, including mental health and substance abuse professionals. The

1 agency shall contract with outside entities as needed to allow for the
2 appropriate portability of coverage under Green Mountain Care for Vermont
3 residents who are temporarily out of the state.

4 (j) The agency shall make available the necessary information, forms,
5 access to eligibility or enrollment systems, and billing procedures to health
6 care professionals to ensure immediate enrollment for individuals in Green
7 Mountain Care at the point of service or treatment.

8 (k) An individual aggrieved by an adverse decision of the agency or plan
9 administrator may appeal to the human services board as provided in 3 V.S.A.
10 § 3090.

11 (l) The agency, in collaboration with the department of banking, insurance,
12 securities, and health care administration, shall monitor the extent to which
13 residents of other states move to Vermont for the purpose of receiving health
14 services and the impact of any such migration on Vermont's health care system
15 and on the state's economy, and recommend to the general assembly strategies
16 to address any related problems the agency and or department identifies.

17 § 1828. BUDGET PROPOSAL

18 The Green Mountain Care board, in collaboration with the agencies of
19 administration and of human services, shall be responsible for developing each
20 year a three-year Green Mountain Care budget for proposal to the general
21 assembly and to the governor, to be adjusted annually in response to realized

1 revenues and expenditures, that reflects any modifications to the benefit
2 package and includes recommended appropriations, revenue estimates, and
3 necessary modifications to tax rates and other assessments.

4 § 1829. GREEN MOUNTAIN CARE FUND

5 (a) The Green Mountain Care fund is established in the state treasury as a
6 special fund to be the single source to finance health care coverage for Green
7 Mountain Care.

8 (b) Into the fund shall be deposited:

9 (1) transfers or appropriations from the general fund, authorized by the
10 general assembly;

11 (2) if authorized by a waiver from federal law, federal funds for
12 Medicaid, Medicare, and the Vermont health benefit exchange established in
13 chapter 18, subchapter 1 of this title; and

14 (3) the proceeds from grants, donations, contributions, taxes, and any
15 other sources of revenue as may be provided by statute or by rule.

16 (c) The fund shall be administered pursuant to 32 V.S.A. chapter 7,
17 subchapter 5, except that interest earned on the fund and any remaining
18 balance shall be retained in the fund. The agency shall maintain records
19 indicating the amount of money in the fund at any time.

20 (d) All monies received by or generated to the fund shall be used only for:

1 (1) the administration and delivery of health services covered by Green
2 Mountain Care as provided in this subchapter; and

3 (2) expenses related to the duties and operation of the Green Mountain
4 Care board pursuant to 18 V.S.A. chapter 220.

5 § 1830. COLLECTIVE BARGAINING RIGHTS

6 Nothing in this subchapter shall be construed to limit the ability of
7 collective bargaining units to negotiate for coverage of health services pursuant
8 to 3 V.S.A. § 904 or any other provision of law.

9 § 1831. PUBLIC PROCESS

10 The agency of human services shall provide a process for soliciting public
11 input on the Green Mountain Care benefit package on an ongoing basis,
12 including a mechanism by which members of the public may request inclusion
13 of particular benefits or services. The process may include receiving written
14 comments on proposed new or amended rules or holding public hearings or
15 both.

16 Sec. 4a. HOUSEHOLD HEALTH INSURANCE SURVEY

17 The department of banking, insurance, securities, and health care
18 administration shall include questions on its household health insurance survey
19 that enable the department to determine the extent to which residents of other
20 states move to Vermont for the purpose of receiving health services. The

1 department shall provide its findings to the agency of human services to enable
2 the agency to monitor migration into the state as required in 33 V.S.A. § 1827.

3 Sec. 4b. EXCHANGE IMPLEMENTATION

4 (a) The commissioner of Vermont health access shall contract with at least
5 two health insurers to provide qualified health benefit plans, in addition to the
6 multistate plans required by the Affordable Care Act, in the Vermont health
7 benefit exchange in 2014; provided that the commissioner shall not be required
8 to solicit participation by insurers outside the state in order to contract with two
9 insurers.

10 (b) Nothing in this section shall be construed to require the commissioner
11 to contract with a health insurer to provide a plan that does not meet the
12 requirements specified in 33 V.S.A. chapter 18, subchapter 1.

13 Sec. 5. 33 V.S.A. § 401 is amended to read:

14 § 401. COMPOSITION OF DEPARTMENT

15 The department of Vermont health access, created under 3 V.S.A. § 3088,
16 shall consist of the commissioner of Vermont health access, the medical
17 director, a health care eligibility unit; and all divisions within the department,
18 including the divisions of managed care; health care reform; the Vermont
19 health benefit exchange; and Medicaid policy, fiscal, and support services.

20 Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY UNIT

1 After March 15, 2012 but not later than July 1, 2013, the secretary of
2 administration shall transfer to and place under the supervision of the
3 commissioner of Vermont health access all employees, professional and
4 support staff, consultants, positions, and all balances of all appropriation
5 amounts for personal services and operating expenses for the administration of
6 health care eligibility currently contained in the department for children and
7 families. No later than January 15, 2012, the secretary shall provide to the
8 house committees on health care and on human services and the senate
9 committee on health and welfare a plan for transferring the positions and
10 funds.

11 * * * Consumer and Health Care Professional Advisory Committee * * *

12 Sec. 7. 33 V.S.A. § 402 is added to read:

13 § 402. MEDICAID AND EXCHANGE ADVISORY COMMITTEE

14 (a) A Medicaid and exchange advisory committee is created for the purpose
15 of advising the commissioner of Vermont health access with respect to policy
16 development and program administration for the Vermont health benefit
17 exchange, Medicaid, and Medicaid-funded programs, consistent with the
18 requirements of federal law.

19 (b)(1) The commissioner shall appoint members of the advisory committee
20 established by this section, who shall serve staggered three-year terms. The
21 total membership of the advisory committee shall be 23 members. The

1 commissioner may remove members of the committee who fail to attend three
2 consecutive meetings and may appoint replacements.

3 (2)(A) The commissioner shall appoint up to three representatives of
4 health insurers licensed to do business in Vermont to serve on the advisory
5 committee.

6 (B) Of the remaining members of the advisory committee, one-
7 quarter of the members shall be from each of the following constituencies:

8 (i) beneficiaries of Medicaid or Medicaid-funded programs.

9 (ii) individuals, self-employed individuals, and representatives of
10 small businesses eligible for or enrolled in the Vermont health benefit
11 exchange.

12 (iii) advocates for consumer organizations.

13 (iv) health care professionals and representatives from a broad
14 range of health care professionals.

15 (3) Members whose participation is not supported through their
16 employment or association shall receive per diem compensation and
17 reimbursement of expenses pursuant to 32 V.S.A. § 1010, including costs of
18 travel, child care, personal assistance services, and any other service necessary
19 for participation in the advisory group and approved by the commissioner.

20 (c)(1) The advisory committee shall have an opportunity to review and
21 comment on agency policy initiatives pertaining to quality improvement

1 initiatives and to health care benefits and eligibility for individuals receiving
2 services through Medicaid, programs funded with Medicaid funds under a
3 Section 1115 waiver, or the Vermont health benefit exchange. It also shall
4 have the opportunity to comment on proposed rules prior to commencement of
5 the rulemaking process pursuant to 3 V.S.A. chapter 25 and on waiver or
6 waiver amendment applications prior to submission to the Centers for
7 Medicare and Medicaid Services.

8 (2) Prior to the annual budget development process, the department of
9 Vermont health access shall engage the advisory committee in setting
10 priorities, including consideration of scope of benefits, beneficiary eligibility,
11 health care professional reimbursement rates, funding outlook, financing
12 options, and possible budget recommendations.

13 (d)(1) The advisory committee shall make policy recommendations on
14 proposals of the department of Vermont health access to the department, the
15 Green Mountain Care board, the health access oversight committee, the senate
16 committee on health and welfare, and the house committees on health care and
17 on human services. When the general assembly is not in session, the
18 commissioner shall respond in writing to these recommendations, a copy of
19 which shall be provided to the members of each of the legislative committees
20 of jurisdiction and to the Green Mountain Care board.

1 (2) During the legislative session, the commissioner shall provide the
2 advisory committee at regularly scheduled meetings with updates on the status
3 of policy and budget proposals.

4 (e) The commissioner shall convene the advisory committee at least 10
5 times during each calendar year. If at least one-third of the members of the
6 advisory committee so choose, the members may convene up to four additional
7 meetings per calendar year on their own initiative by sending a request to the
8 commissioner. The department shall provide the committee with staffing and
9 independent technical assistance as needed to enable it to make effective
10 recommendations.

11 Sec. 8. INTEGRATION PLAN

12 (a) No later than January 15, 2012, the secretary of administration or
13 designee shall make recommendations to the house committee on health care
14 and the senate committee on health and welfare on the following issues:

15 (1) How to fully integrate or align Medicaid, Medicare, private
16 insurance, associations, state employees, and municipal employees into or with
17 the Vermont health benefit exchange and Green Mountain Care established in
18 chapter 18 of Title 33, including:

19 (A) Whether it is advisable to establish a basic health program for
20 individuals with incomes above 133 percent of the federal poverty level (FPL)
21 and at or below 200 percent of FPL pursuant to Section 1331 of the Patient

1 Protection and Affordable Care Act (Public Law 111-148), as amended by the
2 federal Health Care and Education Reconciliation Act of 2010 (Public Law
3 111-152), and as further amended (“Affordable Care Act”), to ensure that the
4 health coverage is comprehensive and affordable for this population.

5 (B)(i) The statutory changes necessary to integrate the private
6 insurance markets with the Vermont health benefit exchange, including
7 whether to impose a moratorium on the issuance of new association policies
8 prior to 2014, as well as whether to continue exemptions for associations
9 pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health
10 benefit exchange and if so, what criteria to use.

11 (ii) The advantages and disadvantages for the state, for employers,
12 and for employees, of defining a small employer for purposes of the Vermont
13 health benefit exchange for the period from January 1, 2014 through December
14 31, 2015 as an employer with up to 50 employees or as an employer with up to
15 100 employees, including an analysis of the impacts of the definition on
16 teachers, municipal employees, and associations. For purposes of the analysis
17 pursuant to this subdivision, “employer” means all for-profit entities, not-for
18 profit entities, and individuals who are self-employed.

19 (C) In consultation with the chair of the Green Mountain Care board,
20 the design of a common benefit package for the Vermont health benefit
21 exchange. When creating the common benefit package, the secretary shall

1 compare the essential benefits package defined under federal regulations
2 implementing the Affordable Care Act with Vermont’s insurance mandates,
3 consider the affordability of cost-sharing both with and without the
4 cost-sharing subsidy provided under federal regulations implementing the
5 Affordable Care Act, and determine the feasibility and appropriate design of
6 cost-sharing amounts for evidence-based health services with proven
7 effectiveness.

8 (D) The impact of the availability of supplemental insurance plans on
9 offerings in the small and individual group markets.

10 (E) The potential for purchasing prescription drugs in Green
11 Mountain Care through Medicaid, the 340B drug pricing program, or another
12 bulk purchasing mechanism.

13 (2) Once Green Mountain Care is implemented, whether to allow
14 employers and individuals to purchase coverage for supplemental health
15 services from Green Mountain Care or to allow private insurers to provide
16 supplemental insurance plans.

17 (3) How to collect data to enable the Green Mountain Care board to
18 monitor the extent to which residents of other states move to Vermont for the
19 purpose of receiving health services and the impact of such migration on the
20 Vermont’s health care system and the state’s economy.

1 (4) How to enable parents to make coverage under Green Mountain
2 Care available to an adult child up to age 26 who would not otherwise be
3 eligible for coverage under the program, including a recommendation on the
4 amount of and mechanism for collecting a financial contribution for such
5 coverage and information on the difference in costs to the system between
6 allowing all adult children up to age 26 to be eligible and limiting eligibility to
7 adult children attending a college or university.

8 (5) whether it is necessary or advisable to implement a financial reserve
9 requirement or reinsurance mechanism to reduce the state's exposure to
10 financial risk in the operation of Green Mountain Care; if so, how to
11 accomplish such implementation; and the impact, if any, on the state's bond
12 rating.

13 (b) The commissioner of labor, in consultation with the commissioner of
14 Vermont health access, the commissioner of banking, insurance, securities, and
15 health care administration, and interested stakeholders, shall evaluate the
16 feasibility of integrating or aligning Vermont's workers' compensation system
17 with Green Mountain Care, including providing any covered services in
18 addition to those in the Green Mountain Care benefit package that may be
19 appropriate for injuries arising out of and in the course of employment. No
20 later than January 15, 2012, the commissioner of labor shall report the results

1 of the evaluation and, if integration or alignment has been found to be feasible,
2 make recommendations on how to achieve it.

3 Sec. 9. FINANCING PLANS

4 (a) The secretary of administration or designee shall recommend two
5 financing plans to the house committees on health care and on ways and means
6 and the senate committees on health and welfare and on finance no later than
7 January 15, 2013.

8 (1) One plan shall recommend the amounts and necessary mechanisms
9 to finance any initiatives which must be implemented by January 1, 2014 in
10 order to provide coverage to all Vermonters in the absence of a waiver from
11 certain federal health care reform provisions established in Section 1332 of the
12 Patient Protection and Affordable Care Act (Public Law 111-148), as amended
13 by the federal Health Care and Education Reconciliation Act of 2010 (Public
14 Law 111-152), and as further amended (“Affordable Care Act”).

15 (2) The second plan shall recommend the amounts and necessary
16 mechanisms to finance Green Mountain Care and any systems improvements
17 needed to achieve a public-private universal health care system. The secretary
18 shall recommend whether nonresidents employed by Vermont businesses
19 should be eligible for Green Mountain Care and solutions to other cross-border
20 issues.

1 (b) In developing both financing plans, the secretary shall consider the
2 following:

3 (1) all financing sources, including adjustments to the income tax, a
4 payroll tax, consumption taxes, provider assessments required under 33 V.S.A.
5 chapter 19, the employer assessment required by 21 V.S.A. chapter 25, other
6 new or existing taxes, and additional options as determined by the secretary;

7 (2) the impacts of the various financing sources, including levels of
8 deductibility of any tax or assessment system contemplated and consistency
9 with the principles of equity expressed in 18 V.S.A. § 9371;

10 (3) issues involving federal law and taxation;

11 (4) impacts of tax system changes:

12 (A) on individuals, households, businesses, public sector entities, and
13 the nonprofit community, including the circumstances under which a particular
14 tax change may result in double payments, such as premiums and tax
15 obligations; and

16 (B) over time, on changing revenue needs;

17 (5) growth in health care spending relative to needs and capacity to pay;

18 (6) anticipated federal funds that may be used for health services and
19 how to maximize the amount of federal funding available for this purpose;

20 (7) the amounts required to maintain existing state insurance benefit
21 requirements and other appropriate considerations in order to determine the

1 state contribution toward federal premium tax credits available in the Vermont
2 health benefit exchange pursuant to the Affordable Care Act;

3 (8) additional funds needed to support recruitment and retention
4 programs for high-quality health care professionals in order to address the
5 shortage of primary care professionals and other specialty care professionals in
6 this state;

7 (9) additional funds needed to provide coverage for the uninsured who
8 are eligible for Medicaid, Dr. Dynasaur, and the Vermont health benefit
9 exchange in 2014;

10 (10) funding mechanisms to ensure that operations of both the Vermont
11 health benefit exchange and Green Mountain Care are self-sustaining;

12 (11) how to maximize the flow of federal funds to the state for
13 individuals eligible for Medicare;

14 (12) the use of financial or other incentives to encourage healthy
15 lifestyles and patient self-management for individuals enrolled in Green
16 Mountain Care;

17 (13) preserving retirement health benefits while enabling retirees to
18 participate in Green Mountain Care;

19 (14) the implications of Green Mountain Care on funds set aside to pay
20 for future retiree health benefits; and

1 (15) changes in federal health funding through reduced payments to
2 health care professionals or through limitations or restrictions on the
3 availability of grant funding or federal matching funds available to states
4 through the Medicaid program.

5 (c) In developing the financing plan for Green Mountain Care, the secretary
6 of administration or designee shall consult with interested stakeholders,
7 including health care professionals, employers, and members of the public, to
8 determine the potential impact of various financing sources on Vermont
9 businesses and on the state's economy and economic climate. No later than
10 February 1, 2012, the secretary or designee shall report his or her findings and
11 recommendations on the impact on businesses and the economy to the house
12 committees on health care and on commerce and to the senate committees on
13 health and welfare and on economic development, housing and general affairs.

14 (d) In addition to the consultation required by subsection (c) of this section,
15 in developing the financing plan for Green Mountain Care, the secretary of
16 administration or designee shall solicit input from interested stakeholders,
17 including health care professionals, employers, and members of the public and
18 shall provide opportunities for public engagement in the design of the
19 financing plan.

1 Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

2 (a) The secretary of administration or designee, in consultation with the
3 Green Mountain Care board and the commissioner of Vermont health access,
4 shall review the health information technology plan required by 18 V.S.A.
5 § 9351 to ensure that the plan reflects the creation of the Vermont health
6 benefit exchange; the transition to a public-private universal health care system
7 pursuant to 33 V.S.A. chapter 18, subchapter 2; and any necessary
8 development or modifications to public health information technology and data
9 and to public health surveillance systems, to ensure that there is progress
10 toward full implementation.

11 (b) In conducting this review, the secretary of administration may issue
12 a request for proposals for an independent design and implementation plan
13 which would describe how to integrate existing health information systems to
14 carry out the purposes of this act, detail how to develop the necessary capacity
15 in health information systems, determine the funding needed for such
16 development, and quantify the funding sources available for such development.
17 The health information technology plan or design and implementation plan
18 shall also include a review of the multi-payer database established in 18 V.S.A.
19 § 9410 to determine whether there are systems modifications needed to use the
20 database to reduce fraud, waste, and abuse; and shall include other systems
21 analysis as specified by the secretary.

1 (B) recommending a plan to institute a public health impact
2 assessment process to ensure appropriate consideration of the impacts on
3 public health resulting from major policy or planning decisions made by
4 municipalities, local entities, and state agencies.

5 (3) In collaboration with the director of the Blueprint for Health
6 established in 18 V.S.A. chapter 13 and health care professionals, how to
7 coordinate quality assurance efforts across state government and private
8 payers; optimize quality assurance programs; and ensure that health care
9 professionals in Vermont utilize, are informed of, and engage in
10 evidence-based practice, using standards and algorithms such as those
11 developed by the National Committee for Quality Assurance.

12 (4) Providing a progress report on payment reform planning and other
13 activities authorized in 18 V.S.A. chapter 220.

14 (5) How to reorganize and consolidate health care-related functions in
15 agencies and departments across state government in order to ensure integrated
16 and efficient administration of all of Vermont's health care programs and
17 initiatives.

18 (b) No later than January 15, 2012, the commissioner of banking,
19 insurance, securities, and health care administration shall review the hospital
20 budget review process provided in 18 V.S.A. chapter 221, subchapter 7, and
21 the certificate of need process provided in 18 V.S.A. chapter 221, subchapter 5

1 and recommend to the house committee on health care and the senate
2 committee on health and welfare statutory modifications needed to enable the
3 participation of the Green Mountain Care board as set forth in 18 V.S.A.
4 § 9375.

5 Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

6 No later than March 15, 2012, the Green Mountain Care board established
7 in 18 V.S.A. chapter 220, in consultation with the commissioner of banking,
8 insurance, securities, and health care administration and the commissioner of
9 Vermont health access, shall recommend to the house committee on health
10 care and the senate committee on health and welfare any necessary
11 modifications to the regulatory processes for health care professionals and
12 managed care organizations in order to align these processes with the payment
13 reform strategic plan.

14 § 1831. HEALTH CARE WORKFORCE; STRATEGIC PLAN

15 (a) The director of health care reform in the agency of administration shall
16 oversee the development and maintenance of a current health care workforce
17 development strategic plan that continues efforts to ensure that Vermont has
18 the health care workforce necessary to provide care to all Vermont residents.
19 The director of health care reform may designate an entity responsible for
20 convening meetings and for drafting the strategic plan.

1 (b) The director or designee shall collaborate with the area health education
2 centers, the workforce development council established in 10 V.S.A. § 541, the
3 prekindergarten-16 council established in 16 V.S.A. § 2905, the department of
4 labor, the department of health, the department of Vermont health access and
5 other interested parties, to develop and maintain the plan. The director of
6 health care reform shall ensure that the strategic plan includes
7 recommendations on how to develop Vermont’s health care workforce,
8 including:

9 (1) the current capacity and capacity issues of the health care workforce
10 and delivery system in Vermont, including the shortages of health care
11 professionals, specialty practice areas that regularly face shortages of qualified
12 health care professionals, issues with geographic access to services, and unmet
13 health care needs of Vermonters.

14 (2) the resources needed to ensure that the health care workforce and the
15 delivery system are able to provide sufficient access to services given
16 demographic factors in the population and in the workforce as well as other
17 factors, and able to participate fully in health care reform initiatives, including
18 how to ensure that all Vermont residents have a medical home through the
19 Blueprint for Health pursuant to 18 V.S.A. chapter 13 and how to transition to
20 electronic medical records; and

1 (3) how state government, universities and colleges, the state's
2 educational system, entities providing education and training programs related
3 to the health care workforce, and others may develop the resources in the
4 health care workforce and delivery system to educate, recruit, and retain health
5 care professionals to achieve Vermont's health care reform principles and
6 purposes.

7 (4) review data on the extent to which individual health care
8 professionals begin and cease to practice in their applicable fields in Vermont.

9 (5) identify factors which either hinder or assist in recruitment or
10 retention of health care professionals, including an examination of the
11 processes for prior authorizations, and make recommendations for further
12 improving recruitment and retention efforts.

13 (6) assess the availability of state and federal funds for health care
14 workforce development.

15 (c) Beginning January 15, 2013, the director or designee shall provide the
16 strategic plan to the general assembly and shall provide periodic updates as
17 necessary.

18 Sec. 13. WORKFORCE ISSUES

19 (a)(1) Currently, Vermont has a shortage of primary care professionals, and
20 many practices are closed to new patients. It also experiences periodic and
21 geographic shortages of specialty care professionals necessary to ensure that

1 Vermonters have reasonable access to a broad range of health services within
2 the state. In order to ensure sufficient patient access now and in the future, it is
3 necessary to plan for the implementation of Green Mountain Care and utilize
4 Vermont's health care professionals to the fullest extent of their professional
5 competence.

6 (2) The board of nursing, the board of medical practice, and the office of
7 professional regulation shall collaborate to determine how to optimize the
8 primary care workforce by reviewing the licensure process, scope of practice
9 requirements, reciprocity of licensure, and efficiency of the licensing process,
10 and by identifying any other barriers to augmenting Vermont's primary care
11 workforce. No later than January 15, 2012, the boards and office shall provide
12 to the house committee on health care and the senate committee on health and
13 welfare joint recommendations for improving the primary care workforce
14 through the boards' and office's rules and procedures, including specific
15 recommendations to modify scopes of practice to enable health care
16 professionals to perform to the fullest extent of their professional competence.

17 (c) The director of health care reform or designee, in collaboration with the
18 department of labor, and the agency of human services, the prekindergarten-16
19 council established in 16 V.S.A. § 2905, the workforce development council,
20 and other interested parties, shall create a plan to address the retraining needs
21 of employees who may become dislocated due to a reduction in health care

1 administrative functions when the Vermont health benefit exchange and Green
2 Mountain Care are implemented. The plan shall include consideration of new
3 training programs and scholarships or other financial assistance necessary to
4 ensure adequate resources for training programs and to ensure that employees
5 have access to these programs. The department and agency shall provide
6 information to employers whose workforce may be reduced in order to ensure
7 that the employees are informed of available training opportunities. The
8 department shall provide the plan to the house committee on health care and
9 the senate committee on health and welfare no later than January 15, 2012.

10 Sec. 13a. PRIOR AUTHORIZATIONS

11 The Green Mountain Care board shall consider:

12 (1) compensating health care providers for the completion of requests
13 for prior authorization; and

14 (2) exempting from any prior authorization requirements in Green
15 Mountain Care those health care professionals whose prior authorization
16 requests are routinely granted.

17 * * * Cost Estimates * * *

18 Sec. 14. COST ESTIMATES

19 (a) No later than April 21, 2011, the legislative joint fiscal office and the
20 department of banking, insurance, securities, and health care administration
21 shall provide to the house committee on health care and the senate committee

1 on health and welfare an initial, draft estimate of the costs of Vermont's
2 current health care system compared to the costs of a reformed health care
3 system upon implementation of Green Mountain Care and the additional
4 provisions of this act. To the extent possible, the estimates shall be based on
5 the department of banking, insurance, securities, and health care
6 administration's expenditure report and additional data available in the
7 multi-payer database established in 18 V.S.A. § 9410.

8 (b) The legislative joint fiscal office and the department of banking,
9 insurance, securities, and health care administration shall report their final
10 estimates of the costs described in subsection (a) of this section to the
11 committees of jurisdiction no later than November 1, 2011.

12 * * * Rate Review * * *

13 Sec. 15. 8 V.S.A. § 4062 is amended to read:

14 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

15 (a)(1) No policy of health insurance or certificate under a policy not
16 exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for
17 delivery in this state nor shall any endorsement, rider, or application which
18 becomes a part of any such policy be used, until a copy of the form, premium
19 rates, and rules for the classification of risks pertaining thereto have been filed
20 with the commissioner of banking, insurance, securities, and health care
21 administration; nor shall any such form, premium rate, or rule be so used until

1 the expiration of 30 days after having been filed, or in the case of a request for
2 a rate increase, until a decision by the Green Mountain Care board as provided
3 herein, unless the commissioner shall sooner give his or her written approval
4 thereto. Beginning July 1, 2013, prior to approving a rate increase, the
5 commissioner shall seek approval for such rate increase from the Green
6 Mountain Care board established in 18 V.S.A. chapter 220, which shall
7 approve or disapprove the rate increase within 10 business days. The
8 commissioner shall apply the decision of the Green Mountain Care board as to
9 rates referred to the board.

10 (2) The commissioner shall review policies and rates to determine
11 whether a policy or rate is affordable, promotes quality care, promotes access
12 to health care, and is not unjust, unfair, inequitable, misleading, or contrary to
13 the laws of this state. The commissioner shall notify in writing the insurer
14 which has filed any such form, premium rate, or rule if it contains any
15 provision which is ~~unjust, unfair, inequitable, misleading, or contrary to the~~
16 ~~law of this state~~ does not meet the standards expressed in this section. In such
17 notice, the commissioner shall state that a hearing will be granted within 20
18 days upon written request of the insurer. ~~In all other cases, the commissioner~~
19 ~~shall give his or her approval.~~

20 (3) ~~After the expiration of such 30 days from the filing of any such~~
21 ~~form, premium rate or rule,~~ the review period provided herein or at any time

1 after having given written approval, the commissioner may, after a hearing of
2 which at least 20 ~~days~~ days' written notice has been given to the insurer using
3 such form, premium rate, or rule, withdraw approval on any of the grounds
4 stated in this section. Such disapproval shall be effected by written order of
5 the commissioner which shall state the ground for disapproval and the date, not
6 less than 30 days after such hearing when the withdrawal of approval shall
7 become effective.

8 (b) In conjunction with a rate filing required by subsection (a) of this
9 section, an insurer shall file a plain language summary of any requested rate
10 increase of five percent or greater. If, during the plan year, the insurer files for
11 rate increases that are cumulatively five percent or greater, the insurer shall file
12 a summary applicable to the cumulative rate increase. All summaries shall
13 include a brief justification of any rate increase requested, the information that
14 the Secretary of the U.S. Department of Health and Human Services (HHS)
15 requires for rate increases over 10 percent, and any other information required
16 by the commissioner. The plain language summary shall be in the format
17 required by the Secretary of HHS pursuant to the Patient Protection and
18 Affordable Care Act of 2010, Public Law 111-148, as amended by the Health
19 Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall
20 include notification of the public comment period established in subsection (c)
21 of this section. In addition, the insurer shall post the summaries on its website.

1 (c)(1) The commissioner shall provide information to the public on the
2 department's website about the public availability of the filings and summaries
3 required under this section.

4 (2) Beginning no later than January 1, 2012, the commissioner shall post
5 the filings pursuant to subsection (a) of this section and summaries pursuant to
6 subsection (b) of this section on the department's website within five days of
7 filing. The department shall provide an electronic mechanism for the public to
8 comment on proposed rate increases over five percent. The public shall have
9 21 days from the posting of the summaries and filings to provide public
10 comment. The department shall review and consider the public comments
11 prior to the expiration of the review period pursuant to subsection (a) of this
12 section. The department shall provide the Green Mountain Care board with the
13 public comments for their consideration in approving any rate increases.

14 Sec. 15a. 8 V.S.A. § 4512(b) is amended to read:

15 (b) Subject to the approval of the commissioner, a hospital service
16 corporation may establish, maintain and operate a medical service plan as
17 defined in section 4583 of this title. The commissioner may refuse approval if
18 the commissioner finds that the rates submitted are excessive, inadequate, or
19 unfairly discriminatory or fail to meet the standards of affordability, promotion
20 of quality care, and promotion of access pursuant to section 4062 of this title.

21 The contracts of a hospital service corporation which operates a medical

1 service plan under this subsection shall be governed by chapter 125 of this title
2 to the extent that they provide for medical service benefits, and by this chapter
3 to the extent that the contracts provide for hospital service benefits.

4 Sec. 15b. 8 V.S.A. § 4515a is amended to read:

5 § 4515a. FORM AND RATE FILING; FILING FEES

6 Every contract or certificate form, or amendment thereof, including the rates
7 charged therefor by the corporation shall be filed with the commissioner for his
8 or her approval prior to issuance or use. Prior to approval, there shall be a
9 public comment period pursuant to section 4062 of this title. In addition, each
10 such filing shall be accompanied by payment to the commissioner of a
11 nonrefundable fee of \$50.00 and the plain language summary of rate increases
12 pursuant to section 4062 of this title.

13 Sec. 15c. 8 V.S.A. § 4587 is amended to read:

14 § 4587. FILING AND APPROVAL OF CONTRACTS

15 A medical service corporation which has received a permit from the
16 commissioner of banking, insurance, securities, and health care administration
17 under section 4584 of this title shall not thereafter issue a contract to a
18 subscriber or charge a rate therefor which is different from copies of contracts
19 and rates originally filed with such commissioner and approved by him or her
20 at the time of the issuance to such medical service corporation of its permit,
21 until it has filed copies of such contracts which it proposes to issue and the

1 rates it proposes to charge therefor and the same have been approved by such
2 commissioner. Prior to approval, there shall be a public comment period
3 pursuant to section 4062 of this title. Each such filing of a contract or the rate
4 therefor shall be accompanied by payment to the commissioner of a
5 nonrefundable fee of \$50.00. A medical service corporation shall file a plain
6 language summary of rate increases pursuant to section 4062 of this title.

7 Sec. 15d. 8 V.S.A. § 5104(a) is amended to read:

8 (a)(1) A health maintenance organization which has received a certificate
9 of authority under section 5102 of this title shall file and obtain approval of all
10 policy forms and rates as provided in sections 4062 and 4062a of this title.
11 This requirement shall include the filing of administrative retentions for any
12 business in which the organization acts as a third party administrator or in any
13 other administrative processing capacity. The commissioner may request and
14 shall receive any information that is needed to determine whether to approve
15 the policy form or rate. In addition to any other information requested, the
16 commissioner shall require the filing of information on costs for providing
17 services to the organization's Vermont members affected by the policy form or
18 rate, including but not limited to Vermont claims experience, and
19 administrative and overhead costs allocated to the service of Vermont
20 members. Prior to approval, there shall be a public comment period pursuant

1 to section 4062 of this title. A health maintenance organization shall file a
2 summary of rate filings pursuant to section 4062 of this title.

3 (2) The commissioner shall refuse to approve the form of evidence of
4 coverage, filing or rate if it contains any provision which is unjust, unfair,
5 inequitable, misleading or contrary to the law of the state or plan of operation,
6 or if the rates are excessive, inadequate or unfairly discriminatory, or fail to
7 meet the standards of affordability, promotion of quality care, and promotion
8 of access pursuant to section 4062 of this title. No evidence of coverage shall
9 be offered to any potential member unless the person making the offer has first
10 been licensed as an insurance agent in accordance with chapter 131 of this title.

11 * * * Health Benefit Information * * *

12 Sec. 16. 21 V.S.A. § 2004 is added to read:

13 § 2004. HEALTH BENEFIT COSTS

14 (a) Employers shall provide their employees with an annual statement
15 indicating:

16 (1) the total monthly premium cost paid for any employer-sponsored
17 health benefit plan;

18 (2) the employer's share and the employee's share of the total monthly
19 premium; and

20 (3) any amount the employer contributes toward the employee's
21 cost-sharing requirement or other out-of-pocket expenses.

1 welfare on the advantages and disadvantages of Vermont adopting the NAIC
2 model act.

3 * * * Single Formulary * * *

4 Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

5 No later than January 15, 2012, the department of Vermont health access,
6 after consultation with health insurers, third-party administrators, and the drug
7 utilization and review board, shall provide recommendations to the house
8 committee on health care and the senate committee on health and welfare
9 regarding:

10 (1) A single prescription drug formulary to be used by all payers of
11 health services which allows for some variations for Medicaid due to the
12 availability of rebates and discounts and which allows health care professionals
13 prescribing drugs purchased pursuant to Section 340B of the Public Health
14 Service Act to use the 340B formulary. The recommendations shall address
15 the feasibility of requesting a waiver from Medicare Part D in order to ensure
16 Medicare participation in the formulary, as well as the feasibility of enabling
17 all prescription drugs purchased by or on behalf of Vermont residents to be
18 purchased through the Medicaid program or pursuant to the 340B drug pricing
19 program.

1 (2) A single mechanism for negotiating rebates and discounts across
2 payers using a single formulary, and the advantages and disadvantages of using
3 a single formulary to achieve uniformity of coverage.

4 (3) A uniform set of drug management rules aligned with Medicare to
5 the extent possible, to minimize administrative burdens and promote
6 uniformity of benefit management. The standards for pharmacy benefit
7 management shall address timely decisions, access to clinical peers, access to
8 evidence-based rationales, exemption processes, and tracking and reporting
9 data on prescriber satisfaction.

10 * * * Repeal of Public Oversight Commission * * *

11 Sec. 19. 18 V.S.A. § 9402 is amended to read:

12 § 9402. DEFINITIONS

13 As used in this chapter, unless otherwise indicated:

14 * * *

15 (15) ~~“Public oversight commission” means the commission established~~
16 ~~in section 9407 of this title.~~

17 (16) “Unified health care budget” means the budget established in
18 accordance with section 9406 of this title.

19 (17)(16) “State health plan” means the plan developed under section
20 9405 of this title.

1 Sec. 20. 18 V.S.A. § 9405 is amended to read:

2 § 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION
3 PLAN

4 * * *

5 (b) On or before July 1, 2005, the commissioner, in consultation with the
6 secretary of human services, shall submit to the governor a four-year health
7 resource allocation plan. The plan shall identify Vermont needs in health care
8 services, programs, and facilities; the resources available to meet those needs;
9 and the priorities for addressing those needs on a statewide basis.

10 * * *

11 (2) In the preparation of the plan, the commissioner shall assemble an
12 advisory committee of no fewer than nine nor more than 13 members who
13 shall reflect a broad distribution of diverse perspectives on the health care
14 system, including health care professionals, payers, third-party payers, and
15 consumer representatives, ~~and up to three members of the public oversight~~
16 ~~commission~~. The advisory committee shall review drafts and provide
17 recommendations to the commissioner during the development of the plan.
18 Upon adoption of the plan, the advisory committee shall be dissolved.

19 (3) The commissioner, with the advisory committee, shall conduct at
20 least five public hearings, in different regions of the state, on the plan as
21 proposed and shall give interested persons an opportunity to submit their views

1 orally and in writing. To the extent possible, the commissioner shall arrange
2 for hearings to be broadcast on interactive television. Not less than 30 days
3 prior to any such hearing, the commissioner shall publish in the manner
4 prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place
5 and period during which to direct written comments to the commissioner. In
6 addition, the commissioner may create and maintain a website to allow
7 members of the public to submit comments electronically and review
8 comments submitted by others.

9 (4) The commissioner shall develop a mechanism for receiving ongoing
10 public comment regarding the plan and for revising it every four years or as
11 needed. ~~The public oversight commission shall recommend revisions to the~~
12 ~~plan at least every four years and at any other time it determines revisions are~~
13 ~~warranted.~~

14 * * *

15 Sec. 21. 18 V.S.A. § 9405a is amended to read:

16 § 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

17 Each hospital shall have a protocol for meaningful public participation in its
18 strategic planning process for identifying and addressing health care needs that
19 the hospital provides or could provide in its service area. Needs identified
20 through the process shall be integrated with the hospital's long-term planning
21 ~~and shall be described as a component of its four-year capital expenditure~~

1 ~~projections provided to the public oversight commission under subdivision~~
2 ~~9407(b)(2) of this title.~~ The process shall be updated as necessary to continue
3 to be consistent with such planning and capital expenditure projections, and
4 identified needs shall be summarized in the hospital's community report.

5 Sec. 22. 18 V.S.A. § 9405b is amended to read:

6 § 9405b. HOSPITAL COMMUNITY REPORTS

7 (a) The commissioner, in consultation with representatives from ~~the public~~
8 ~~oversight commission,~~ hospitals, other groups of health care professionals, and
9 members of the public representing patient interests, shall adopt rules
10 establishing a standard format for community reports, as well as the contents,
11 which shall include:

12 * * *

13 (c) The community reports shall be provided to the ~~public oversight~~
14 ~~commission and the~~ commissioner. The commissioner shall publish the
15 reports on a public website and shall develop and include a format for
16 comparisons of hospitals within the same categories of quality and financial
17 indicators.

18 Sec. 23. 18 V.S.A. § 9433(c) is amended to read:

19 (c) The commissioner shall consult with hospitals, nursing homes and
20 professional associations and societies, ~~the public oversight commission,~~ the

1 secretary of human services, and other interested parties in matters of policy
2 affecting the administration of this subchapter.

3 Sec. 24. 18 V.S.A. § 9440 is amended to read:

4 § 9440. PROCEDURES

5 * * *

6 (c) The application process shall be as follows:

7 * * *

8 (4) Within 90 days of receipt of an application, the commissioner shall
9 notify the applicant that the application contains all necessary information
10 required and is complete, or that the application review period is complete
11 notwithstanding the absence of necessary information. The commissioner may
12 extend the 90-day application review period for an additional 60 days, or for a
13 period of time in excess of 150 days with the consent of the applicant. The
14 time during which the applicant is responding to the commissioner's notice
15 that additional information is required shall not be included within the
16 maximum review period permitted under this subsection. The ~~public oversight~~
17 ~~commission may recommend, or the~~ commissioner may determine that the
18 certificate of need application shall be denied if the applicant has failed to
19 provide all necessary information required to review the application.

20 * * *

21 (d) The review process shall be as follows:

1 (1) The ~~public oversight commission~~ commissioner shall review:

2 (A) The application materials provided by the applicant.

3 (B) ~~The assessment of the applicant's materials provided by the~~
4 ~~department.~~

5 (C) Any information, evidence, or arguments raised by interested
6 parties or amicus curiae, and any other public input.

7 (2) The ~~public oversight commission~~ department shall hold a public
8 hearing during the course of a review.

9 (3) ~~The public oversight commission shall make a written findings and a~~
10 ~~recommendation to the commissioner in favor of or against each application. A~~
11 ~~record shall be maintained of all information reviewed in connection with each~~
12 ~~application.~~

13 (4) ~~A review shall be completed and the~~ The commissioner shall make a
14 final decision within 120 days after the date of notification under subdivision
15 (c)(4) of this section. Whenever it is not practicable to complete a review
16 within 120 days, the commissioner may extend the review period up to an
17 additional 30 days. Any review period may be extended with the written
18 consent of the applicant and all other applicants in the case of a review cycle
19 process.

20 (5)(4) After reviewing each application ~~and after considering the~~
21 ~~recommendations of the public oversight commission~~, the commissioner shall

1 make a decision either to issue or to deny the application for a certificate of
2 need. The decision shall be in the form of an approval in whole or in part, or
3 an approval subject to such conditions as the commissioner may impose in
4 furtherance of the purposes of this subchapter, or a denial. In granting a partial
5 approval or a conditional approval the commissioner shall not mandate a new
6 health care project not proposed by the applicant or mandate the deletion of
7 any existing service. Any partial approval or conditional approval must be
8 directly within the scope of the project proposed by the applicant and the
9 criteria used in reviewing the application.

10 ~~(6)(A)(5)~~ If the commissioner proposes to render a final decision
11 denying an application in whole or in part, or approving a contested
12 application, the commissioner shall serve the parties with notice of a proposed
13 decision containing proposed findings of fact and conclusions of law, and shall
14 provide the parties an opportunity to file exceptions and present briefs and oral
15 argument to the commissioner. The commissioner may also permit the parties
16 to present additional evidence.

17 ~~(B) If the commissioner's proposed decision is contrary to the~~
18 ~~recommendation of the public oversight commission:~~

19 ~~(i) the notice of proposed decision shall contain findings of fact~~
20 ~~and conclusions of law demonstrating that the commissioner fully considered~~
21 ~~all the findings and conclusions of the public oversight commission and~~

1 ~~explaining why his or her proposed decision is contrary to the recommendation~~
2 ~~of the public oversight commission and necessary to further the policies and~~
3 ~~purposes of this subchapter; and~~

4 ~~(ii) the commissioner shall permit the parties to present additional~~
5 ~~evidence.~~

6 ~~(7)~~(6) Notice of the final decision shall be sent to the applicant,
7 competing applicants, and interested parties. The final decision shall include
8 written findings and conclusions stating the basis of the decision.

9 ~~(8)~~(7) The commissioner shall establish rules governing the compilation
10 of the record used by ~~the public oversight commission and~~ the commissioner in
11 connection with decisions made on applications filed and certificates issued
12 under this subchapter.

13 (e) The commissioner shall adopt rules governing procedures for the
14 expeditious processing of applications for replacement, repair, rebuilding, or
15 reequipping of any part of a health care facility or health maintenance
16 organization destroyed or damaged as the result of fire, storm, flood, act of
17 God, or civil disturbance, or any other circumstances beyond the control of the
18 applicant where the commissioner finds that the circumstances require action
19 in less time than normally required for review. If the nature of the emergency
20 requires it, an application under this subsection may be reviewed by the

1 commissioner only, without notice and opportunity for public hearing or
2 intervention by any party.

3 (f) Any applicant, competing applicant, or interested party aggrieved by a
4 final decision of the commissioner under this section may appeal the decision
5 to the supreme court. ~~If the commissioner's decision is contrary to the~~
6 ~~recommendation of the public oversight commission, the standard of review on~~
7 ~~appeal shall require that the commissioner's decision be supported by a~~
8 ~~preponderance of the evidence in the record.~~

9 * * *

10 Sec. 25. 18 V.S.A. § 9440a is amended to read:

11 § 9440a. APPLICATIONS, INFORMATION, AND TESTIMONY; OATH
12 REQUIRED

13 (a) Each application filed under this subchapter, any written information
14 required or permitted to be submitted in connection with an application or with
15 the monitoring of an order, decision, or certificate issued by the commissioner,
16 and any testimony taken before the ~~public oversight commission, the~~
17 commissioner, or a hearing officer appointed by the commissioner shall be
18 submitted or taken under oath. The form and manner of the submission shall
19 be prescribed by the commissioner. The authority granted to the commissioner
20 under this section is in addition to any other authority granted to the
21 commissioner under law.

1 (b) Each application shall be filed by the applicant's chief executive officer
2 under oath, as provided by subsection (a) of this section. The commissioner
3 may direct that information submitted with the application be submitted under
4 oath by persons with personal knowledge of such information.

5 (c) A person who knowingly makes a false statement under oath or who
6 knowingly submits false information under oath to the commissioner ~~or the~~
7 ~~public oversight commission~~ or a hearing officer appointed by the
8 commissioner or who knowingly testifies falsely in any proceeding before the
9 commissioner ~~or the public oversight commission~~ or a hearing officer
10 appointed by the commissioner shall be guilty of perjury and punished as
11 provided in 13 V.S.A. § 2901.

12 Sec. 25a. 18 V.S.A. § 9456(h) is amended to read:

13 (h)(1) If a hospital violates a provision of this section, the commissioner
14 may maintain an action in the superior court of the county in which the
15 hospital is located to enjoin, restrain or prevent such violation.

16 * * *

17 (3)(A) The commissioner shall require the officers and directors of a
18 hospital to file under oath, on a form and in a manner prescribed by the
19 commissioner, any information designated by the commissioner and required
20 pursuant to this subchapter. The authority granted to the commissioner under

1 this subsection is in addition to any other authority granted to the
2 commissioner under law.

3 (B) A person who knowingly makes a false statement under oath or
4 who knowingly submits false information under oath to the commissioner ~~or to~~
5 ~~the public oversight commission~~ or to a hearing officer appointed by the
6 commissioner or who knowingly testifies falsely in any proceeding before the
7 commissioner ~~or the public oversight commission~~ or a hearing officer
8 appointed by the commissioner shall be guilty of perjury and punished as
9 provided in 13 V.S.A. § 2901.

10 * * * Conforming Revisions * * *

11 Sec. 26. 18 V.S.A. § 5 is amended to read:

12 § 5. DUTIES OF DEPARTMENT OF HEALTH

13 The department of health ~~is hereby designated as the sole state agency for~~
14 ~~the purposes of~~ shall:

15 (1) ~~Conducting~~ Conduct studies, ~~developing~~ develop state plans, and
16 ~~administering~~ administer programs and state plans for hospital survey and
17 construction, hospital operation and maintenance, medical care, and treatment
18 of ~~alcoholics and alcoholic rehabilitation~~ substance abuse.

19 (2) ~~Providing~~ Provide methods of administration and such other action
20 as may be necessary to comply with the requirements of federal acts and
21 regulations as relate to studies, ~~developing~~ development of plans and

1 ~~administering~~ administration of programs in the fields of health, public health,
2 health education, hospital construction and maintenance, and medical care.

3 (3) ~~Appointing~~ Appoint advisory councils, with the approval of the
4 governor.

5 (4) ~~Cooperating~~ Cooperate with necessary federal agencies in securing
6 federal funds ~~now or~~ may hereafter become available to the state for all
7 prevention, public health, wellness, and medical programs.

8 (5) Seek accreditation through the Public Health Accreditation Board.

9 (6) Create a state health improvement plan and facilitate local health
10 improvement plans in order to encourage the design of healthy communities
11 and to promote policy initiatives that contribute to community, school, and
12 workplace wellness, which may include providing assistance to employers for
13 wellness program grants, encouraging employers to promote employee
14 engagement in healthy behaviors, and encouraging the appropriate use of the
15 health care system.

16 Sec. 27. 18 V.S.A. § 9410(a)(1) is amended to read:

17 (a)(1) The commissioner shall establish and maintain a unified health care
18 data base to enable the commissioner and the Green Mountain Care board to
19 carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title
20 8, including:

21 (A) Determining the capacity and distribution of existing resources.

1 (B) Identifying health care needs and informing health care policy.

2 (C) Evaluating the effectiveness of intervention programs on
3 improving patient outcomes.

4 (D) Comparing costs between various treatment settings and
5 approaches.

6 (E) Providing information to consumers and purchasers of health
7 care.

8 (F) Improving the quality and affordability of patient health care and
9 health care coverage.

10 Sec. 28. Sec. 10 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is
11 amended to read:

12 Sec. 10. IMPLEMENTATION OF CERTAIN FEDERAL HEALTH
13 CARE REFORM PROVISIONS

14 (a) From the effective date of this act through July 1, ~~2011~~ 2014, the
15 commissioner of health shall undertake such planning steps and other actions
16 as are necessary to secure grants and other beneficial opportunities for
17 Vermont provided by the Patient Protection and Affordable Care Act of 2010,
18 Public Law 111-148, as amended by the Health Care and Education
19 Reconciliation Act of 2010, Public Law 111-152.

20 (b) From the effective date of this act through July 1, ~~2011~~ 2014, the
21 commissioner of Vermont health access shall undertake such planning steps as

1 are necessary to ensure Vermont's participation in beneficial opportunities
2 created by the Patient Protection and Affordable Care Act of 2010, Public Law
3 111-148, as amended by the Health Care and Education Reconciliation Act of
4 2010, Public Law 111-152.

5 Sec. 29. Sec. 31(d) of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is
6 amended to read:

7 (d) Term of committee. The committee shall cease to exist on January 31,
8 ~~2011~~ 2012.

9 Sec. 30. Sec. 14 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is
10 amended to read:

11 Sec. 14. PAYMENT REFORM; PILOTS

12 * * *

13 ~~(4)(A)~~ No later than February 1, 2011, the director of payment reform
14 shall provide a strategic plan for the pilot projects to the house committee on
15 health care and the senate committee on health and welfare. The strategic plan
16 shall provide:

17 ~~(i)(A)~~ A description of the proposed payment reform pilot projects,
18 including a description of the possible organizational model or models for
19 health care providers or professionals to coordinate patient care, a detailed
20 design of the financial model or models, and an estimate of savings to the

1 health care system from cost reductions due to reduced administration, from a
2 reduction in health care inflation, or from other sources.

3 ~~(ii)(B)~~ An ongoing program evaluation and improvement protocol.

4 ~~(iii)(C)~~ An implementation time line for pilot projects, with the first
5 project to become operational no later than January 1, 2012, and with two or
6 more additional pilot projects to become operational no later than July 1, 2012.

7 ~~(B) The director shall not implement the pilot projects until the~~
8 ~~strategic plan has been approved or modified by the general assembly.~~

9 Sec. 31. GREEN MOUNTAIN CARE BOARD NOMINATIONS;

10 APPOINTMENTS

11 (a) Notwithstanding the provisions of 18 V.S.A. § 9390(b)(2), within 15
12 days following the enactment of this act, the governor, the speaker of the house
13 of representatives, and the president pro tempore of the senate shall appoint the
14 members of the Green Mountain Care board nominating committee. The
15 members shall serve until their replacements are appointed pursuant to 18
16 V.S.A. § 9390 between January 1, 2013 and February 1, 2013.

17 (b) No earlier than August 15, 2011, the governor may appoint the chair of
18 the Green Mountain Care board from the names provided pursuant to the
19 process set forth in 18 V.S.A. chapter 220, subchapter 2. The governor shall
20 appoint the four additional members of the board no earlier than January 1,
21 2012, pursuant to the process described in 18 V.S.A. chapter 220, subchapter

1 2. In making the initial appointments to the board, the governor shall ensure
2 that the skills and qualifications of the board members complement those of
3 the other members of the board.

4 Sec. 32. REPEAL

5 (a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective
6 July 1, 2012.

7 (b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective
8 July 1, 2011.

9 Sec. 33. APPROPRIATIONS

10 (a) In fiscal year 2012, the sum of \$686,443.00 in general funds and
11 \$315,481.00 in federal funds is appropriated to the Green Mountain Care board
12 to carry out its functions.

13 (b) In fiscal year 2012, the sum of \$48,000.00 is appropriated from the
14 general fund to the secretary of administration for the medical malpractice
15 proposal pursuant to Sec. 2(e) of this act.

16 (c) In fiscal year 2012, the sum of \$138,000.00 is appropriated from the
17 general fund to the agency of administration for salary and benefits for the
18 director of health care reform.

19 Sec. 34. EFFECTIVE DATES

20 (a) Secs. 1 (intent), 1a (principles), 1b (agency of administration), and 2
21 (strategic plan); Sec. 3, 18 V.S.A. chapter 220, subchapter 2 (Green Mountain

1 Care board nominating committee); Secs. 8 (integration plan), 9 (financing
2 plans); 10 (HIT); 11 (health planning); 12 (regulatory process);
3 13 (workforce); 14 (cost estimates); 17 (discretionary clauses); 18 (single
4 formulary); 25 (health care reform); 26 (department of health); 28 (ACA
5 grants); 29 (primary care workforce committee); 30 (approval of pilot
6 projects); and 31 (initial Green Mountain Care board nominating committee
7 appointments) of this act and this section shall take effect on passage.

8 (b) Sec. 3, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Care
9 board) and Secs. 3a (health care ombudsman), 3b (positions), 3c (payment
10 reform), 3d and 3e (manufacturers of prescribed products), 5 (DVHA), 6
11 (Health care eligibility), 13a (prior authorizations), 19-25a and 32 (repeal of
12 public oversight commission), and 33 (appropriations) shall take effect on
13 July 1, 2011.

14 (c)(1) Secs. 4 (Vermont health benefit exchange; Green Mountain Care), 4a
15 (household health insurance survey), and 4b (exchange implementation) shall
16 take effect on July 1, 2011.

17 (2) The Vermont health benefit exchange shall begin enrolling
18 individuals no later than November 1, 2013 and shall be fully operational no
19 later than January 1, 2014.

20 (3) Green Mountain Care shall be implemented 90 days following the
21 last to occur of:

1 (A) Enactment of a law establishing the financing for Green
2 Mountain Care.

3 (B) Approval by the Green Mountain Care board of the initial Green
4 Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

5 (C) Enactment of the appropriations for the initial Green Mountain
6 Care benefit package proposed by the Green Mountain Care board pursuant to
7 18 V.S.A. § 9375.

8 (D) Receipt of a waiver under Section 1332 of the Affordable Care
9 Act pursuant to 33 V.S.A. § 1829(b).

10 (d) Sec. 7, 3 V.S.A. § 402 (Medicaid and exchange advisory board), shall
11 take effect on July 1, 2012.

12 (e) Sec. 15 (rate review) shall take effect on January 1, 2012 and shall
13 apply to all filings on and after January 1, 2012.

14 (f) Sec. 27 (VHCURES) shall take effect on October 1, 2011.

15 (g) Secs. 16 (health benefit information) and 16a (Medicaid program costs)
16 shall take effect on January 1, 2012, and the reporting requirement shall apply
17 to each calendar year, beginning with 2012.

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1 (Committee vote: 5-0-0)

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Senator Ayer

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FOR THE COMMITTEE