S.88

Introduced by Senators Flanagan, McCormack, Ashe, Ayer, Campbell, Choate, Cummings, Giard, Hartwell, Kittell, Lyons, MacDonald. Shumlin, Starr and White

Referred to Committee on Health and Welfare

Date: February 17, 2009

Subject: Health care; universal access; reform; department organization

Statement of purpose: This bill proposes to establish the goal of universal access to essential health care services in Vermont through a publicly financed, integrated, regional health care delivery system; provide mechanisms for cost containment in the system; and provide a framework, schedule, and process to achieve that goal.

An act relating to health care financing and universal access to health care in Vermont

It is hereby enacted by the General Assembly of the State of Vermont:

Sec. 1. FINDINGS

The general assembly finds that:

(1) Vermont's health care infrastructure and services are public goods that are essential to the well-being of every Vermonter, and yet the

~~infrastructure and services, including hospitals and other care systems, are~~ financially threatened.

(A) The financial danger to Vermont's nonprofit hospitals is evidenced by extremely narrow operating margins, rising costs, and increasing levels of uncompensated care.

(B) Hospital budgets are challenged by uneven and uncertain reimbursements received from a multitude of payers and by the escalating costs associated with insurance administration and bill collection.

(C) Competition between hospitals for a market share has forced hospitals to make decisions purely on the basis of financial concerns, rather than on the basis of community needs.

(D) The closing or for-profit conversion of any of Vermont's hospitals would severely impact Vermonters' access to quality health care services.

(E) Primary care and preventive services in Vermont have become more difficult to sustain because reimbursement rates favor advanced and specialty care over primary care.

(F) Fewer medical students are choosing to practice primary care, and many Vermont primary care physicians are nearing retirement.

~~(G) Insurance administration and bill collection have become~~ increasing burdens for primary care physicians, detracting from clinical practice.

~~(H)~~ Increasing numbers of uninsured patients pose high-stakes ethical dilemmas for physicians and other health professionals making treatment decisions.

(I) Prevention, which can save lives as well as money, is short-changed as primary care options are diminished.

(2) Health care costs are rising at an unsustainable rate, causing hardships to individuals, families, businesses, taxpayers, and public institutions, and uncontrolled costs are threatening to paralyze the economy of the state of Vermont.

(A) In 2008, total Vermont health care spending was projected to be $4.58 billion.

(B) Health care costs have risen an average of 9–10 percent per year over the past 30–40 years, with the rate rising to 12–13 percent in more recent years. These figures are well above the Consumer Price Index and, moreover, exceed by far the state's capacity to pay for health care costs as measured against the state's gross state product and personal income. For example, between 2001 and 2006, health care spending in Vermont grew at an average annual rate of eight percent, while personal income grew at four percent and

~~the gross state product grew at three percent. Between 2001 and 2006, health~~ care spending increased approximately 48 percent, from $2.5 billion to $3.7 billion, while over the same period, personal income rose approximately 20 percent and the gross state product rose approximately 16 percent.

(C) The department of banking, insurance, securities, and health care administration projects that health care spending for Vermont residents will exceed $5 billion by 2010.

(D) Over one-half of bankruptcies nationally are associated with high medical expenses. In approximately three-quarters of health-related bankruptcies, the patient had insurance.

(E) In 2006, the state of Vermont spent $6,321.00 per capita on health care, more than any nation in the Organization for Economic Cooperation and Development—except the United States itself—when measured as a proportion of gross domestic product.

(F) Vermont's health care spending was 16 percent of the gross state product in 2006.

(G) The cost of health care has a strong negative impact on the ability of Vermont businesses and employers to compete in national and international markets.

(3) The current financing of health care is complex, fragmented, and inequitable.

~~(A) The current financing of health care is accomplished through an~~ inefficient and uncoordinated patchwork of public programs, private sector employer-sponsored self-insurance, commercial insurance, and individual payers.

(B) In general, costs fall disproportionately on those with serious health conditions, on those with moderate and lower incomes, and on those who pay for care out-of-pocket because they have no health insurance.

(C) The current financing of health care in Vermont creates incentives and disincentives within the system that often contradict the standards of best medical practice.

(D) The fragmented financing of health care results in a lack of coordination and accountability among health care professionals, payers, and patients at both the regional and statewide levels. The ability of the system to provide the highest quality of care to the greatest number of people and to respond to rapid changes in technology and medical advances is compromised.

(4) For a growing number of Vermonters, health care is unaffordable and therefore not available without incurring serious debt.

(A) Over 60,000 Vermonters have no health insurance. As a result, these citizens often do not receive care in the most timely and effective manner.

~~(B) Lack of insurance is associated with an increased rate of illness~~ and a shorter life expectancy.

(C) Premium cost increases have contributed to the growing rate of underinsurance, with more and more Vermonters purchasing high-deductible and less comprehensive plans.

(D) The disparities in coverage result in an unreasonable rationing of available health care services.

(E) The costs of health services provided to individuals who are unable to pay are shifted onto others. Those who bear the burden of this cost shift have an increasingly difficult time affording their own health care costs, including premiums.

(5) Although the quality of health care services in Vermont is generally very good, there is a need to improve quality, efficiency, and safety.

(A) Nationwide, there are an unacceptable number of adverse events attributable to medical errors, according to an Institute of Medicine report. Vermont is not immune to this problem.

(B) Disease and injury prevention, health promotion, and health protection continue to be overlooked as investments in public health.

Sec. 2. 3 V.S.A. § 212(23) is added to read:

(23) The department of health care administration.

~~Sec. 3. 18 V.S.A. chapter 8 is added to read:~~

CHAPTER 8. HEALTH CARE SERVICES AND ADMINISTRATION

Subchapter 1. General Provisions

§ 401. GUIDELINES FOR HEALTH CARE REFORM

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

(1) The health care infrastructure, including hospitals, primary care, and other services, must be preserved so that Vermonters continue to have care available to them within their own communities.

(2) A system for eliminating unnecessary expenditures and containing costs must be implemented so that health care spending does not bankrupt the Vermont economy.

(3) The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable, and such financing is best obtained when broad-based taxes replace insurance premiums and out-of-pocket payments.

(4) Universal access to health care is a public good, and therefore it is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.

(5) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be accountable in access, cost, quality, and reliability.

~~§ 402. GOALS OF HEALTH CARE REFORM~~

Consistent with the adopted guidelines for reforming health care in Vermont, the general assembly adopts the following goals:

(1) Vermont's nonprofit community hospital system will be preserved through a system of negotiated payments that are drawn from public revenues and which are based on annual global budgets.

(2) Vermont's primary care providers will be adequately compensated from public revenues through a uniform payment system that eliminates multiple insurers and reduces administrative burdens on providers.

(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems that:

(A) are integrated with each other;

(B) focus on meeting community health needs;

(C) match service capacity to community needs;

(D) coordinate and integrate care across the health care continuum;

(E) provide information on costs, quality, outcomes, and patient satisfaction;

(F) use financial incentives and organizational structure to achieve specific objectives; and

(G) improve continuously the quality of care provided.

~~(4) To ensure financial sustainability of Vermont's health care system,~~ the state is committed to slowing the rate of growth of health care costs to seven percent or less by the year 2014.

(5) Health care costs will be controlled by:

(A) a reduction in the number of payers of health care services and, therefore, the simplification of reimbursement mechanisms throughout the health care system;

(B) paying hospitals on the basis of annually negotiated global budgets;

(C) the elimination of administrative costs associated with private insurance and bill collection;

(D) the collective purchase of pharmaceuticals and other supplies through the establishment of a state drug formulary;

(E) the alignment of health care professional reimbursement with best practices and outcomes rather than utilization;

(F) efficient health facility planning, particularly with respect to technology;

(G) reductions in the prevalence of defensive medicine along with the prudent and efficient utilization of medical technology;

(H) encouraging the appropriate distribution of primary care services throughout the state; and

~~(I) removing competitive pressure between hospitals and other~~ facilities.

(6) To ensure fair financing of Vermont's health care system, all services covered by a state-sponsored benefits package will be financed primarily from broad-based taxes.

(7) To alleviate the historical dependence of health care access on employment, employers will be relieved of the burden of purchasing private health insurance for their employees. Instead, employers will be required to contribute a fair share of taxes toward the health care needs of the general population.

(8) All Vermont residents, subject to reasonable residency requirements, will be covered under a publicly sponsored benefits package, regardless of their age, employment, economic status, or their town of residency, even if they require health care while outside Vermont.

(9) All essential health services will be covered under the publicly sponsored benefits package. A process will be developed to define essential health services, taking into consideration scientific evidence, available funds, and the values and priorities of Vermonters. Coverage will follow the individual from birth to death and be responsive and seamless through employment and life changes.

~~(10) Vermonters' health outcomes and key indicators of public health~~ will show continuous improvement across all segments of the population.

(11) The number of adverse events from medical errors will be reduced.

(12) Disease and injury prevention, health promotion, and health protection will be incorporated into a publicly sponsored health care system.

§ 403. DEFINITIONS

As used in this chapter:

(1) "Board" means the Vermont health care board established by section 407 of this title to develop policy, approve reimbursement rates, hear appeals, and perform other quasi-judicial functions relating to the administration and implementation of VermontCare under this chapter.

(2) "Department" means the department of health care administration established by section 404 of this title to administer the publicly sponsored health care benefits package established under this chapter.

(3) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(4) "Health service" means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services provided pursuant to a physician's order and services to assist in activities of daily living.

~~(5) "Hospital" shall have the same meaning as in section 1902 of this title~~ and may include a hospital located outside Vermont.

(6) "Hospital service" means any health service received in a hospital and any associated costs for professional services.

(7) "Preventive care" means screening, counseling, treatment, or medication determined by scientific evidence to be effective in preventing or detecting disease.

(8) "Primary care" means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis. Primary care services include health promotion, preventive care, health maintenance, counseling, patient education, case management, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

(9) "VermontCare" means the package of essential health services established pursuant to this chapter.

(10) "Vermont resident" means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent. The health care board shall establish specific criteria to demonstrate residency.

~~Subchapter 2. Governance~~

§ 404. DEPARTMENT OF HEALTH CARE ADMINISTRATION

(a) On July 1, 2009, the department of health care administration is created and shall have the powers and duties established by this chapter. The department is the successor to and continuation of the division of health care administration of the department of banking, insurance, securities, and health care administration under chapter 221 of this title; the office of Vermont health access under section 3088 of Title 3; and the division of rate setting under chapter 9 of Title 33; and shall continue the duties of those departments as established in chapter 107 of Title 8, chapter 221 of this title, and chapters 9 and 19 of Title 33.

(b) The department shall be under the direction and supervision of a commissioner who shall be appointed by the governor with the advice and consent of the senate and shall serve at the pleasure of the governor.

(c) The department shall carry out its duties in such a way as to further the public good and shall follow the guidelines and goals established under this chapter.

(d) A health care quality unit is established in the commissioner's office and is responsible for establishing policy and procedures to improve, promote, and ensure quality of care and patient safety. The unit shall provide policy advice and oversight to the department to ensure that the department's

~~functions are carried out in such a way as to promote quality and safety. The~~ unit shall also collaborate with government and private entities and organizations which are engaged in efforts to improve quality of care.

§ 405. AUTHORITY OF THE COMMISSIONER

(a) The commissioner shall be responsible to the governor and shall plan, coordinate, and direct the functions vested in the department. The commissioner shall prepare and submit to the governor an annual budget and shall prepare and submit to the governor and the general assembly in November of each year a report concerning the operations of the department for the preceding state fiscal year and the future goals and objectives of the department.

(b) The commissioner shall establish such divisions as are necessary to carry out the duties of the department under this chapter and may establish advisory panels as necessary to further the goals of this chapter. The commissioner may employ professional and support staff necessary to carry out the functions of the department and may employ consultants and contract with individuals and entities for the provision of services.

(c) The commissioner may, subject to the provisions of section 5 of Title 32, apply for and accept gifts, grants, or contributions from any person for purposes consistent with this chapter.

(d) The commissioner shall meet regularly with representatives of the

~~community health boards established in section 408 of this title, professional~~ organizations, consumer groups, and other statewide organizations in order to ensure that there is public input into the implementation and ongoing administration of the provisions of this chapter.

(e) The commissioner shall consult and collaborate with the secretary of human services and the commissioner of education to ensure the effective and efficient operation of the provisions of this chapter.

(f) The commissioner may delegate the powers and assign the duties transferred from other departments, offices, and divisions to the department of health care administration in such a manner as the commissioner deems appropriate.

(g) The commissioner may adopt rules pursuant to chapter 25 of Title 3 to implement VermontCare as established by this chapter.

(h) Subject to the approval of the general assembly, the commissioner may apply for any waivers of federal law or regulation necessary to carry out the provisions of this chapter.

§ 406. DUTIES OF THE DEPARTMENT

In addition to the duties transferred pursuant to subsection 404(a) of this title, the department of health care administration shall:

(1) As directed by the health care board, implement a system of payment methodologies and amounts for hospitals and health care professionals under

~~this chapter.~~

(2) Implement the cost reduction targets established under subsection 410(c) of this title.

(3) Conduct planning and analysis, including designing and implementing procedures to evaluate, measure, and report to the governor and general assembly whether the guidelines under section 401 of this title and the goals under section 402 of this title are being met.

(4) Establish and maintain a database with information needed to carry out the commissioner's duties and obligations.

(5) Administer any spending for VermontCare established under this chapter, which may include any billing or collection functions necessary to implement this chapter.

(6) Establish a Vermont drug formulary that will negotiate discounts from manufacturers and establish uniform standards for prescription drug utilization under VermontCare.

§ 407. HEALTH CARE BOARD

(a) On July 1, 2009, a Vermont health care board is created and shall have the powers and duties established by this chapter. The board shall receive administrative support from the department. The board shall consist of one member appointed by the governor, one member appointed by the speaker of the house of representatives, and one member appointed by the president pro

~~tempore of the senate. The initial term of the member appointed by the~~ governor shall be three years, the initial term of the member appointed by the speaker of the house shall be two years, and the initial term of the member appointed by the president pro tempore of the senate shall be one year. Thereafter, each term shall be for three years. Members shall be removed only for cause. The member appointed by the governor shall be the chair. All members shall be part-time state employees. All members shall be exempt from the state classified system. A person in the employ of or holding any official relation to any health care provider subject to the supervision of the board, or engaged in the management of such health care provider, or owning stock, bonds, or other securities thereof, or who is, in any manner, connected with the operation of such health care provider shall not be a member of the board; nor shall any person holding the office of member personally or in connection with a partner or agent render professional health care services or make or perform any business contract with any health care provider subject to the board's supervision if such service or contract relates to the business of the health care provider, except contracts made as an individual or family in the regular course of obtaining health care services.

(b) The board shall:

(1) Develop the package of essential health services to be covered under VermontCare pursuant to section 409 of this title. The board shall ensure the

~~package of essential health services will provide a choice of services and of~~ health care professionals, contain costs over time, and improve the quality of care and health outcomes. In developing the package of essential health services, the board shall:

(A) engage in a public process designed to respond to Vermonters' health care values and priorities;

(B) consider the current range of health services received by Vermonters through public and private benefit packages;

(C) consider credible evidence-based scientific research and comments by health care professionals both nationally and internationally concerning clinical efficacy and risk;

(D) consider health care ethics;

(E) consider the cost-effectiveness of health services and technology;

(F) consider revenues anticipated to be available to finance VermontCare;

(G) consider the state health plan and the health resource allocation plan established under section 9405 of this title; and

(H) consider any Vermont-specific initiatives.

(2) Establish a system of payment methodologies and amounts for hospitals and health care professionals under this chapter.

(c) On or before February 1, 2011, the board shall propose to the general

~~assembly the package of essential health services to be covered under~~ VermontCare, to begin July 1, 2013.

(d) The board shall have the authority provided, and its proceedings shall be governed by provisions of the Administrative Procedure Act relating to contested cases in chapter 25 of Title 3.

(e) Beginning July 1, 2011, the board shall have jurisdiction to:

(1) hear contested cases for aggrieved parties of an adverse decision under chapter 19 of Title 33 and under this chapter;

(2) hear consumer complaints relating to health services;

(3) approve or amend reimbursement rates and methodologies established under this chapter, including global hospital budgets under section 414 of this title; and

(4) approve or amend certificate of need proposals under subchapter 5 of chapter 221 of this title, the unified health care budget under section 9406 of this title, and hospital budget reviews under subchapter 7 of chapter 221 of this title.

§ 408. INTEGRATED SYSTEMS OF CARE; COMMUNITY HEALTH BOARDS

(a) The delivery of health care in Vermont shall be integrated in order to provide a coordinated continuum of services to the citizens of Vermont and to improve health outcomes. Communities will integrate their health care

~~systems by organizing existing health care professionals, health care~~ institutions, and community members into a community health board that will act to assess, prioritize, and define community health needs.

(b) Based on a plan adopted by the general assembly, there shall be established a community health board in each region of the state. There shall be no fewer than three regions. The community health boards shall be implemented no later than January 1, 2011.

(c) Each community health board shall have the following duties: solicit public input; conduct a community needs assessment for incorporation into the health resources allocation plan; plan for community health needs based on the community needs assessment; develop budget recommendations and resource allocations for the region; and provide oversight and evaluation regarding the delivery of care in its region.

Subchapter 3. VermontCare

§ 409. VERMONTCARE; IMPLEMENTATION DATES

(a) The department of health care administration shall implement VermontCare to provide Vermont residents coverage for hospital services no later than July 1, 2011 and coverage for primary and preventive health services no later than July 1, 2012.

~~(b) No later than July 1, 2013, VermontCare shall include all other essential~~ health services in addition to primary care, preventive care, and hospital services to Vermont residents.

§ 410. BUDGET FOR PACKAGE OF HEALTH SERVICES

(a) After approval of the package of health services by the general assembly pursuant to subsection 407(c) of this title, the department shall develop a budget for the package based on the payment methodologies under section 411 of this title, negotiated payment amounts under section 412 of this title, and the cost containment targets under subsection (c) of this section.

(b) For each state fiscal year, beginning with state fiscal year 2012, the department shall propose its budget for the package of health services to the general assembly on or before January 15 of each year, including recommended expenditures during the next succeeding state fiscal year broken down by health care sector and region, and anticipated revenues available to support such expenditures.

(c) To further the goals established in section 402 of this title, the department shall develop and issue a cost containment target for each health care sector. The cost containment target shall be considered when negotiating payment amounts under section 412 of this title.

§ 411. PAYMENT METHODOLOGIES FOR HEALTH CARE PROFESSIONALS AND HOSPITALS

(a) Under the direction of the board, by February 1, 2010, the department shall determine by rule pursuant to chapter 25 of Title 3 the type of payment method to be used for each health care sector which provides health services under VermontCare. The payment methods shall be in alignment with the goals of this chapter and shall encourage cost-containment, provision of high quality, evidence-based health services in an integrated setting, patient self-management, and healthy lifestyles. In developing the payment methods, the board shall consult with health care professionals prior to the department filing draft rules for comment.

(b) The board shall consider the following payment methods:

(1) periodic payments based on approved annual global budgets;

(2) capitated payments;

(3) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of medications;

~~(4) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region; and~~

(5) fee for service.

§ 412. PAYMENT AMOUNTS

(a) The intent of this section is to ensure reasonable payments to health care professionals and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals under VermontCare is sufficient.

(b) The department shall negotiate with hospitals, health care professionals, and groups of health care professionals to establish payment amounts for health services provided by VermontCare. The amounts shall be sufficient to provide reasonable access to health services, provide sufficient uniform payment to health care professionals, and encourage the financial stability of health care professionals. In determining the payment amounts, the board shall consider:

(1) the advice and recommendations of the board;

(2) the actual cost of the health service;

(3) expected revenues;

(4) cost containment targets; and

(5) shared costs between affiliated health care professionals.

~~(c) The department shall negotiate with each hospital to establish a global~~ hospital payment for health services covered by VermontCare and provided by the hospital. The department shall consider the global hospital budget under section 414 of this title and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The global hospital payment shall be reflected as a specific line item in the department's annual budget submitted to the general assembly.

(d) The department shall negotiate a contract including payment methods and amounts with any out-of-state hospital that regularly treats a sufficient volume of Vermont residents to provide health services under VermontCare. The department may also contract with out-of-state hospitals for the provision of specialized health services under VermontCare that are not available locally to Vermonters.

(e) The department shall pay the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered by VermontCare received in an out-of-state hospital with which the department has not established a contract. The department shall develop a reference pricing system for nonemergency health services usually covered by VermontCare which are received in an out-of-state hospital with which the department has not contracted.

~~(f) To facilitate negotiation of payment amounts under this section, the~~ commissioner may approve the creation of one or more health care professional bargaining groups, consisting of health care professionals who choose to participate. The commissioner shall adopt by rule criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section. In authorizing the activities provided for in this section, the general assembly intends to displace state and federal antitrust laws by granting state action immunity for actions that might otherwise be considered to be in violation of state or federal antitrust laws.

§ 413. VERMONTCARE TRUST FUND

(a) The VermontCare trust fund is hereby established in the state treasury for the purpose of establishing a special fund to be the single source to finance health care coverage for beneficiaries of VermontCare as established under this subchapter.

(b) Into the fund shall be deposited:

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

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

(c) The fund shall be administered pursuant to subchapter 5 of chapter 7 of Title 32, except that interest earned on the fund and any remaining balance

~~shall be retained in the fund. The department of health care administration~~ shall maintain records indicating the amount of money in the fund at any time.

(d) All monies received by or generated to the fund shall be used only for the administration and delivery of health care covered through the VermontCare program administered by the department of health care administration under this subchapter.

(e) To the extent permitted under federal law and any Medicaid waiver, including the Global Commitment for Health Medicaid Section 1115 waiver, the monies received by or generated to the fund shall be matched by federal funds.

§ 414. GLOBAL HOSPITAL BUDGETS

(a) For each hospital fiscal year, beginning with hospital fiscal year 2012, the department shall develop a global hospital budget for each hospital located in Vermont. When developing the global hospital budget, the department shall consider the health resource allocation plan under section 9405 of this title and the unified health care budget under section 9406 of this title, as applicable to hospitals, the hospital budget review under section 9456 of this title, the global hospital payments under subsection 412(c) of this title, and all other revenue received by hospitals. The global hospital budget shall be submitted to the board for approval with sufficient time for the board to approve the budget no later than September 1 prior to the hospital fiscal year.

~~(b) For hospital fiscal year 2012 and thereafter, the global hospital budget~~ developed under subsection (a) of this section shall serve as a spending cap within which hospital costs are controlled, resources directed, and quality and access assured. The global hospital budget shall limit the total annual growth of hospital costs to the Consumer Price Index plus three percent. Prior to hospital fiscal year 2012, the growth rate of the Consumer Price Index plus three percent shall serve as a target amount. The department shall ensure that hospital budget reviews and certificates of need are consistent with the global hospital budget.

(c) The department shall adopt rules specifying the circumstances under which a hospital may seek amendment of its budget after approval by the board. An amendment to a hospital's budget shall be reviewed by the department before submission to the board for approval.

(d) The department may adopt rules for the development of a voluntary three-year global hospital budget process to facilitate long-term planning and to moderate variation in utilization. The rules shall include a process for annual budget adjustment within the three-year period.

(e) A hospital or health care professional aggrieved by an adverse decision of the department may appeal to the board.

~~§ 415. ADMINISTRATION; ENROLLMENT~~

(a) The department shall administer VermontCare or, under an open bidding process, solicit and receive bids from insurance carriers or third-party administrators for administration.

(b) Nothing in this chapter shall require an individual to enroll in VermontCare. Notwithstanding this provision, an individual who qualifies for enrollment and who seeks services covered by VermontCare shall be automatically enrolled.

(c) Nothing in this chapter shall require an individual covered by health insurance to terminate that insurance. Notwithstanding this provision, after July 1, 2013, private insurance companies shall hereby be prohibited from selling health insurance policies in Vermont that cover services already covered by VermontCare.

(d) An individual may elect to maintain supplemental health insurance if the individual so chooses, provided that after July 1, 2013, the supplemental insurance covers only services that are not already covered by VermontCare.

(e) Vermonters shall not be billed any additional amount for health services covered by VermontCare.

(f) The assistance provided under this chapter shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XVIII of the Social Security Act (Medicare) or by any other health

~~benefit plan funded solely with federal funds, such as federal health benefit~~ plans offered by the Veterans' Administration or to federal employees.

(g) The department shall ensure that VermontCare complies with the provisions of Title XIX of the Social Security Act (Medicaid) unless the department, after approval of the general assembly, seeks and receives a federal waiver.

(h) Any prescription drug coverage offered by VermontCare required by this chapter shall be consistent with the standards and procedures applicable to the pharmacy best practices and cost control program established by sections 1996 and 1998 of Title 33 and the state drug formulary.

(i) The department or plan administrator shall make available the necessary information, forms, and billing procedures to health care professionals to ensure payment for health services covered under VermontCare.

(j) An individual aggrieved by an adverse decision of the department or plan administrator may appeal to the board.

Sec. 4. TRANSFER OF POSITIONS

(a) Effective October 1, 2009 and consistent with the provisions of this act, the secretary of administration shall transfer to the department of health care administration and place under the supervision of the department's commissioner:

~~(1) All employees, contracts, consultants, and positions of the office of~~ Vermont health access under section 3088 of Title 3 and the remaining balances of all appropriation amounts for personal services and operating expenses.

(2) All employees, contracts, consultants, and positions of the division of rate setting under chapter 9 of Title 33 and the remaining balances of all appropriation amounts for personal services and operating expenses.

(3) All employees, contracts, consultants, and positions of the division of health care administration pursuant to chapter 221 of Title 18 and the remaining balances of all appropriation amounts for personal services and operating expenses.

(b) On or before November 1, 2009, the secretary of administration, in consultation with the commissioner of health care administration, shall provide a detailed report to the joint fiscal committee of all the transfers made under this section.

Sec. 5. STATUTORY REVISION AND RECODIFICATION

The legislative council shall revise the Vermont Statutes Annotated as necessary to reflect the purposes of this act, including recodification of the provisions in chapter 107 of Title 8, chapters 9 and 19 of Title 33, and chapter 221 of Title 18, and the renaming throughout the statutes of the department of

~~banking, insurance, securities, and health care administration as the department~~ of banking, insurance, and securities.

Sec. 6. APPROPRIATION; POSITIONS

(a) Fiscal year 2009. The amount of $60,000.00 is appropriated from the general fund to the secretary of administration in fiscal year 2009 for the health care board established in section 407 of Title 18 by Sec. 2 of this act.

(b) Fiscal year 2010. The amount of $120,000.00 is appropriated from the general fund to the department of health care administration in fiscal year 2010 for the purposes of establishing the department of health care administration. Beginning in fiscal year 2010, there are established in the department two new exempt positions: one commissioner of the department of health care administration and one staff assistant. These positions shall be transferred and converted from existing vacant positions in the executive branch of state government.

(c) The department of health care administration is authorized to seek matching funds to assist with carrying out the purposes of this act. In addition, it may accept any and all donations, gifts, and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof and from any person, firm, or corporation for any of its purposes and functions under this act and may receive and use the same subject

~~to the terms, conditions, and regulations governing such donations, gifts, and~~ grants.

Sec. 7. REPEAL

(a) Section 9403 of Title 18 (division of health care administration of the department of banking, insurance, securities, and health care administration), section 3088 of Title 3 (the office of Vermont health access), and section 902 of Title 33 (the division of rate setting) are repealed October 1, 2009, and the divisions and offices are transferred to the department of health care administration established in this act.

(b) Section 4080f of Title 8 (Catamount Health) is repealed on July 1, 2011 with respect to hospital services, on July 1, 2012 with respect to primary and preventive care services, and on July 1, 2013 with respect to all other services covered by VermontCare.

(c) Section 4080c of Title 8 (health insurance safety net) is repealed on July 1, 2013.

(d) Chapter 25 of Title 21 (employers' health care premium contribution) is repealed on July 1, 2013.

(e) Section 1986 of Title 33 (Catamount fund) is repealed on July 1, 2013 and any monies remaining in the fund shall be transferred to the general fund.

Sec. 8. EFFECTIVE DATES AND TRANSITION

(a) This act shall take effect upon passage.

(b) The commissioner of the department of health care administration shall be appointed within 60 days after passage.

(c) Unless explicitly repealed by this act, current law and regulation are intended to remain effective and operational, and these functions shall remain with the agency, department, or division designated by law or its successor in interest.

Sec. 1. FINDINGS

The general assembly finds that:

(1) The escalating costs of health care in the United States and in Vermont are not sustainable.

(2) Health care costs are hurting Vermont's families, employers, local governments, nonprofit organizations and the state budget, with serious economic problems as the consequence.

(3) The cost of health care in Vermont is estimated to increase by $1 billion, from $4.9 billion to $5.9 billion, by 2012.

(4) Vermont's per-capita health care expenditures are estimated to be $9,463.00 in 2012, compared to $7,414.00 per capita in 2008.

(5) The average annual increase in Vermont per-capita health care expenditures from 2009 to 2012 is expected to be 6.3 percent. National per-capita health care spending is projected to grow at an average annual rate of 4.8 percent during the same period.

(6) From 2004 to 2008, Vermont's per-capita health care expenditures grew at an average annual rate of eight percent compared to five percent for the United States.

(7) At the national level, health care expenses are estimated at 18 percent of GDP and are estimated to rise to 34 percent by 2040.

(8) Vermont's health care system covers a larger percentage of the population than that of most other states, but still about seven percent of Vermonters lack health insurance coverage.

(9) In 2008, 15.4 percent of Vermonters with private insurance were underinsured, meaning that the out-of-pocket health insurance expenses exceeded five to 10 percent of a family's annual income depending on income

level or that the annual deductible for the health insurance plan exceeded five percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums. Most Vermonters are a job loss away from being uninsured.

(10) Vermont's health care reform efforts to date, including Dr. Dynasaur, VHAP, Catamount, the Blueprint for Health, health information technology, and the department of health's wellness and prevention initiatives have been beneficial to thousands of Vermonters, and hold promise for helping to provide access and to control costs in the future.

(11) Testimony received by the senate committee on health and welfare and the house committee on health care makes it clear that the current best efforts described in subdivision (10) of this section will neither provide insurance coverage for all Vermonters nor significantly reduce the escalation of health care costs.

(12) It is clear that only structural reform will provide all Vermonters with access to affordable, high quality health care.

(13) As this state has done before in so many areas of public policy, Vermont must show leadership on health care reform.

** * * HEALTH CARE SYSTEM DESIGN * * **

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for health services for all Vermonters. All Vermonters must have access to comprehensive, quality health care. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time.

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

(3) Primary care must be preserved and enhanced so that Vermonters have care available to them; preferably, within their own communities. Other aspects of Vermont's health care infrastructure must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.

(4) Vermont's health delivery system must model continuous

improvement of health care quality and safety and, therefore, the system must be accountable in access, cost, quality, and reliability.

(5) A system for eliminating unnecessary expenditures; reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and containing all system costs must be implemented so that health care spending does not bankrupt the Vermont economy.

(6) The financing of health care in Vermont must be sufficient, fair, sustainable, and shared equitably.

(7) State government must ensure that the health care system satisfies the principles in this section.

Sec. 3. GOALS OF HEALTH CARE REFORM

Consistent with the adopted principles for reforming health care in Vermont, the general assembly adopts the following goals:

(1) The purpose of the health care system design proposals created by this act is to ensure that individual programs and initiatives can be placed into a larger, more rational design for access to, the delivery of, and the financing of health care in Vermont.

(2) Vermont's primary care providers will be adequately compensated through a payment system that reduces administrative burdens on providers.

(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems that:

(A) are coordinated;

(B) focus on meeting community health needs;

(C) match service capacity to community needs;

(D) provide information on costs, quality, outcomes, and patient satisfaction;

(E) use financial incentives and organizational structure to achieve specific objectives;

(F) improve continuously the quality of care provided; and

(G) contain costs.

(4) To ensure financial sustainability of Vermont's health care system, the state is committed to slowing the rate of growth of total health care costs and preferably to reducing health care costs below today's amounts.

(5) Health care costs will be controlled or reduced using a combination of options, including:

(A) increasing the availability of primary care services throughout the state;

(B) simplifying reimbursement mechanisms throughout the health care system;

(C) reducing of administrative costs associated with private and public insurance and bill collection;

(D) reducing the cost of pharmaceuticals, medical devices, and other supplies through a variety of mechanisms;

(E) aligning health care professional reimbursement with best practices and outcomes rather than utilization;

(F) efficient health facility planning, particularly with respect to technology; and

(G) increasing price and quality transparency.

(6) All Vermont residents, subject to reasonable residency requirements, will have universal access to and coverage for health services that meet defined benefits standards, regardless of their age, employment, economic status, or their town of residency, even if they require health care while outside Vermont.

(7) A system of health care will provide access to health services needed by individuals from birth to death and be responsive and seamless through employment and other life changes.

(8) A process will be developed to define packages of health services, taking into consideration scientific and research evidence, available funds, the values and priorities of Vermonters, and federal health care reform if enacted.

(9) Health care reform will ensure that Vermonters' health outcomes and key indicators of public health will show continuous improvement across all segments of the population.

(10) Health care reform will reduce the number of adverse events from medical errors.

(11) Disease and injury prevention, health promotion, and health protection will be key elements in the health care system.

Sec. 4. 2 V.S.A. § 901 is amended to read:

§ 901. CREATION OF COMMISSION

(a) There is established a commission on health care reform. The commission, under the direction of co-chairs who shall be appointed by the speaker of the house and president pro tempore of the senate, shall monitor

health care reform initiatives and recommend to the general assembly actions needed to attain health care reform.

(b)(1) Members of the commission shall include ~~four~~ three representatives appointed by the speaker of the house, ~~four~~ three senators appointed by the committee on committees, ~~and~~ two nonvoting members appointed by the governor, one nonvoting member with experience in health care appointed by the speaker of the house, and one nonvoting member with experience in health care appointed by the president pro tempore of the senate.

(2) The two nonvoting members with experience in health care shall not be in the employ of or holding any official relation to any health care provider or insurer, or engaged in the management of a health care provider or insurer, or owning stock, bonds, or other securities thereof, or who is, in any manner, connected with the operation of a health care provider or insurer. In addition, these two members shall not render professional health care services or make or perform any business contract with any health care provider or insurer if such service or contract relates to the business of the health care provider or insurer, except contracts made as an individual or family in the regular course of obtaining health care services.

* * *

Sec. 5. APPOINTMENT; COMMISSION ON HEALTH CARE REFORM

Within 15 days of enactment, the speaker of the house, the president pro tempore of the senate, and the committee on committees shall appoint members of the joint legislative commission on health care reform as necessary to reflect the changes in Sec. 4 of this act. All other current members, including those appointed by the governor, shall continue to serve their existing terms.

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1) By February 1, 2011, the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general assembly and the governor at least three design options, including implementation plans, for creating a single system of health care which ensures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multipayer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act.

(2) One option shall include the design of a government-administered and publicly financed "single-payer" health benefits system decoupled from employment which prohibits insurance coverage for the health services provided by this system and allows for private insurance coverage only of supplemental health services.

(3) Each design option shall include sufficient detail to allow the

governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.

(4) The proposal to the general assembly and the governor shall include a recommendation for which of the design options best meets the principles and goals outlined in Secs. 2 and 3 of this act in an affordable, timely, and efficient manner.

(b) No later than 45 days after enactment, the commission shall propose to the joint fiscal committee a recommendation, including the requested amount, for one or more outside consultants who have demonstrated experience in health care systems or designing health care systems that have expanded coverage and contained costs to provide the expertise necessary to do the analysis and design required by this act. Within seven days of the commission's proposal, the joint fiscal committee shall meet and may accept, reject, or modify the commission's proposal.

(c) In creating the design options, the consultant shall review and consider the following:

(1) the findings and reports from previous studies of health care reform in Vermont, including the Universal Access Plan Report from the health care authority, November 1, 1993; reports from the Hogan Commission; relevant studies provided to the state of Vermont by the Lewin Group; and studies and reports provided to the commission.

(2) existing health care systems or components thereof in other states or countries as models.

(3) Vermont's current health care reform efforts as defined in 3 V.S.A. § 2222a.

(4) the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act.

(d) Each design option shall propose a single system of health care which maximizes the federal funds to support the system and is composed of the following components, which are described in subsection (e) of this section:

(1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;

(2) coordinated local delivery systems;

(3) health system planning, regulation, and public health;

(4) financing and proposals to maximize federal funding; and

(5) a method to address compliance of the proposed design option or options with federal law.

(e) In creating the design options, the consultant shall include the following components for each option:

(1) A payment system for health services.

(A) Packages of health services. Each design shall include one or more packages of health services providing for the integration of physical and mental health:

(i) all of which shall include access to and coverage for primary care, preventive care, chronic care, acute episodic care, hospital services, prescription drugs, and mental health services;

(ii) one or more may include coverage for additional health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental or vision services; and

(iii) all of which shall include a cost-sharing proposal.

(B) Administration. The consultant shall include a recommendation for:

(i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination.

(ii) enrollment processes.

(iii) integration of the pharmacy best practices and cost control program established by 33 V.S.A. §§ 1996 and 1998 and other mechanisms, to promote evidence-based prescribing, clinical efficacy, and cost-containment, such as a single statewide preferred drug list, prescriber education, or utilization reviews.

(iv) appeals processes for decisions made by entities or agencies administering coverage for health services.

(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. The consultant shall consider:

(i) amendments necessary to current law on the unified health

care budget, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) how to align the unified health care budget with the health resource allocation plan under 18 V.S.A. § 9405; the hospital budget review process under 18 V.S.A. § 9456; and the proposed global budgets and payments, if applicable and recommended in a design option.

(iii) recommending a global budget where it is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination. Any recommendation shall include a process for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.

(iv) payment methods to be used for each health care sector which are aligned with the goals of this act and provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles. Payment methods may include:

(I) periodic payments based on approved annual global budgets;

(II) capitated payments;

(III) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of medications;

(IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region;

(V) diagnosis-related groups;

(VI) global payments based on a global budget, including whether the global payment should be population-based, cover specific line items, provide a mixture of a lump sum payment, diagnosis-related group (DRG) payments, incentive payments for participation in the Blueprint for Health, quality improvements, or other health care reform initiatives as defined in 3 V.S.A. § 2222a; and

(VIII) fee for service.

(v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should provide reasonable access to health services, provide sufficient uniform payment to health care professionals, reduce unnecessary care, and encourage the financial stability of health care professionals. The consultant shall consider the following processes:

(I) Negotiations with hospitals, health care professionals, and groups of health care professionals;

(II) Establishing a global payment for health services provided by a particular hospital, health care provider, or group of professionals and providers. In recommending a process for determining a global payment, the board shall consider the interaction with a global budget and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The recommendation may include that the global payment be reflected as a specific line item in the annual budget.

(III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of specialized health services that are not available locally to Vermonters.

(IV) Paying the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered and received in an out-of-state hospital with which there is not an established contract;

(V) Developing a reference pricing system for nonemergency health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract.

(VI) Utilizing one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section.

(D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the

option may include a fee assessed on insurers combined with a global budget to streamline administration of health services.

(2) Coordinated local delivery systems. The consultant shall propose a local delivery system to ensure that the delivery of health care in Vermont is coordinated in order to provide health services to the citizens of Vermont, to improve health outcomes, and to improve the efficiency of the health care system by ensuring that health care professionals, hospitals, health care facilities and home- and community-based providers offer patient care in an integrated manner designed to optimize patient care at a lower cost and to reduce redundancies in the health care delivery system as a whole. The consultant shall consider the following models:

(A) mechanisms in each region of the state to solicit public input; conduct a community needs assessment for incorporation into the health resources allocation plan; a plan for community health needs based on the community needs assessment; develop budget recommendations and resource allocations for the region; provide oversight and evaluation regarding the delivery of care in its region; and other functions determined to be necessary in managing the region's health care delivery system or furthering cost-containment.

(B) a regional entity organized by health care professionals and providers to coordinate health services for that region's population, including developing payment methodologies and budgeting, incentive payments, and other functions determined to be necessary in managing the region's health care delivery system or furthering cost-containment.

(3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

(4) Financing, including federal financing. The consultant shall provide:

(A) an estimate of any additional costs for providing access to and coverage for health services to the uninsured and underinsured, any estimated savings from streamlining the administration of health care, and financing proposals for sustainable revenue necessary for funding the system, including by maximizing federal revenues.

(B) a proposal to the Centers on Medicare and Medicaid Services to

waive provisions of Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act if necessary to align the federal programs with the proposals contained within the design options in order to maximize federal funds or to promote the simplification of administration, cost-containment, or promotion of health care reform initiatives as defined by 3 V.S.A. § 2222a; and

(C) a proposal to participate in a federal insurance exchange established by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 or for a waiver from these provisions when available.

(5) A method to address compliance of the proposed design option or options with federal law, including the Employee Retirement Income Security Act (ERISA), if necessary. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options.

(f)(1) The agency of human services and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the commission and its consultant have the information necessary to create the design options.

(2) The consultant may request legal and fiscal assistance from the office of legislative council and the joint fiscal office.

(3) The commission or its consultant may engage with interested parties, such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont.

(g)(1) By January 1, 2011, the commission shall release a draft of the design options to the public and provide 15 days for public review and the submission of comments on the design options. The commission shall review and consider the public comments and revise the draft design options as necessary prior to the final submission to the general assembly and the governor.

(2) In the proposal and implementation plan provided to the general assembly and the governor, the commission shall include an analysis of each design option as compared to the current state of health care in Vermont, including:

(A) the costs of providing health care to the uninsured and underinsured in Vermont;

(B) any potential savings from creating an integrated system of health care;

(C) the impacts on the current private and public insurance system;

(D) the expected net fiscal impact on individuals and on businesses from the modifications to the health care system proposed in the design;

(E) impacts on the state's economy;

(F) the pros and cons of alternative timing for the implementation of each design, including the sequence and rationale for the phasing in of the major components; and

(G) the pros and cons of each design option and of no changes to the current system.

Sec. 7. GRANT FUNDING

The staff director of the joint legislative commission on health care reform shall apply for grant funding, if available, for the design and implementation analysis provided for in Sec. 6 of this act. Any amounts received in grant funds, up to the amount appropriated in Sec. 8 of this act, shall offset the general fund appropriation by allowing any remaining general funds appropriated to revert to the general fund or reducing future general fund appropriations. Any grant funds received in excess of the appropriated amount may be used for the analysis.

Sec. 7a. HOSPITAL BUDGETS

(a) The commissioner of banking, insurance, securities, and health care administration shall implement this section consistent with 18 V.S.A. § 9456, with the goals identified in Sec. 50 of No. 61 of the Acts of 2009, and with the goals of systemic health care reform, including the goals of containing costs, ensuring solvency for efficient and effective hospitals, and promoting fairness and equity in health care financing. In addition to the commissioner's authority under subchapter 7 of chapter 221 of Title 8 (hospital budget reviews), the commissioner of banking, insurance, securities, and health care administration shall target hospital budgets for fiscal years 2011 and 2012 consistent with the following:

(1) Except as provided in subdivision (5) of this subsection, the total systemwide rate increase for all hospitals reviewed by the commissioner shall not exceed 4.0 percent;

(2) Except as provided in subdivision (5) of this subsection, the total systemwide net patient revenue increase for all hospitals reviewed by the commissioner shall not exceed 4.5 percent;

(3) Except as provided in subdivision (5) of this subsection, the total systemwide hospital operating margin percentages shall not exceed those percentages allowed in fiscal year 2010;

(4) Consistent with the goals of lowering overall cost increases in health care without compromising the quality of health care, the commissioner may restrict or disallow specific expenditures, such as new programs. In his or her own discretion, the commissioner may identify or may require hospitals to identify the specific expenditures to be restricted or disallowed.

(5) The commissioner may exempt hospital revenue and expenses associated with health care reform and other expenses, such as all or a portion of the provider tax, from the limits established in subdivisions (1) through (3) of this subsection if necessary to achieve the goals identified in this section. The expenditures shall be specifically reported, shall be supported with sufficient documentation as required by the commissioner, and may only be exempt if approved by the commissioner.

(b) Consistent with this section and the overarching goal of containing health care and hospital costs, and notwithstanding 18 V.S.A. § 9456(e) which permits the commissioner to exempt a hospital from the budget review process, the commissioner may exempt a hospital from the hospital budget process for more than two years consecutively. This provision does not apply to a tertiary teaching hospital.

(c) Upon a showing that a hospital's financial health or solvency will be severely compromised, the commissioner may approve or amend a hospital budget in a manner inconsistent with subsection (a) of this section.

Sec. 7b. 18 V.S.A. § 9453(c) is added to read:

(c) The commissioner's authority shall extend to affiliated corporations or similar affiliated entities of the hospital as defined by subdivision 9402(13) of this title to the extent that the commissioner reasonably believes that the action is necessary to carry out of the purposes of this subchapter.

Sec. 7c. 18 V.S.A. § 9456(h)(2) is amended to read:

(2)(A) After notice and an opportunity for hearing, the commissioner may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

(B)(i) The commissioner may order a hospital to:

(I)(aa) cease material violations of this subchapter or of a regulation or order issued pursuant to this subchapter; or

(bb) cease operating contrary to the budget established for the hospital under this section, provided such a deviation from the budget is material; and

(II) take such corrective measures as are necessary to remediate the violation or deviation and to carry out the purposes of this subchapter.

(ii) Orders issued under this subdivision (2)(B) shall be issued after notice and an opportunity to be heard, except that where the commissioner finds that a hospital's financial or other emergency circumstances pose an immediate threat of harm to the public or to the financial condition of the hospital. Where there is an immediate threat, the commissioner may issue orders under this subdivision (2)(B) without written or oral notice to the hospital. Where an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. The hearing shall be held within 30 days of receipt for the hospital's request for a hearing, and a decision shall be issued within 30 days after the conclusion of the hearing. The commissioner may expand the time to hold the hearing or render the decision for good cause shown. Hospitals may appeal any decision in this section to superior court. An appeal shall be on the record as developed by the commissioner in the administrative proceeding, and the standard of review shall be as provided in 8 V.S.A. § 16.

Sec. 7d. REPEAL

18 V.S.A. § 9439(f) (annual review cycles of certificate of need applications) is repealed on July 1, 2010.

Sec. 7e. INSURANCE REGULATION; INTENT

It is the intent of the general assembly that the commissioner of banking, insurance, securities, and health care administration use the insurance rate review and approval authority to control the costs of health insurance unrelated to the cost of medical care where consistent with other statutory obligations, such as ensuring solvency. Rate review and approval authority could include imposing limits on producer commissions in specified markets or limiting administrative costs as a percentage of the premium.

Sec. 7f. 8 V.S.A § 4080a(h)(2)(D) is added to read:

(D) The commissioner may require a registered small group carrier to identify that percentage of a requested premium increase which is attributed to the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care costs, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall be at the time of seeking a rate increase and shall be in the manner and form as directed

by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

Sec. 7g. 8 V.S.A § 4080b(h)(2)(D) is added to read:

(D) The commissioner may require a registered nongroup carrier to identify that percentage of a requested premium increase which is attributed to the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care costs, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall be at the time of seeking a rate increase and shall be in the manner and form as directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

Sec. 8. APPROPRIATION

The amount of $250,000.00 is appropriated from the general fund to the joint fiscal office in fiscal year 2011 to accomplish the purposes of this act.

Sec. 9. EFFECTIVE DATES

(a) This section and Secs. 1 through 7 of this act shall take effect upon passage.

(b) Secs. 7a through 7g and 8 shall take effect on July 1, 2010.