

1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred House Bill No. 202
3 entitled “An act relating to a single-payer and unified health system”
4 respectfully reports that it has considered the same and recommends that the
5 bill be amended by striking out all after the enacting clause and inserting in
6 lieu thereof the following:

7 Sec. 1. [Deleted.]

8 * * * Road Map to a ~~Single-Payer~~ Universal and a Unified Health ~~Care~~
9 System * * *

10 Sec. 2. STRATEGIC PLAN; ~~SINGLE-PAYER~~ UNIVERSAL AND
11 UNIFIED HEALTH SYSTEM

12 (a) As provided in Sec. 4 of this act, upon receipt by the state of necessary
13 waivers from federal law, all Vermont residents shall be eligible for Green
14 Mountain Care, a universal health care program that will provide health
15 benefits through a single payment system. To the maximum extent allowable
16 under federal law and waivers from federal law, Green Mountain Care shall
17 include health coverage provided under the health benefit exchange established
18 under chapter 18, subchapter 1 of Title 33; under Medicaid; under Medicare;
19 by employers that choose to participate; and to state employees and municipal
20 employees, including teachers.

1 (b) The Green Mountain Care board is created to develop mechanisms to
2 reduce the rate of growth in health care through cost-containment,
3 establishment of budgets, and payment reform.

4 (c) The secretary of administration or designee shall create Green Mountain
5 Care as a universal health care program by implementing the following
6 initiatives and planning efforts:

7 (1) No later than November 1, 2013, the Vermont health benefit
8 exchange established in subchapter 1 of chapter 18 of Title 33 shall begin
9 enrolling individuals and small employers for coverage beginning January 1,
10 2014. The intent of the general assembly is to establish the Vermont health
11 benefit exchange in a manner such that it may become the foundation for a
12 Green Mountain Care.

13 (2) No later than November 1, 2016, the Vermont health benefit
14 exchange established in subchapter 1 of chapter 18 of Title 33 shall begin
15 enrolling large employers for coverage beginning January 1, 2017.

16 (3) No later than January 1, 2014, the commissioner of banking,
17 insurance, securities, and health care administration shall require that all
18 individual and small group health insurance products be sold only through the
19 Vermont health benefit exchange and shall require all large group insurance
20 products to be aligned with the administrative requirements and essential
21 benefits required in the Vermont health benefit exchange. The commissioner

1 shall provide recommendations for statutory changes as part of the integration
2 plan established in Sec. 8 of this act.

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

11 (5) The secretary shall supervise the planning efforts, reports of which
12 are due January 15, 2013, as provided in Sec. 9 of this act, to establish the
13 financing necessary for Green Mountain Care, for recruitment and retention
14 programs for primary care health professionals, and for covering the uninsured
15 and underinsured through Medicaid and the Vermont health benefit exchange.

16 (d) The secretary of administration or designee shall obtain waivers,
17 exemptions, agreements, legislation, or a combination thereof to ensure that, to
18 the extent possible under federal law, all federal payments provided within the
19 state for health services are paid directly to Green Mountain Care. Green
20 Mountain Care shall assume responsibility for the benefits and services
21 previously paid for by the federal programs, including Medicaid, Medicare,

1 and, after implementation, the Vermont health benefit exchange. In obtaining
2 the waivers, exemptions, agreements, legislation, or combination thereof, the
3 secretary shall negotiate with the federal government a federal contribution for
4 health care services in Vermont that reflects medical inflation, the state gross
5 domestic product, the size and age of the population, the number of residents
6 living below the poverty level, the number of Medicare-eligible individuals,
7 and other factors that may be advantageous to Vermont and that does not
8 decrease in relation to the federal contribution to other states as a result of the
9 waivers, exemptions, agreements, or savings from implementation of Green
10 Mountain Care.

11 (e) No later than January 15, 2012, the secretary of administration or
12 designee shall submit to the house committees on health care and on judiciary
13 and the senate committees on health and welfare and on judiciary a proposal to
14 reform the medical malpractice system for Vermont. The proposal shall be
15 designed to address the incidence of defensive medicine, reduce health care
16 costs, and maintain adequate protections for patients, and shall reflect the
17 secretary's or designee's consideration of a no-fault system. The proposal also
18 shall be designed to take effect on or before the date of implementation of
19 Green Mountain Care pursuant to 33 V.S.A. chapter 18, subchapter 2.

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

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

1 CHAPTER 220. GREEN MOUNTAIN CARE BOARD

2 Subchapter 1. Green Mountain Care Board

3 § 9371. PRINCIPLES FOR HEALTH CARE REFORM

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

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

11 (2) **Overall health Health** care costs must be contained and growth in
12 health care spending in Vermont ~~should not outpace growth in the state's~~
13 ~~economy and spending capacity~~ must balance the health care needs of the
14 population with the ability to pay for such care.

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

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

1 and research missions of the state's academic medical center, must be
2 supported in such a way that all Vermonters have access to necessary health
3 services and that these health services are sustainable.

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

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

8 (7) Individuals have a personal responsibility to maintain their own
9 health and to use health resources wisely.

10 (8) The health care system must recognize the primacy of the
11 patient-provider relationship, respecting the professional judgment of
12 providers and the informed decisions of patients.

13 (9) Vermont's health delivery system must seek continuous
14 improvement of health care quality and safety and of the health of the
15 population, and the system therefore must be evaluated regularly for
16 improvements in access, quality, and cost containment.

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

1 of excess cost growth.

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

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

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

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

13 § 9372. PURPOSE

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

16 (1) improve the health of the population;

17 (2) enhance the patient experience of care; and

18 (3) reduce 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.

21 § 9373. DEFINITIONS

1 As used in this chapter:

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

4 (2) “Green Mountain Care” means the public–private ~~single-payer~~
5 ~~health system~~ universal health care program designed to provide health
6 benefits through a simplified, uniform, single administrative system
7 established in pursuant to 33 V.S.A. chapter 18, subchapter 2.

8 (3) “Health care professional” means an individual, partnership,
9 corporation, facility, or institution licensed or certified or otherwise authorized
10 by law to provide professional health care services.

11 (4) “Health insurer” means any health insurance company, nonprofit
12 hospital and medical service corporation, managed care organization, and, to
13 the extent permitted under federal law, any administrator of an insured,
14 self-insured, or publicly funded health care benefit plan offered by a public or
15 a private entity. The term does not include Medicaid, the Vermont health
16 access plan, or any other state health care assistance program financed in
17 whole or in part through a federal program.

18 (5) “Health services” means any medically necessary treatment or
19 procedure to maintain, diagnose, or treat an individual’s physical or mental
20 health, including services ordered by a health care professional and medically
21 necessary services to assist in activities of daily living.

1 (6) “Manufacturers of prescribed products” shall have the same meaning
2 as “manufacturers” in section 4631a of this title.

3 § 9374. BOARD MEMBERSHIP; AUTHORITY

4 (a)(1) On July 1, 2011, the Green Mountain Care board is created and shall
5 consist of a chair and four members. The chair shall be a full-time state
6 employee and the four other members shall be part-time state employees. The
7 chair and all of the members shall be exempt from the state classified system,
8 ~~and none shall be required to be licensed to practice law in this state.~~

9 (2) The chair and the members of the board shall be appointed pursuant
10 to the process described in subchapter 2 of this chapter.

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

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

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

18 (4) Members of the board may be removed only for cause.

19 (c)(1) No board member shall, during his or her term or terms on the board,
20 be an officer of, director of, organizer of, employee of, consultant to, or
21 attorney for any person subject to supervision or regulation by the board; nor

1 receive directly or indirectly any payment or gratuity from any person subject
2 to supervision or regulation by the board; nor have a direct or indirect financial
3 relationship with any person or interest in any entity subject to supervision or
4 regulation by the board.

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

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

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

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

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

17 (e)(1) The board shall establish a consumer, patient, and health care
18 professional advisory group to provide input and recommendations to the
19 board. Members of such advisory group who are not state employees or whose
20 participation is not supported through their employment or association shall
21 receive per diem compensation and reimbursement of expenses pursuant to 32

1 V.S.A. § 1010, including costs of travel, child care, personal assistance
2 services, and any other service necessary for participation in the advisory
3 group and approved by the board.

4 (2) The board may establish additional advisory groups and
5 subcommittees as needed to carry out its duties.

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

13 § 9375. DUTIES

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

16 (b) Beginning on July 1, 2011, the board shall have the following duties:

17 (1) ~~Develop, implement~~ Oversee the development and
18 implementation, and evaluate the effectiveness, of the payment reform pilot
19 projects set forth in section 9377 of this title.

20 (2)(A) Develop by rule, pursuant to chapter 25 of Title 3, methodologies
21 for achieving payment reform and containing costs, which may include the

1 creation of health care professional cost-containment targets, global payments,
2 bundled payments, global budgets, risk-adjusted capitated payments, or other
3 uniform payment methods and amounts for accountable care organizations,
4 health care professionals, or other provider arrangements.

5 (B) Prior to the initial adoption of the rules described in subdivision
6 (A) of this subdivision (2), report the board's proposed methodologies to the
7 house committee on health care and the senate committee on health and
8 welfare.

9 (C) In developing methodologies pursuant to subdivision (A) of this
10 subdivision (2), engage Vermonters in seeking ways to equitably distribute
11 health services while acknowledging the connection between fair and
12 sustainable payment and access to health care.

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

17 (4) Develop and maintain a health care workforce development strategic
18 plan that continues efforts to ensure that Vermont has the health care
19 workforce necessary to provide care to all Vermont residents, including
20 reviewing the adequacy of health care professional reimbursement rates to
21 determine their impact on health care professional recruitment and retention.

1 (c) No later than July 1, 2013, the board shall have the following duties in
2 addition to the duties described in subsection (b) of this section:

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

6 (2) 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, on any insurance rate
9 increases pursuant to 8 V.S.A. chapter 107, on hospital budgets pursuant to
10 chapter 221, subchapter 7 of this title, and on certificates of need pursuant to
11 chapter 221, subchapter 5 of this title, taking into consideration the
12 requirements in the underlying statutes, changes in health care delivery,
13 changes in payment methods and amounts, and other issues at the discretion of
14 the board.

15 (3) Provide information and recommendations to the commissioner of
16 Vermont health access related to contracts with health insurers to provide
17 qualified health benefit plans in the Vermont health benefit exchange
18 established in chapter 18, subchapter 1 of Title 33.

19 (4) Review and approve, with recommendations from the commissioner
20 of Vermont health access, the benefit package for qualified health benefit plans
21 pursuant to chapter 18, subchapter 1 of Title 33. The board shall report to the

1 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 (5)(A) Develop and maintain a method for evaluating system-wide
5 performance and quality, including identification of the appropriate process
6 and outcome measures:

7 (i) for determining public satisfaction with the health system;

8 (ii) for utilization of health services;

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

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

14 (v) for other measures as determined by the board.

15 (B) The board shall develop the evaluation method pursuant to
16 subdivision (A) of this subdivision (5) by October 15, 2013 and shall report the
17 results of its evaluations and any resulting recommendations in its annual
18 report as required by subsection (d) of this section.

19 (6)(A)(i) In preparation for implementing Green Mountain Care,
20 develop and approve, upon recommendation from the agency of human

1 services, the Green Mountain Care benefit package within the parameters
2 established in chapter 18, subchapter 2 of Title 33.

3 (ii) The board shall consider whether to impose cost-sharing
4 requirements; if so, whether to make the cost-sharing requirements income-
5 sensitized; and the impact of any cost-sharing requirements on individuals'
6 ability to access care. There shall be a waiver of any cost-sharing requirement
7 for chronic care for individuals participating in chronic care management and
8 for primary and preventive care.

9 (B) Prior to issuing its final approval of the benefit package or any
10 substantive modifications to the benefit package pursuant to subdivision (A) of
11 this subdivision (6), the board shall present a report on the benefit package or
12 modifications to the house committee on health care and the senate committee
13 on health and welfare. The report shall describe the covered services to be
14 included in the Green Mountain Care benefit package, any cost-sharing
15 requirements, and any proposed modifications. If the general assembly is not
16 in session at the time that the board is preparing to issue its final approval, the
17 board shall send its report by first class mail to each member of the house
18 committee on health care and the senate committee on health and welfare at
19 least 10 days before issuing the approval.

20 (7) In preparation for implementing Green Mountain Care and every
21 three years after implementation, recommend to the general assembly and the

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

6 (8) Monitor the extent to which residents of other states move to
7 Vermont for the purpose of receiving health services and the impact of any
8 such migration on Vermont's health care system and on the state's economy
9 and recommend to the general assembly in the annual report required by
10 subsection (d) of this section strategies to address any related problems the
11 board identifies.

12 (d) Annually on or before January 15, the board shall submit a report of its
13 activities for the preceding state fiscal year to the house committee on health
14 care and the senate committee on health and welfare. The report shall include
15 any changes to the payment rates for health care professionals pursuant to
16 section 9376 of this title, any new developments with respect to health
17 information technology, the status of efforts to implement the health care
18 workforce development strategic plan pursuant to subdivision (b)(4) of this
19 section, any substantive changes to the benefit package for qualified health
20 benefit plans pursuant to subdivision (c)(3) of this section, the results of the
21 systemwide performance and quality evaluations required by subdivision (c)(4)

1 of this section, the rationale for any decision to impose or alter cost-sharing
2 requirements for Green Mountain Care pursuant to subdivision (c)(6) of this
3 section, and the extent and impacts of migration to Vermont for health services
4 as described in subdivision (c)(8) of this section.

5 § 9376. PAYMENT AMOUNTS; METHODS

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

14 (b) The board shall ensure that health care professionals, health care
15 provider bargaining groups created pursuant to section 9409 of this title,
16 manufacturers of prescribed products, medical supply companies, and other
17 companies providing health services or health supplies receive reasonable
18 rates, as determined by the board based on the methodologies developed
19 pursuant to section 9375 of this title and after consultation with the affected
20 parties, in order to have a consistent reimbursement amount accepted by these
21 persons.

1 (c) The board, in collaboration with the director of payment reform in the
2 department of Vermont health access, shall establish payment methodologies
3 for health services, including using innovative payment methodologies
4 consistent with any payment reform pilot projects and with evidence-based
5 practices, and may include fee-for-service payments if the board determines
6 such payments to be appropriate. The payment methods shall encourage cost
7 containment; provision of high-quality, evidence-based health services in an
8 integrated setting; patient self-management; and healthy lifestyles.

9 (d) To the extent required to avoid federal antitrust violations and in
10 furtherance of the policy identified in subsection (a) of this section, the board
11 shall facilitate and supervise the participation of health care professionals and
12 health care provider bargaining groups in the process described in subsection
13 (b) of this section.

14 § 9377. PAYMENT REFORM; PILOTS

15 (a) It is the intent of the general assembly to achieve the principles stated in
16 section 9371 of this title. In order to achieve this goal and to ensure the
17 success of health care reform, it is the intent of the general assembly that
18 payment reform be implemented and that payment reform be carried out as
19 described in this section. It is also the intent of the general assembly to ensure
20 sufficient state involvement and action in the design and implementation of the
21 payment reform pilot projects described in this section to comply with federal

1 and state antitrust provisions by replacing competition between payers and
2 others with state-supervised cooperation and regulation.

3 (b)(1) The board shall be responsible for **oversight of the** pilot projects to
4 test payment reform methodologies as provided in this section. The **board, in**
5 **collaboration with the** director of payment reform in the department of
6 Vermont health access, shall **oversee the development and implementation**
7 **develop and implement the payment reform pilot projects and the board**
8 shall evaluate **the their** effectiveness **of the payment reform pilot projects.**

9 Whenever health insurers are involved, the director and the board shall
10 collaborate with the commissioner of banking, insurance, securities, and health
11 care administration. The terms used in this section shall have the same
12 meanings as in chapter 13 of this title.

13 (2) The board, in consultation with the director of payment reform, shall
14 convene a broad-based group of stakeholders, including health care
15 professionals who provide health services, health insurers, professional
16 organizations, community and nonprofit groups, consumers, businesses, school
17 districts, the state health care ombudsman, and state and local governments to
18 advise the director and the board in developing and implementing the pilot
19 projects.

20 (3) Payment reform pilot projects shall be developed and implemented
21 to manage the costs of the health care delivery system, improve health

1 outcomes for Vermonters, provide a positive health care experience for
2 patients and health care professionals, and further the following objectives:

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

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

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

18 (D) the scope of services in any capitated payment should be broad
19 and comprehensive, including prescription drugs, diagnostic services, services
20 received in a hospital, mental health and substance abuse services, and services
21 from a licensed health care practitioner.

1 (4) 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, whether to include
7 home health services and long-term care services as part of capitated
8 payments.

9 (c) Health insurer participation.

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

17 (B) The board may establish procedures to exempt or limit the
18 participation of health insurers offering a stand-alone dental plan or specific
19 disease or other limited-benefit coverage or participation by insurers with a
20 minimal number of covered lives as defined by the board, in consultation with
21 the commissioner of banking, insurance, securities, and health care

1 administration. Health insurers shall be exempt from participation if the
2 insurer offers only benefit plans which are paid directly to the individual
3 insured or the insured's assigned beneficiaries and for which the amount of the
4 benefit is not based upon potential medical costs or actual costs incurred.

5 (C) After the pilot projects are implemented, health insurers shall
6 have appeal rights pursuant to section 9381 of this title.

7 (2) In the event that the secretary of human services is denied
8 permission from the Centers for Medicare and Medicaid Services to include
9 financial participation by Medicare in the pilot projects, health insurers shall
10 not be required to cover the costs associated with individuals covered by
11 Medicare.

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

1 countervailing benefit of improving patient care, improving access to health
2 care, increasing efficiency, or reducing costs by modifying payment methods.

3 (e) The board or designee shall apply for grant funding, if available, for the
4 design and implementation of the pilot projects described in this section.

5 (f) The first pilot project shall become operational no later than January 1,
6 2012, and two or more additional pilot projects shall become operational no
7 later than July 1, 2012.

8 § 9378. PUBLIC PROCESS

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

15 § 9379. AGENCY COOPERATION

16 The secretary of administration shall ensure that the Green Mountain Care
17 board has access to data and analysis held by any executive branch agency
18 which is necessary to carry out the board's duties as described in this chapter.

19 § 9380. RULES

20 The board may adopt rules pursuant to chapter 25 of Title 3 as needed to
21 carry out the provisions of this chapter.

1 § 9381. APPEALS

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

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

11 Subchapter 2. Green Mountain Care Board Nominating Committee

12 § 9390. GREEN MOUNTAIN CARE BOARD NOMINATING

13 COMMITTEE CREATED; COMPOSITION

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

16 (b)(1) The committee shall consist of ~~eleven~~ 11 members who shall be
17 selected as follows:

18 (A) Two members appointed by the governor.

19 (B) Three members of the senate ~~committee on health and welfare,~~
20 not all of whom shall be members of the same party, to be appointed by the
21 committee on committees.

1 (C) Three members of the house ~~committee on health care of~~
2 **representatives**, not all of whom shall be members of the same party, to be
3 appointed by the speaker of the house of representatives.

4 (D) One member representing health care professionals, to be
5 appointed by the Vermont Medical Society.

6 (E) One member representing hospitals, to be appointed by the
7 Vermont Association of Hospitals and Health Systems **in consultation with**
8 **each Vermont hospital that is not a member of such association.**

9 (F) The state health care ombudsman.

10 (2) The members of the committee appointed by the governor shall
11 serve for terms of two years and may serve for no more than three terms. The
12 members of the committee appointed by the house and senate shall serve for
13 terms of two years and may serve for no more than three consecutive terms.
14 The remaining members of the committee shall serve for terms of two years
15 and may serve for no more than three consecutive terms. All appointments or
16 elections shall be between January 1 and February 1 of each odd-numbered
17 year, except to fill a vacancy. Members shall serve until their successors are
18 elected or appointed.

19 (3) The members shall elect their own chair who ~~will~~ **shall** serve for a
20 term of two years.

1 (c) The members of the Green Mountain Care board nominating committee
2 shall be entitled to compensation of \$30.00 a day for the time spent in the
3 performance of their duties, and reimbursement for their actual and necessary
4 expenses incurred in the performance of their duties.

5 (d) The Green Mountain Care board nominating committee shall adopt
6 rules under chapter 25 of Title 3 establishing the process, criteria, and
7 standards for the nomination of qualified candidates for the chair and members
8 of the Green Mountain Care board. The criteria and standards shall include
9 such factors as integrity, impartiality, health, experience, diligence,
10 administrative and **communicative communication** skills, social
11 consciousness, and public service.

12 (e) A quorum of the committee shall consist of **eight seven** members.

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

15 **§ 9391. DUTIES NOMINATION PROCESS**

16 (a) Whenever a vacancy occurs on the Green Mountain Care board, or
17 when an incumbent does not declare that he or she will be a candidate to
18 succeed himself or herself, the Green Mountain Care board nominating
19 committee shall select by majority vote, provided that a quorum is present,
20 from the list of persons interested in serving on the Green Mountain Care

1 board as many candidates as it deems qualified for the position or positions to
2 be filled.

3 (b) The committee shall submit to the governor the names of the persons it
4 deems qualified to be appointed to ~~the~~ fill the position or positions. There shall
5 be included in the qualifications for appointment that the person shall have
6 knowledge of or expertise in health care policy or health care financing to
7 complement that of the remaining members of the board.

8 (c) All proceedings of the committee, including the names of candidates
9 considered by the committee and information about any candidate submitted
10 by any source, shall be confidential.

11 Sec. 3a. 8 V.S.A. § 4089w(b) is amended to read:

12 (b) The health care ombudsman office shall:

13 * * *

14 (5) Analyze and monitor the development and implementation of
15 federal, state and local laws, regulations, and policies relating to patients and
16 health insurance consumers, including the activities and policies of the Green
17 Mountain Care board established in chapter 220 of Title 18, and recommend
18 changes it deems necessary.

19 * * *

20 Sec. 3b. GREEN MOUNTAIN CARE BOARD; AND EXCHANGE
21 POSITIONS

1 (a) On July 1, 2011, five exempt positions are created on the Green

2 Mountain Care board, including:

3 (1) one full-time chair, Green Mountain Care board; and

4 (2) four part-time members, Green Mountain Care board.

5 (b) By October 1, 2011, nine positions and appropriate amounts for

6 personal services and operating expenses shall be transferred from the division

7 of health care administration in the department of banking, insurance,

8 securities, and health care administration to the Green Mountain Care board.

9 In addition, one exempt attorney position shall be transferred from the

10 administrative division in the department of banking, insurance, securities, and

11 health care administration to the Green Mountain Care board.

12 ~~(c) By October 1, 2011, the director of payment reform shall be~~

13 ~~transferred from the division of health care reform in the department of~~

14 ~~Vermont health access to the Green Mountain Care board.~~

15 ~~(d)~~ On or after January 1, 2012, one exempt deputy commissioner position

16 is created in the department of Vermont health access to support the functions

17 provided for in Sec. 4 of this act establishing 33 V.S.A. chapter 18, subchapter

18 1. The salary and benefits for this position shall be funded from federal funds

19 provided to establish the Vermont health benefit exchange.

20 Sec. 3c. 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. 3d. 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. For
2 a clinical trial for which disclosure is delayed under this subdivision (iii), the
3 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 aggregate amounts expended on the Green Mountain Care board
19 established 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.

(6) After issuance of the report required by subdivision (5) of this subsection and except as otherwise provided in subdivision (2)(A)(i) of this subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

* * *

* * * Public-Private ~~Single-Payer~~ Universal Health Care System * * *

Sec. 4. 33 V.S.A. chapter 18 is added to read

CHAPTER 18. PUBLIC-PRIVATE ~~SINGLE-PAYER~~ UNIVERSAL
HEALTH CARE SYSTEM

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

(a) It is the intent of the general assembly to establish a Vermont health benefit exchange which meets the policy established in 18 V.S.A. § 9401 and, to the extent allowable under federal law or a waiver of federal law, becomes the mechanism to create Green Mountain Care.

(b) The purpose of the Vermont health benefit exchange is to facilitate the purchase of affordable, qualified health benefit plans in the individual and group markets in this state in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to promote

1 health, prevention, and healthy lifestyles by individuals; and to improve quality
2 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 board established in section 402
10 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 chapter 53 of Title 3.

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) If the Vermont health benefit exchange is required by the secretary
6 of the U.S. Department of Health and Human Services to contract with more
7 than one health insurer, the Vermont health benefit exchange may determine
8 an appropriate method to provide a unified, simplified administration system
9 for health insurers offering qualified health benefit plans. The exchange may
10 include claims administration, benefit management, billing, or other
11 components in the unified system and may achieve simplification by
12 contracting with a single entity for administration and management of all
13 qualified health benefit plans, by licensing or requiring the use of particular
14 software, by requiring health insurers to conform to a standard set of systems
15 and rules, or by another method determined by the commissioner.

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

20 (d) The Vermont health benefit exchange may enter into
21 information-sharing agreements with federal and state agencies and other state

1 exchanges to carry out its responsibilities under this subchapter provided such
2 agreements include adequate protections with respect to the confidentiality of
3 the information to be shared and provided such agreements comply with all
4 applicable state and federal laws and regulations.

5 § 1804. QUALIFIED EMPLOYERS

6 [Reserved.]

7 § 1805. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

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

6 (3) Creating and maintaining consumer assistance tools, including a
7 website through which enrollees and prospective enrollees of qualified health
8 benefit plans may obtain standardized comparative information on such plans
9 and a toll-free telephone hotline to respond to requests for assistance.

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 ~~sub~~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 of 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 providers with satisfaction surveys and
6 other mechanisms for evaluating the performance of qualified health benefit
7 plans and informing the commissioner of Vermont health access and the
8 commissioner of banking, insurance, securities, and health care administration
9 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 board established in section 402 of
14 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 high-
4 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 board established
11 in section 402 of this title and after approval from the Green Mountain Care
12 board established in chapter 220 of Title 18.

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 board established in
3 section 402 of this title and after approval from the Green Mountain Care
4 board established in chapter 220 of Title 18.

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 board and after
9 approval from the Green Mountain Care board established in chapter 220 of
10 Title 18.

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 board 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 in-person assistance to individuals in all regions of the
20 state.

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 chapter 25 of
11 Title 3 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 health care coverage for all Vermont
17 residents in a seamless manner regardless of income, assets, health status, or
18 availability of other health coverage. Green Mountain Care shall contain costs
19 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. DEFINITIONS

7 For purposes of this subchapter:

8 (1) “Agency” means the agency of human services.
9 (2) “CHIP funds” means federal funds available under Title XXI of the
10 Social Security Act.
11 (3) “Chronic care” means health services provided by a health care
12 professional for an established clinical condition that is expected to last one
13 year or more; that requires ongoing clinical management; and that requires
14 health services that attempt to restore the individual to highest function,
15 minimize the negative effects of the condition, **and** prevent complications
16 related to chronic conditions. Examples of chronic conditions include
17 diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary
18 disease, substance abuse, mental illness, spinal cord injury, and
19 hyperlipidemia.

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

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

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

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

17 (8) “Primary care” means health services provided by health care
18 professionals specifically trained for and skilled in first-contact and continuing
19 care for individuals with signs, symptoms, or health concerns, not limited by
20 problem origin, organ system, or diagnosis, and shall include prenatal care and
21 mental health and substance abuse treatment.

1 (9) “Secretary” means the secretary of human services.

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

8 § 1823. ELIGIBILITY

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

13 (2)(A) If an individual is determined to be eligible for Green Mountain
14 Care based on information later found to be false, the agency shall make
15 reasonable efforts to recover from the individual the amounts expended for his
16 or her care. In addition, if the individual **knowingly provided the false**
17 **information, he or she** shall be assessed a civil penalty of not more than
18 \$5,000.00.

19 **(B) The agency shall include information on the Green Mountain**
20 **Care application to provide notice to applicants of the penalty for**

1 **knowingly providing false information as established in subdivision (2)(A)**
2 **of this subsection.**

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

5 (B) An individual covered under Green Mountain Care shall inform
6 the agency within 60 days of becoming a resident of another state. An
7 individual who obtains or attempts to obtain health services through Green
8 Mountain Care more than 60 days after becoming a resident of another state
9 shall reimburse the agency for the amounts expended for his or her care and
10 shall be assessed a civil penalty of not more than \$1,000.00 for a first violation
11 and not more than \$2,000.00 for any subsequent violation.

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

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

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

1 (3) If an individual presumed eligible for Green Mountain Care pursuant
2 to subdivision (1) of this subsection is later determined not to be eligible for
3 the program, the agency shall make reasonable efforts to recover from the
4 individual the amounts expended for his or her care.

5 (d) The agency shall adopt rules pursuant to chapter 25 of Title 3 to ensure
6 that Vermont residents who are temporarily out of the state on a short-term
7 basis and who intend to return and reside in Vermont remain eligible for Green
8 Mountain Care while outside Vermont. ~~The rules shall also reflect the intent~~
9 ~~of the general assembly that the children of Vermont residents remain~~
10 ~~eligible for Green Mountain Care until age 26 while attending a college or~~
11 ~~university.~~

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

17 § 1824. HEALTH BENEFITS

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

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

4 (3)(A) The Green Mountain Care board established in 18 V.S.A. chapter
5 220 shall consider whether to include dental, vision, and hearing benefits in the
6 Green Mountain Care benefit package.

7 ~~(B) The Green Mountain Care board shall consider whether to~~
8 ~~include in Green Mountain Care health services for individuals injured in~~
9 ~~accidents arising out of and in the course of employment.~~

10 (4) The Green Mountain Care board shall approve the benefit package
11 and present it to the general assembly as part of its recommendations for the
12 Green Mountain Care budget.

13 (b)(1)(A) For individuals eligible for Medicaid or CHIP, the benefit
14 package shall include the benefits required by federal law, as well as any
15 additional benefits provided as part of the Green Mountain Care benefit
16 package.

17 (B) Upon implementation of Green Mountain Care, the benefit
18 package for individuals eligible for Medicaid or CHIP shall also include any
19 optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services
20 covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc for
21 which these individuals are eligible on January 1, 2014. Beginning with the

1 second year of Green Mountain Care and going forward, the Green Mountain
2 Care board may, consistent with federal law, modify these optional benefits, as
3 long as at all times the benefit package for these individuals contains at least
4 the benefits described in subdivision (A) of this subdivision (b)(1).

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

8 (3) For individuals eligible for Medicare, the benefit package shall
9 include, at a minimum, the benefits provided to these individuals under federal
10 law. ~~The board shall consider whether to provide individuals eligible for~~
11 ~~Medicare with any additional benefits provided as part of the Green~~
12 ~~Mountain Care benefit package.~~

13 § 1825. BLUEPRINT FOR HEALTH

14 (a) It is the intent of the general assembly that within five years following
15 the implementation of Green Mountain Care, each individuals enrolled in
16 Green Mountain Care will have a primary health care professional who is
17 involved with the Blueprint for Health established in 18 V.S.A. chapter 13.

18 (b) Consistent with the provisions of 18 V.S.A. chapter 13, if an individual
19 enrolled in Green Mountain Care does not have a medical home through the
20 Blueprint for Health, the individual may choose a primary health care

1 professional who is not participating in the Blueprint to serve as the
2 individual's primary care point of contact.

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

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

11 § 1826. ADMINISTRATION; ENROLLMENT

12 (a)(1) The agency may, under an open bidding process, solicit bids from
13 and award contracts to public or private entities for administration of certain
14 elements of Green Mountain Care, such as claims administration and provider
15 relations.

16 (2) The agency shall ensure that entities awarded contracts pursuant to
17 this subsection do not have a financial incentive to restrict individuals' access
18 to health services. The agency may establish performance measures that
19 provide incentives for contractors to provide timely, accurate, transparent, and
20 courteous services to individuals enrolled in Green Mountain Care and to
21 health care professionals, where applicable.

1 (3) To the extent practicable, preference in awarding contracts pursuant
2 to this subsection shall be given to entities that maintain a place of business in
3 Vermont.

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

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

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

10 (e) The agency shall seek permission from the Centers for Medicare and
11 Medicaid Services to be the administrator for the Medicare program in
12 Vermont. If the agency is unsuccessful in obtaining such permission, Green
13 Mountain Care shall be the secondary payer with respect to any health service
14 that may be covered in whole or in part by Title XVIII of the Social Security
15 Act (Medicare).

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

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

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

12 (i) Green Mountain Care shall maintain a robust and adequate network of
13 health care professionals located in Vermont or regularly serving Vermont
14 residents, including mental health and substance abuse professionals. The
15 agency shall contract with outside entities as needed to allow for the
16 appropriate portability of coverage under Green Mountain Care for Vermont
17 residents who are temporarily out of the state.

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

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

4 § 1827. BUDGET PROPOSAL

5 The Green Mountain Care board, in collaboration with the agency of human
6 services, shall be responsible for developing a three-year Green Mountain Care
7 budget as provided in 18 V.S.A. § 9375, to be adjusted annually in response to
8 realized revenues and expenditures, for proposal to the general assembly.

9 § 1828. GREEN MOUNTAIN CARE FUND

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

13 (b) Into the fund shall be deposited:

14 (1) transfers or appropriations from the general fund, authorized by the
15 general assembly;

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

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

1 (c) The fund shall be administered pursuant to chapter 7, subchapter 5 of
2 Title 32, except that interest earned on the fund and any remaining balance
3 shall be retained in the fund. The agency shall maintain records indicating the
4 amount of money in the fund at any time.

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

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

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

10 § 1829. IMPLEMENTATION; WAIVER

11 (a) Green Mountain Care shall be implemented 90 days following the last
12 to occur of:

13 (1) Enactment of a law establishing the financing for Green Mountain
14 Care.

15 (2) Approval by the Green Mountain Care board of the initial Green
16 Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

17 (3) Enactment of the appropriations for the initial Green Mountain Care
18 benefit package proposed by the Green Mountain Care board pursuant to 18
19 V.S.A. § 9375.

20 (4) Receipt of a waiver under Section 1332 of the Affordable Care Act
21 pursuant to subsection (b) of this section.

1 (b) As soon as available under federal law, the secretary of administration
2 shall seek a waiver to allow the state to suspend operation of the Vermont
3 health benefit exchange and to enable Vermont to receive the appropriate
4 federal fund contribution in lieu of the federal premium tax credits,
5 cost-sharing subsidies, and small business tax credits provided in the
6 Affordable Care Act. The secretary may seek a waiver from other provisions
7 of the Affordable Care Act as necessary to ensure the operation of Green
8 Mountain Care.

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

10 § 401. COMPOSITION OF DEPARTMENT

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

16 Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY

17 UNIT

18 After March 15, 2012 but not later than July 1, 2013, the secretary of
19 administration shall transfer to and place under the supervision of the
20 commissioner of Vermont health access all employees, professional and
21 support staff, consultants, positions, and all balances of all appropriation

1 amounts for personal services and operating expenses for the administration of
2 health care eligibility currently contained in the department for children and
3 families. No later than January 15, 2012, the secretary shall provide to the
4 house committees on health care and on human services and the senate
5 committee on health and welfare a plan for transferring the positions and
6 funds.

7 * * * Consumer and Health Care Professional Advisory Board * * *

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

9 § 402. ~~CONSUMER AND HEALTH CARE PROFESSIONAL~~

10 **MEDICAID AND EXCHANGE ADVISORY BOARD**

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

16 (b)(1) The commissioner shall appoint members of the advisory board
17 **established by this section,** who shall serve staggered three-year terms. The
18 total membership of the advisory board shall be no less than 20 members nor
19 more than 24 members. The commissioner may remove members of the board
20 who fail to attend three consecutive meetings and may appoint replacements.

1 (2) One-quarter of the members of the advisory board shall be from each
2 of the following constituencies:

3 (A) beneficiaries of Medicaid or Medicaid-funded programs.

4 (B) individuals, self-employed individuals, and representatives of
5 small businesses eligible for or enrolled in the Vermont health benefit
6 exchange.

7 (C) advocates for consumer organizations.

8 (D) health care professionals and representatives from a broad range
9 of health care professionals.

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

15 (c)(1) The **advisory** board shall have an opportunity to review and
16 comment ~~upon~~ agency policy initiatives pertaining to quality improvement
17 initiatives and to health care benefits and eligibility for individuals receiving
18 services through Medicaid, programs funded with Medicaid funds under a
19 Section 1115 waiver, or the Vermont health benefit exchange. It also shall
20 have the opportunity to comment on proposed rules prior to commencement of
21 the rulemaking process pursuant to chapter 25 of Title 3 and on waiver or

1 waiver amendment applications prior to submission to the Centers for
2 Medicare and Medicaid Services.

3 (2) Prior to the annual budget development process, the department of
4 Vermont health access shall engage the advisory committee in setting
5 priorities, including consideration of scope of benefits, beneficiary eligibility,
6 funding outlook, financing options, and possible budget recommendations.

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

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

18 (e) The commissioner shall convene the advisory committee at least 10
19 times during each calendar year. ~~One-third~~ If at least one-third of the
20 members of the advisory board ~~members so choose, the members~~ may
21 convene up to four additional meetings per calendar year on their own

1 initiative by sending a request to the commissioner. The department shall
2 provide the board with staffing and independent technical assistance as needed
3 to enable it to make effective recommendations.

4 * * * Planning Initiatives * * *

5 Sec. 8. INTEGRATION PLAN

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

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

13 (A) Whether it is advisable to establish a basic health program for
14 individuals with incomes above 133 percent of the federal poverty level (FPL)
15 and at or below 200 percent of FPL pursuant to Section 1331 of the Patient
16 Protection and Affordable Care Act (Public Law 111-148), as amended by the
17 federal Health Care and Education Reconciliation Act of 2010 (Public Law
18 111-152), and as further amended (“Affordable Care Act”), to ensure that the
19 health coverage is comprehensive and affordable for this population.

20 (B)(1) The statutory changes necessary to integrate the private
21 insurance markets with the Vermont health benefit exchange, including

1 whether to impose a moratorium on the issuance of new association policies
2 prior to 2014, as well as whether to continue exemptions for associations
3 pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health
4 benefit exchange and if so, what criteria to use.

5 **(2) The advantages and disadvantages of defining a small employer**
6 **for purposes of the Vermont health benefit exchange for the period from**
7 **January 1, 2014 through December 31, 2015 as an employer with up to 50**
8 **employees or as an employer with up to 100 employees.**

9 (C) In consultation with the Green Mountain Care board, the design
10 of a common benefit package for the Vermont health benefit exchange. When
11 creating the common benefit package, the secretary shall compare the essential
12 benefits package defined under federal regulations implementing the
13 Affordable Care Act with Vermont's insurance mandates, consider the
14 affordability of cost-sharing both with and without the cost-sharing subsidy
15 provided under federal regulations implementing the Affordable Care Act, and
16 determine the feasibility and appropriate design of cost-sharing amounts which
17 provide an incentive to patients to seek evidence-based health interventions
18 and to avoid health services with less proven effectiveness.

19 (D) The potential for purchasing prescription drugs in Green
20 Mountain Care through Medicaid, the 340B drug pricing program, or another
21 bulk purchasing mechanism.

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

5 (3)(A) How to collect data to enable the Green Mountain Care board to
6 monitor the extent to which residents of other states move to Vermont for the
7 purpose of receiving health services and the impact of such migration on the
8 Vermont's health care system and the state's economy.

9 (B) How to collect data to enable the agency of human services to
10 monitor the extent to which residents of other states move to Vermont for the
11 purpose of receiving public benefits other than health care.

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

19 **(5) whether it is necessary or advisable to implement a financial**
20 **reserve requirement or reinsurance mechanism to reduce the state's**
21 **exposure to financial risk in the operation of Green Mountain Care;**

1
2 (b) The commissioner of labor, in consultation with the commissioner of
3 Vermont health access, the commissioner of banking, insurance, securities, and
4 health care administration, and interested stakeholders, shall evaluate the
5 feasibility of integrating or aligning Vermont's workers' compensation system
6 with Green Mountain Care, **including providing any covered services in**
7 **addition to those in the Green Mountain Care benefit package that may be**
8 **appropriate for injuries arising out of and in the course of employment.**

9 No later than January 15, 2012, the commissioner of labor shall report the
10 results of the evaluation and, if integration or alignment has been found to be
11 feasible, make recommendations on how to achieve it.

12 Sec. 9. FINANCING PLANS

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

17 (1) One plan shall recommend the amounts and necessary mechanisms
18 to finance any initiatives which must be implemented by January 1, 2014 in
19 order to provide coverage to all Vermonters in the absence of a waiver from
20 certain federal health care reform provisions established in Section 1332 of the
21 Patient Protection and Affordable Care Act (Public Law 111-148), as amended

1 by the federal Health Care and Education Reconciliation Act of 2010 (Public
2 Law 111-152), and as further amended (“Affordable Care Act”).

3 (2) The second plan shall recommend the amounts and necessary
4 mechanisms to finance Green Mountain Care and any systems improvements
5 needed to achieve a public-private single payer health care system. The
6 secretary shall recommend whether nonresidents employed by Vermont
7 businesses should be eligible for Green Mountain Care and solutions to other
8 cross-border issues.

9 (b) In developing both financing plans, the secretary shall consider the
10 following:

11 (1) financing sources, including adjustments to the income tax, a payroll
12 tax, consumption taxes, provider assessments required under 33 V.S.A. chapter
13 19, the employer assessment required by 21 V.S.A. chapter 25, other new or
14 existing taxes, and additional options as determined by the secretary;

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

18 (3) issues involving federal law and taxation;

19 (4) impacts of tax system changes:

20 (A) on individuals, households, businesses, public sector entities, and
21 the nonprofit community;

1 (B) over time, on changing revenue needs; and

2 (C) for the transitional period, while the tax system and health care
3 cost structure are changing, on the potential for double payments, such as
4 premiums and tax obligations;

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

6 (6) the costs of maintaining existing state insurance mandates and other
7 appropriate considerations in order to determine the state contribution required
8 under the Affordable Care Act;

9 (7) additional funds needed to support recruitment and retention
10 programs for ~~primary care~~ health professionals in order to address the
11 ~~shortage of primary care~~ **shortage professionals and other specialty care**
12 **professionals in this state;**

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

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

18 (10) ~~how to enable parents to make coverage under Green~~
19 ~~Mountain Care available to an adult child up to age 26 who would not~~
20 ~~otherwise be eligible for coverage under the program, how to collect a~~
21 ~~financial contribution for such coverage, and whether to allow all adult~~

1 ~~children up to age 26 to be eligible or limit eligibility to adult children~~
2 ~~attending a college or university.~~

3 ~~(11) whether it is necessary or advisable to implement a financial~~
4 ~~reserve requirement or reinsurance mechanism to reduce the state's~~
5 ~~exposure to financial risk in the operation of Green Mountain Care;~~

6 ~~(12) whether to provide individuals eligible for Medicare with any~~
7 ~~additional benefits provided as part of the Green Mountain Care benefit~~
8 ~~package and, if so, how to include such individuals in contributing to the~~
9 ~~financing for the additional benefits require eligible individuals to enroll~~
10 ~~in Medicare in order to become eligible or maintain eligibility for Green~~
11 ~~Mountain Care;~~

12 ~~(11) using financial or other incentives to encourage healthy lifestyles~~
13 ~~and patient self-management for individuals enrolled in Green Mountain Care;~~
14 ~~and~~

15 ~~(12) the implications of Green Mountain Care on funds set aside to pay~~
16 ~~for future retiree health benefits.~~

17 ~~(c) In developing the financing plan for Green Mountain Care, the secretary~~
18 ~~of administration or designee shall solicit input from interested stakeholders,~~
19 ~~including health care professionals, employers, and members of the public and~~
20 ~~shall provide opportunities for public engagement in the design of the 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 single payer health 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 a
12 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 existing funding sources available for such
17 development. The health information technology plan or design and
18 implementation plan shall also include;

19 ~~(1) the creation of a smart card as defined in 33 V.S.A. § 1822 in~~
20 ~~order to ensure that this technology is developed prior to the~~
21 ~~implementation of Green Mountain Care;~~

1 ~~(2)~~ a review of the multi-payer database established in 18 V.S.A. § 9410
2 to determine whether there are systems modifications needed to use the
3 database to reduce fraud, waste, and abuse; and

4 ~~(3)~~ **shall include** other systems analysis as specified by the secretary.

5 (c) The secretary shall make recommendations to the house committee on
6 health care and the senate committee on health and welfare based on the design
7 and implementation plan no later than January 15, 2012.

8 Sec. 11. HEALTH SYSTEM PLANNING, REGULATION, AND PUBLIC
9 HEALTH

10 (a) No later than January 15, 2012, the secretary of administration or
11 designee shall make recommendations to the house committee on health care
12 and the senate committee on health and welfare on how to unify Vermont's
13 current efforts around health system planning, regulation, and public health,
14 including:

15 (1) How best to align the agency of human services' public health
16 promotion activities with Medicaid, the Vermont health benefit exchange
17 functions, Green Mountain Care, and activities of the Green Mountain Care
18 board established in 18 V.S.A. chapter 220.

19 (2) After reviewing current resources, including the community health
20 assessments, how to create an integrated system of community health
21 assessments, health promotion, and planning, including by:

1 (A) improving the use and usefulness of the health resource
2 allocation plan established in 18 V.S.A. § 9405 in order to ensure that health
3 resource planning is effective and efficient; and

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

8 (3) In collaboration with the director of the Blueprint for Health
9 established in 18 V.S.A. chapter 13 and health care professionals, how to
10 coordinate quality efforts across state government and private payers; optimize
11 quality assurance programs; and ensure that health care professionals in
12 Vermont utilize, are informed of, and engage in evidence-based practice.

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

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

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

1 the certificate of need process provided in 18 V.S.A. chapter 221, subchapter 5
2 and recommend to the house committee on health care and the senate
3 committee on health and welfare statutory modifications needed to enable the
4 participation of the Green Mountain Care board as set forth in 18 V.S.A.
5 § 9375.

6 Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

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

15 Sec. 13. WORKFORCE ISSUES

16 (a)(1) Currently, Vermont has a shortage of primary care professionals, and
17 many practices are closed to new patients. **It also experiences periodic and**
18 **geographic shortages of specialty care professionals necessary to ensure**
19 **that Vermonters have reasonable access to a broad range of health**
20 **services within the state.** In order to ensure sufficient patient access now and
21 in the future, it is necessary to plan for the implementation of Green Mountain

1 Care and utilize Vermont's health care professionals to the fullest extent of
2 their professional competence.

3 (2) The board of nursing, the board of medical practice, and the office of
4 professional regulation, in consultation with the primary care workforce
5 development committee established in Sec. 31 of No. 128 of the Acts of the
6 2009 Adj. Sess. (2010), shall collaborate to determine how to optimize the
7 primary care workforce by reviewing the licensure process, scope of practice
8 requirements, reciprocity of licensure, and efficiency of the licensing process,
9 and by identifying any other barriers to augmenting Vermont's primary care
10 workforce. No later than January 15, 2012, the boards and office shall provide
11 to the house committee on health care and the senate committee on health and
12 welfare joint recommendations for improving the primary care workforce
13 through the boards' and office's rules and procedures.

14 (3) The Green Mountain Care board, in consultation with hospitals,
15 the Vermont Medical Society, and other professional organizations and
16 individuals, shall identify specialty practice areas that regularly face
17 shortages of qualified health care professionals and shall develop
18 strategies for ensuring that Vermont residents have reasonable access to
19 these health services while leveraging existing resources to the extent
20 possible.

1 **(b) No later than January 15, ~~2012~~ 2013, the secretary of administration or**
2 **designee shall make recommendations to the house committee on health care**
3 **and the senate committee on health and welfare on how to ensure that all**
4 **Vermont residents have a medical home through the Blueprint for Health**
5 **pursuant to 18 V.S.A. chapter 13.**

6 **(c) The department of labor and the agency of human services shall**
7 **collaborate to create a plan to address the retraining needs of employees who**
8 **may become dislocated due to a reduction in health care administrative**
9 **functions when the Vermont health benefit exchange and Green Mountain**
10 **Care are implemented. The plan shall include consideration of new training**
11 **programs and scholarships or other financial assistance necessary to ensure**
12 **adequate resources for training programs and to ensure that employees have**
13 **access to these programs. The department and agency shall provide**
14 **information to employers whose workforce may be reduced in order to ensure**
15 **that the employees are informed of available training opportunities. The**
16 **department shall provide the plan to the house committee on health care and**
17 **the senate committee on health and welfare no later than January 15, 2012.**

18 **(d) The department of Vermont health access, in consultation with the**
19 **area health education centers, shall monitor the extent to which individual**
20 **health care professionals begin and cease to practice in their applicable**
21 **fields in Vermont during each state fiscal year. No later than February 15**

1 of each year, the department shall report to the house committee on health
2 care and the senate committee on health and welfare on the changes in the
3 number of each type of health care professional practicing in Vermont
4 during the preceding fiscal year.

5 * * * Cost Estimates * * *

6 Sec. 14. ~~{Deleted}~~ COST ESTIMATES

7 (a) No later than April 21, 2011, the legislative joint fiscal office and the
8 department of banking, insurance, securities, and health care administration
9 shall provide to the house committee on health care and the senate committee
10 on health and welfare an initial, draft estimate of the costs of Vermont's
11 current health care system compared to the costs of a reformed health care
12 system upon implementation of Green Mountain Care and ~~based on the~~
13 additional provisions of this act. To the extent possible, the estimates shall be
14 based on the ~~BISHCA~~ department of banking, insurance, securities, and
15 health care administration's expenditure report and additional data available
16 in the multi-payer database ~~provided for in~~ established in 18 V.S.A. § 9410.

17 (b) The legislative joint fiscal office and the department of banking,
18 insurance, securities, and health care administration shall report their
19 final estimates of the costs described in subsection (a) of this section ~~shall~~
20 be reported to the committees of jurisdiction no later than November 1,
21 2011.

* * * Rate Review * * *

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

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates, and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, or in the case of a request for a rate increase, until a decision by the **Green Mountain Care** board as provided herein, unless the commissioner shall sooner give his or her written approval thereto. Beginning July 1, 2013, prior to approving a rate increase, the commissioner shall seek approval for such rate increase from the Green Mountain Care board established in 18 V.S.A. chapter 220, which shall approve or disapprove the rate increase within 10 business days. The commissioner shall apply the decision of the health reform board as to rates referred to the board.

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access

1 to health care, and is not unjust, unfair, inequitable, misleading, or contrary to
2 the law of this state. The commissioner shall notify in writing the insurer
3 which has filed any such form, premium rate, or rule if it contains any
4 provision which is ~~unjust, unfair, inequitable, misleading, or contrary to the~~
5 ~~law of this state~~ does not meet the standards expressed in this section. In such
6 notice, the commissioner shall state that a hearing will be granted within 20
7 days upon written request of the insurer. ~~In all other cases, the commissioner~~
8 ~~shall give his or her approval.~~

9 (3) After the expiration of ~~such 30 days from the filing of any such~~
10 ~~form, premium rate or rule,~~ the review period provided herein or at any time
11 after having given written approval, the commissioner may, after a hearing of
12 which at least 20 ~~days~~ days' written notice has been given to the insurer using
13 such form, premium rate, or rule, withdraw approval on any of the grounds
14 stated in this section. Such disapproval shall be effected by written order of
15 the commissioner which shall state the ground for disapproval and the date, not
16 less than 30 days after such hearing when the withdrawal of approval shall
17 become effective.

18 (b) In conjunction with a rate filing required by subsection (a) of this
19 section, an insurer shall file a plain language summary of any requested rate
20 increase of five percent or greater. If, during the plan year, the insurer files for
21 rate increases that are cumulatively five percent or greater, the insurer shall file

1 a summary applicable to the cumulative rate increase. The summary shall
2 include a brief justification of any rate increase requested, information required
3 by the Secretary of the U.S. Department of Health and Human Services (HHS)
4 for rate increases over 10 percent, and any other information required by the
5 commissioner. The plain language summary shall be in the format required by
6 the Secretary of HHS pursuant to the Patient Protection and Affordable Care
7 Act of 2010, Public Law 111-148, as amended by the Health Care and
8 Education Reconciliation Act of 2010, Public Law 111-152, and shall include
9 notification of the public comment period established in subsection (c) of this
10 section. In addition, the insurer shall post the summaries on its website.

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

14 (2) Beginning no later than January 1, 2012, the commissioner shall post
15 the filings pursuant to subsection (a) of this section and summaries pursuant to
16 subsection (b) of this section on the department's website within five days of
17 filing. The department shall provide an electronic mechanism for the public to
18 comment on proposed rate increases over five percent. The public shall have
19 21 days from the posting **of** the summaries and filings to provide public
20 comment. The department shall review and consider the public comments prior
21 to the expiration of the review period pursuant to subsection (a) of this section.

1 The department shall provide the Green Mountain Care board with the public
2 comments for their consideration in approving any rate increases.

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

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

10 The contracts of a hospital service corporation which operates a medical
11 service plan under this subsection shall be governed by chapter 125 of this title
12 to the extent that they provide for medical service benefits, and by this chapter
13 to the extent that the contracts provide for hospital service benefits.

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

15 § 4515a. FORM AND RATE FILING; FILING FEES

16 Every contract or certificate form, or amendment thereof, including the rates
17 charged therefor by the corporation shall be filed with the commissioner for his
18 or her approval prior to issuance or use. Prior to approval, there shall be a
19 public comment period pursuant to section 4062 of this title. In addition, each
20 such filing shall be accompanied by payment to the commissioner of a

1 nonrefundable fee of \$50.00 and the plain language summary of rate increases
2 pursuant to section 4062 of this title.

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

4 § 4587. FILING AND APPROVAL OF CONTRACTS

5 A medical service corporation which has received a permit from the
6 commissioner of banking, insurance, securities, and health care administration
7 under section 4584 of this title shall not thereafter issue a contract to a
8 subscriber or charge a rate therefor which is different from copies of contracts
9 and rates originally filed with such commissioner and approved by him or her
10 at the time of the issuance to such medical service corporation of its permit,
11 until it has filed copies of such contracts which it proposes to issue and the
12 rates it proposes to charge therefor and the same have been approved by such
13 commissioner. Prior to approval, there shall be a public comment period
14 pursuant to section 4062 of this title. Each such filing of a contract or the rate
15 therefor shall be accompanied by payment to the commissioner of a
16 nonrefundable fee of \$50.00. A medical service corporation shall file a plain
17 language summary of rate increases pursuant to section 4062 of this title.

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

19 (a)(1) A health maintenance organization which has received a certificate of
20 authority under section 5102 of this title shall file and obtain approval of all
21 policy forms and rates as provided in sections 4062 and 4062a of this title. This

1 requirement shall include the filing of administrative retentions for any
2 business in which the organization acts as a third party administrator or in any
3 other administrative processing capacity. The commissioner may request and
4 shall receive any information that is needed to determine whether to approve
5 the policy form or rate. In addition to any other information requested, the
6 commissioner shall require the filing of information on costs for providing
7 services to the organization's Vermont members affected by the policy form or
8 rate, including but not limited to Vermont claims experience, and
9 administrative and overhead costs allocated to the service of Vermont
10 members. Prior to approval, there shall be a public comment period pursuant to
11 section 4062 of this title. A health maintenance organization shall file a
12 summary of rate filings pursuant to section 4062 of this title.

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

* * * Employer Benefit Information * * *

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

§ 2004. HEALTH BENEFIT COSTS

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

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

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

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

(b) Notwithstanding the provisions of subsection (a) of this section, an employer who reports the cost of coverage under an employer-sponsored health benefit plan as required by 26 U.S.C. § 6051(a)(14) shall be deemed to be in full compliance with the requirements of this section.

* * * Consumer Protection * * *

**Sec. 17. ~~CONSUMER PROTECTION STUDY~~ REVIEW OF BAN ON
DISCRETIONARY CLAUSES**

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting ~~the a~~ National Association of Insurance Commissioners (NAIC) model act, ~~which prohibits~~ prohibiting insurers from

1 using discretionary clauses in their health benefit contracts. The purpose of the
2 NAIC model act is to prohibit insurance clauses that purport to reserve
3 discretion to the insurer to interpret the terms of the policy, **or** to provide
4 standards of interpretation or review that are inconsistent with the laws of this
5 state.

6 (b) No later than January 15, 2012, the commissioner of banking, insurance,
7 securities, and health care administration shall provide a report to the house
8 committee on health care and the senate committee on health and welfare on
9 the advantages and disadvantages of Vermont adopting the NAIC model act.

10 * * * Single Formulary * * *

11 Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

12 No later than January 15, 2012, the department of Vermont health access
13 shall provide recommendations to the house committee on health care and the
14 senate committee on health and welfare regarding:

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

**feasibility of enabling all prescription drugs purchased by or on behalf of
Vermont residents to be purchased through the Medicaid program or
pursuant to the 340B drug pricing program.**

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

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

Secs. 18-24. [Deleted.]

* * * Conforming Revisions * * *

Sec. 25. 3 V.S.A. § 2222a is amended to read:

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

(a) The secretary of administration shall be responsible for the coordination
of health care system reform initiatives among executive branch agencies,
departments, and offices.

1 (b) The secretary shall ensure that those executive branch agencies,
2 departments, and offices responsible for the development, improvement, and
3 implementation of Vermont's health care system reform do so in a manner that
4 is timely, **equitable**, patient-centered, evidence-based, and seeks to inform and
5 improve the quality and affordability of patient care and public health.

6 (c) Vermont's health care system reform initiatives include:

7 (1) The state's chronic care infrastructure, disease prevention, and
8 management program contained in the blueprint for health established by
9 chapter 13 of Title 18, the goal of which is to achieve a unified,
10 comprehensive, statewide system of care that improves the lives of all
11 Vermonters with or at risk for a chronic condition or disease.

12 (2) The Vermont health information technology project pursuant to
13 chapter 219 of Title 18.

14 (3) The multi-payer data collection project pursuant to 18 V.S.A.
15 § 9410.

16 (4) The common claims administration project pursuant to 18 V.S.A.
17 § 9408.

18 (5) The consumer price and quality information system pursuant to
19 18 V.S.A. § 9410.

20 (6) Any information technology work done by the quality assurance
21 system pursuant to 18 V.S.A. § 9416.

1 (7) The public health promotion programs of the agency of human
2 services, including primary prevention for chronic disease, community
3 assessments, school wellness programs, public health information technology,
4 data and surveillance systems, healthy retailers, healthy community design,
5 and alcohol and substance abuse treatment and prevention programs.

6 (8) ~~Medicaid, the Vermont health access plan, Dr. Dynasaur, premium~~
7 ~~assistance programs for employer sponsored insurance, VPharm, and Vermont~~
8 ~~Rx, which are established in chapter 19 of Title 33 and provide health care~~
9 ~~coverage to elderly, disabled, and low to middle income Vermonters. The~~
10 creation of a **single-payer universal** health care system to provide affordable,
11 high-quality health care coverage to all Vermonters and to include federal
12 funds to the maximum extent allowable under federal law and waivers from
13 federal law.

14 (9) ~~Catamount Health, established in 8 V.S.A. § 4080f, which provides a~~
15 ~~comprehensive benefit plan with a sliding scale premium based on income to~~
16 ~~uninsured Vermonters. A reformation of the payment system for health care~~
17 set forth in 18 V.S.A. chapter 220 in order to ensure that payment for services
18 encourages health care quality and efficiency, and reduces unnecessary
19 services.

20 (10) ~~The uniform hospital uncompensated care policies. A strategic~~
21 approach to workforce needs, including retraining programs for workers

1 displaced through increased efficiency and reduced administration in the health
2 care system and ensuring an adequate **primary health** care workforce to
3 provide access to **primary health** care for all Vermonters.

4 ~~(d) The secretary shall report to the commission on health care reform, the~~
5 ~~health access oversight committee, the house committee on health care, the~~
6 ~~senate committee on health and welfare, and the governor on or before~~
7 ~~December 1, 2006, with a five year strategic plan for implementing Vermont's~~
8 ~~health care system reform initiatives, together with any recommendations for~~
9 ~~administration or legislation. Annually, beginning January 15, 2007, the~~
10 ~~secretary shall report to the general assembly on the progress of the reform~~
11 ~~initiatives.~~

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

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

17 § 5. DUTIES OF DEPARTMENT OF HEALTH

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

20 (1) ~~Conducting~~ Conduct studies, ~~developing~~ develop state plans, and
21 ~~administering~~ administer programs and state plans for hospital survey and

1 construction, hospital operation and maintenance, medical care, and treatment
2 of ~~alcoholics and alcoholic rehabilitation~~ substance abuse.

3 (2) ~~Providing~~ Provide methods of administration and such other action
4 as may be necessary to comply with the requirements of federal acts and
5 regulations as relate to studies, ~~developing~~ development of plans and
6 ~~administering~~ administration of programs in the fields of health, public health,
7 health education, hospital construction and maintenance, and medical care.

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

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

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

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

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

1 (a)(1) The commissioner shall establish and maintain a unified health care
2 data base to enable the commissioner and the Green Mountain Care board to
3 carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title
4 8, including:

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

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

7 (C) Evaluating the effectiveness of intervention programs on
8 improving patient outcomes.

9 (D) Comparing costs between various treatment settings and
10 approaches.

11 (E) Providing information to consumers and purchasers of health
12 care.

13 (F) Improving the quality and affordability of patient health care and
14 health care coverage.

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

17 Sec. 10. IMPLEMENTATION OF CERTAIN FEDERAL HEALTH
18 CARE REFORM PROVISIONS

19 (a) From the effective date of this act through July 1, ~~2014~~ 2014, the
20 commissioner of health shall undertake such planning steps and other actions
21 as are necessary to secure grants and other beneficial opportunities for

1 Vermont provided by the Patient Protection and Affordable Care Act of 2010,
2 Public Law 111-148, as amended by the Health Care and Education
3 Reconciliation Act of 2010, Public Law 111-152.

4 (b) From the effective date of this act through July 1, ~~2014~~ 2014, the
5 commissioner of Vermont health access shall undertake such planning steps as
6 are necessary to ensure Vermont's participation in beneficial opportunities
7 created by the Patient Protection and Affordable Care Act of 2010, Public Law
8 111-148, as amended by the Health Care and Education Reconciliation Act of
9 2010, Public Law 111-152.

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

12 (d) Term of committee. The committee shall cease to exist on January 31,
13 ~~2014~~ 2012.

14 Sec. 30. REPEAL

15 (a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective
16 ~~December 31, 2013~~ July 1, 2012.

17 (b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective
18 ~~June 30, 2011~~ July 1, 2011.

1 Sec. 31. APPROPRIATIONS

2 (a) In fiscal year 2012, the sum of ~~\$855,244.00~~ **\$807,182.00** in general
3 funds and ~~\$285,081.00~~ **\$355,727.00** in federal funds is appropriated to the
4 Green Mountain Care board to carry out its functions.

5 (b) In fiscal year 2012, the sum of ~~\$100,000.00~~ **\$48,000.00** is appropriated
6 from the general fund to the secretary of administration for the malpractice
7 **study created in proposal pursuant to Sec. 14 2(e)** of this act.

8 Sec. 32. EFFECTIVE DATES

9 (a) Secs. 2 (strategic plan), 8 (integration plan), 9 (financing plans), 10
10 (HIT), 11 (health planning), 12 (regulatory process), 13 (workforce), **14 (cost**
11 **estimates)**, 17 (discretionary clauses), **18** (single formulary), 25 (health care
12 reform), 26 (department of health), 28 (ACA grants), and 29 (primary care
13 workforce committee) of this act and this section shall take effect on passage.

14 (b) Secs. 3 (Green Mountain Care board), 3a (health care ombudsman), **3b**
15 **(positions), 3c and 3d (manufacturers of prescribed products), 5 (DVHA),**
16 **6 (Health care eligibility), 30 (repeal), and 31 (appropriations) shall take effect**
17 **on July 1, 2011.**

18 (c)(1) Sec. 4 (Vermont health benefit exchange; Green Mountain Care)
19 shall take effect on July 1, 2011.

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

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

6 (A) Enactment of a law establishing the financing for Green
7 Mountain Care.

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

10 (C) Enactment of the appropriations for the initial Green Mountain
11 Care benefit package proposed by the Green Mountain Care board pursuant to
12 18 V.S.A. § 9375.

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

15 (d) Sec. 7, 3 V.S.A. § 402 (~~patient and health care professionals~~
16 Medicaid and exchange advisory board), shall take effect ~~on January 1,~~
17 ~~2014 July 1, 2012.~~

18 (e) Sec. 15 (rate review) shall take effect on October 1, 2011 and shall
19 apply to all filings on and after October 1, 2011, except that the amendments to
20 § 4062(c)(2) shall take effect on January 1, 2012 and shall apply to all filings
21 on and after that date.

1 (f) Secs. 16 (health benefit information) and 27 (VHCURES) shall take
2 effect on October 1, 2011.

3

4 **and that after passage the title of the bill be amended to read: “An act**
5 **relating to a universal and unified health system”**

6

7 (Committee vote: _____)

8

9

Representative [surname]

10

FOR THE COMMITTEE