

1 H.146

2 Introduced by Representative Poirier of Barre City

3 Referred to Committee on

4 Date:

5 Subject: Health care; coverage; public option; Medicaid; individual mandate;  
6 payroll tax

7 Statement of purpose: This bill proposes to provide comprehensive,  
8 affordable, high-quality health care coverage for all Vermont residents and to  
9 contain health care costs. It would establish a public health care coverage  
10 option called Green Mountain Care with sliding-scale premiums and  
11 cost-sharing that would be available to all Vermont residents and would be  
12 funded, in part, with a payroll tax. The bill would also focus on hospital cost  
13 containment by implementing a statewide global hospital budget and  
14 negotiated hospital payments for individual hospitals while providing hospital  
15 services to all Vermont residents. The bill would require all Vermont residents  
16 to have health care coverage at least equivalent to the actuarial value of Green  
17 Mountain Care and would assess a financial penalty against those who fail to  
18 maintain such coverage. It would require the department of banking,  
19 insurance, securities, and health care administration to recommend a process  
20 by which Green Mountain Care may obtain an insurance license and offer the  
21 public option through Vermont's health benefit exchange. To help fund Green

1 Mountain Care, the bill would institute a candy and soft drink tax as well as a  
2 10-percent payroll tax on all employers with more than four employees. The  
3 bill would eliminate private insurance exclusions on coverage of preexisting  
4 conditions and would allow individuals to purchase insurance in the nongroup  
5 market regardless of whether they are eligible for an employer-sponsored plan.  
6 Finally, the bill would appropriate \$500,000.00 to the state's health care  
7 provider and educator loan repayment program and would direct the  
8 department of Vermont health access to analyze the impact on Vermonters of  
9 federal premium tax credits and cost-sharing subsidies.

10 An act relating to a public health care coverage option

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

12 Sec. 1. 33 V.S.A. chapter 18 is added to read:

13 CHAPTER 18. GREEN MOUNTAIN CARE

14 Subchapter 1. General Provisions

15 § 1801. DEFINITIONS

16 In this chapter:

17 (1) "Agency" means the agency of human services or its designee.

18 (2) "Board" or "drug utilization review board" means the drug  
19 utilization review board established in connection with the Medicaid program.

1           (3) “Children’s Health Insurance Program” or “CHIP” means the  
2           medical assistance program established under Title XXI of the Social Security  
3           Act.

4           (4) “CHIP funds” means federal funds available under Title XXI of the  
5           Social Security Act.

6           (5) “Chronic care” means health services provided by a health care  
7           professional for an established clinical condition that is expected to last a year  
8           or more and that requires ongoing clinical management that attempts to restore  
9           the individual to highest function, to minimize the negative effects of the  
10          condition, and to prevent complications related to chronic conditions.

11          Examples of chronic conditions include diabetes, hypertension, cardiovascular  
12          disease, cancer, asthma, pulmonary disease, substance abuse, mental illness,  
13          spinal cord injury, and hyperlipidemia.

14          (6) “Chronic care management” means a system of coordinated health  
15          care interventions and communications for individuals with chronic conditions,  
16          including significant patient self-care efforts, systemic supports for the  
17          physician and patient relationship, and a plan of care emphasizing prevention  
18          of complications utilizing evidence-based practice guidelines, patient  
19          empowerment and functional capacity development strategies, and evaluation  
20          of clinical, humanistic, and economic outcomes on an ongoing basis with the  
21          goal of improving overall health.

1           (7) “Commissioner” means the commissioner of banking, insurance,  
2           securities, and health care administration.

3           (8) “Health benefit plan” means a health benefit plan offered or  
4           administered by a health insurer, as defined by 18 V.S.A. § 9402, and the  
5           out-of-state counterparts to such plans.

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

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

12           (11) “Medicaid” means the medical assistance program established  
13           under Title XIX of the Social Security Act.

14           (12) “Medicaid funds” means federal funds available under Title XIX of  
15           the Social Security Act or through a Medicaid waiver under section 1115 or  
16           1915 of the Social Security Act.

17           (13) “Participating health benefit plan” means a health benefit plan that  
18           has agreed to participate in one or more components of the pharmacy  
19           best-practices and cost-control program.

20           (14) “Preventive care” means health services provided by health care  
21           professionals to identify and treat asymptomatic individuals who have

1 developed risk factors or preclinical disease but in whom the disease is not  
2 clinically apparent, including immunizations and screening, counseling,  
3 treatment, and medication determined by scientific evidence to be effective in  
4 preventing or detecting a condition.

5 (15) “Primary care” means health services provided by health care  
6 professionals specifically trained for and skilled in first-contact and continuing  
7 care for individuals with signs, symptoms, or health concerns, not limited by  
8 problem origin, organ system, or diagnosis, and include prenatal care and the  
9 treatment of mental illness.

10 (16) “Secretary” means the secretary of the agency of human services or  
11 designee.

12 (17) “Vermont resident” means an individual domiciled in Vermont as  
13 evidenced by an intent to maintain a principal dwelling place in Vermont  
14 indefinitely and to return to Vermont if temporarily absent, coupled with an act  
15 or acts consistent with that intent.

16 Subchapter 2. Health Care Coverage

17 § 1802. GREEN MOUNTAIN CARE

18 (a) The agency of human services shall establish Green Mountain Care, a  
19 public health care coverage option with sliding-scale premiums and  
20 cost-sharing for all Vermont residents. Green Mountain Care shall include

1 coverage for eligible low income residents with Medicaid funds to the extent  
2 approved by the Centers for Medicare and Medicaid Services.

3 (b) The purpose of Green Mountain Care is to provide comprehensive,  
4 affordable, high-quality health care coverage for all Vermont residents in a  
5 seamless manner regardless of income, assets, health status, or availability of  
6 other health insurance. Green Mountain Care shall contain costs by providing  
7 incentives to residents to avoid preventable health conditions, promote health,  
8 and avoid emergency-room visits; by establishing innovative payment  
9 mechanisms to providers, such as global payments; and by encouraging the  
10 management of chronic conditions through the Blueprint for Health.

11 § 1803. ELIGIBILITY

12 (a) Green Mountain Care shall be available to all Vermont residents, except  
13 that an individual who is eligible for Medicare shall not be eligible for Green  
14 Mountain Care.

15 (b) Green Mountain Care shall guarantee acceptance of all Vermont  
16 residents and their dependents for coverage under the program.

17 (c) An individual may enroll in Green Mountain Care regardless of whether  
18 the individual's employer offers health insurance for which the individual is  
19 eligible.

20 (d) The agency shall fund Green Mountain Care benefits with Medicaid or  
21 CHIP funds for eligible individuals as determined through a Medicaid waiver

1 under Section 1115 of the Social Security Act. The agency may provide  
2 long-term care services through Choices for Care instead of through Green  
3 Mountain Care. Green Mountain Care shall comply with the provisions of  
4 subchapter 1 of chapter 19 of this title and of all applicable federal laws.

5 § 1804. COVERED HEALTH SERVICES

6 (a)(1) Green Mountain Care shall provide coverage for primary care,  
7 preventive care, chronic care, acute episodic care, and hospital services.

8 (2) Green Mountain Care shall provide coverage for palliative care  
9 services, including hospice services.

10 (3) Green Mountain Care shall provide a basic dental benefit, to be  
11 established by the agency by rule and modeled on common benefits offered in  
12 plans available in the dental insurance market in this state.

13 (4) Green Mountain Care shall provide coverage for treatment of a  
14 mental health condition and shall:

15 (A) not establish any rate, term, or condition that places a greater  
16 burden on an enrollee for access to treatment for a mental health condition than  
17 for access to treatment for other health conditions;

18 (B) not exclude from its network or list of authorized providers any  
19 licensed mental health or substance abuse provider located within the  
20 geographic coverage area of Green Mountain Care if the provider is willing to

1 meet the terms and conditions for participation established by Green Mountain  
2 Care; and

3 (C) make the deductible and out-of-pocket limits required under  
4 Green Mountain Care comprehensive for coverage of both mental health and  
5 physical health conditions.

6 (b)(1) For individuals eligible for Medicaid, the benefit package shall  
7 include the benefits provided to these individuals on December 31, 2013,  
8 except that, consistent with federal law, the general assembly may modify  
9 benefits to these individuals. Individuals whose benefits are paid for with  
10 Medicaid or CHIP funds shall receive, at a minimum, the Green Mountain  
11 Care benefit package.

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

15 (c) Notwithstanding any provision of law to the contrary, Green Mountain  
16 Care shall not limit coverage of preexisting conditions which existed prior to  
17 the individual's enrollment in Green Mountain Care.

18 § 1805. CHRONIC CARE MANAGEMENT

19 (a)(1) The agency shall create a chronic care management program as  
20 provided in this section, which may be administered or provided by a private  
21 care management organization, for individuals with one or more chronic

1 conditions who are enrolled in Green Mountain Care. The program shall not  
2 include individuals who are also eligible for Medicare, who are enrolled in the  
3 Choices for Care Medicaid Section 1115 waiver, or who are in an institute for  
4 mental disease as defined in 42 C.F.R. § 435.1009.

5 (2) The agency may also establish a care coordination program for  
6 individuals who need intensive chronic care management.

7 (b) The agency shall include a broad range of chronic conditions in the  
8 chronic care management program.

9 (c) The chronic care management program shall be designed to coordinate  
10 with the Blueprint for Health and shall include:

11 (1) a method for involving the health care professional in identifying  
12 eligible patients, including the use of the chronic care information system  
13 established in 18 V.S.A. § 702, an enrollment process which provides  
14 incentives and strategies for maximum patient participation, and a standard  
15 statewide health risk assessment for each individual;

16 (2) a process for coordinating care among health care professionals;

17 (3) methods for increasing communications among health care  
18 professionals and patients, including patient education, self-management, and  
19 follow-up plans;

1           (4) educational, wellness, and clinical management protocols and tools ,  
2           including management guideline materials for health care professionals to  
3           assist in patient-specific recommendations;

4           (5) process and outcome measures to provide performance feedback for  
5           health care professionals and information on the quality of care, including  
6           patient satisfaction and health status outcomes;

7           (6) payment methodologies to align reimbursements and create financial  
8           incentives and rewards for health care professionals to establish management  
9           systems for chronic conditions, to improve health outcomes, and to improve  
10          the quality of care, including case management fees, pay for performance,  
11          payment for technical support and data entry associated with patient registries,  
12          the cost of staff coordination within a medical practice, and any reduction in a  
13          health care professional's productivity;

14          (7) a payment structure such that all or a portion of the care management  
15          organization's fee would be at risk if the management is not successful in  
16          reducing costs to the state;

17          (8) a requirement that the data on enrollees be shared, to the extent  
18          allowable under federal law, with the secretary of administration in order to  
19          inform the health care reform initiatives under 3 V.S.A. § 2222a;

20          (9) a method for the care management organization to participate closely  
21          in the Blueprint for Health and other health care reform initiatives; and

1           (10) participation in the pharmacy best-practices and cost-control  
2 program under subchapter 3 of this chapter, including the joint purchasing  
3 consortium and the statewide preferred drug list.

4           (d) The agency may issue a request for proposals for the program  
5 established under this section. Any contract under this section may allow the  
6 entity to subcontract some services to other entities if it is cost-effective,  
7 efficient, or in the best interest of the individuals enrolled in the program.

8           (e) The agency shall ensure that the chronic care management program is  
9 modified over time to comply with the Vermont Blueprint for Health strategic  
10 plan and, to the extent feasible, shall collaborate in its initiatives.

11           (f) The terms used in this section shall have the meanings defined in  
12 18 V.S.A. § 701.

13           § 1806. SLIDING-SCALE PREMIUMS

14           (a)(1) Except as provided in section 1901 of this title, the agency shall  
15 establish individual, two-person, and family premium amounts on a sliding  
16 scale for Green Mountain Care. In the sliding scale, the agency shall use  
17 income increments based on the federal poverty level that include the same  
18 number of percentage points per increment as the federal government uses in  
19 determining premium tax credits under the Patient Protection and Affordable  
20 Care Act of 2010, Public Law 111-148, as amended by the Health Care and  
21 Education Reconciliation Act of 2010, Public Law 111-152.

1           (2) Individuals, two-person groups, and families with incomes at or  
2           below 100 percent of the federal poverty level shall not pay a premium. For  
3           individuals, two-person groups, and families with incomes over 100 percent of  
4           the federal poverty level, premiums shall vary from 1.5 percent of individual,  
5           two-person group, or family income at the lowest income level to a maximum  
6           of 10 percent of individual, two-person group, or family income at higher  
7           income levels. When 10 percent of an individual's, two-person group's, or  
8           family's income is equal to or greater than the per-member per-month cost  
9           including administrative expenses of Green Mountain Care, the individual,  
10           two-person group, or family shall pay no more than the per-member per-month  
11           cost for each individual covered under the plan. The agency shall propose the  
12           premiums for each income increment annually as part of the legislative budget  
13           process.

14           (b)(1) The agency shall establish rules pursuant to chapter 25 of Title 3 for  
15           calculating income for purposes of establishing a premium. The agency shall  
16           determine income annually and shall ensure that individuals may report  
17           changes in income in order for the premium to be responsive to seasonal work,  
18           expected changes in income, and unexpected changes in income. Income shall  
19           be calculated based on either an individual, joint, or head of household income  
20           tax return for the most recent tax year or an individual's, two-person group's,  
21           or family's most recent two months of income, unless that income is unlikely

1 to continue. If the income is unlikely to continue, the income calculation shall  
2 be based on projected income.

3 (2) Reported changes in income shall be acted on within 15 days, and  
4 the agency shall retroactively decrease premium amounts. Any amounts paid  
5 by an individual, a two-person group, or a family in excess of a retroactively  
6 decreased premium shall apply to current or future premium amounts due.  
7 Green Mountain Care shall not be terminated for an individual, a two-person  
8 group, or a family while a change in income request is pending.

9 (3) An individual, a two-person group, or a family shall not be required  
10 to report income changes of less than 10 percent or income changes expected  
11 to continue for fewer than 45 days.

12 (c) If allowable under federal law, the agency of human services shall  
13 provide employed individuals with the option of paying the premium by  
14 payroll deduction on a pretax basis.

15 § 1807. SLIDING-SCALE COST-SHARING

16 Except as provided in section 1901 of this title, cost-sharing amounts under  
17 Green Mountain Care shall be as follows:

18 (1) There shall be sliding-scale deductibles based on income with a  
19 range from \$0.00 to \$250.00 for an individual, \$0.00 to \$350.00 for a  
20 two-person group, and \$0.00 to \$500.00 for a family for health services  
21 received in network, and a range from \$0.00 to \$500.00 for an individual,

1 \$0.00 to \$750.00 for a two-person group, and \$0.00 to \$1,000.00 for a family  
2 for health services received out of network. The agency shall propose the  
3 applicable income increments and amounts for each deductible level annually  
4 as part of the legislative budget process. Individuals, two-person groups, and  
5 families with incomes at or below 100 percent of the federal poverty level shall  
6 not pay a deductible.

7 (2) Except for individuals, two-person groups, and families with  
8 incomes at or below 100 percent of the federal poverty level, there shall be 20  
9 percent coinsurance in and out of network.

10 (3) Co-payments shall be as follows:

11 (A) \$10.00 for an office visit;

12 (B) \$25.00 for emergency care received in the emergency room of a  
13 hospital;

14 (C) \$75.00 for nonemergency care received in the emergency room  
15 of a hospital; provided, however, that an individual shall be charged the  
16 co-payment pursuant to subdivision (3)(B) of this section if a prudent  
17 layperson would have believed that an emergency medical condition existed at  
18 the time the individual sought treatment in an emergency room for what was  
19 later determined not to be an emergency.

20 (4) Prescription drug coverage shall be provided without a deductible.

21 Co-payments for prescription drugs shall be on a sliding scale based on

1 income, with a range from \$1.00 to \$10.00 for generic drugs, \$2.00 to \$30.00  
2 for drugs on the preferred drug list, and \$3.00 to \$50.00 for nonpreferred  
3 drugs. The agency shall propose the applicable income increments and  
4 amounts for each co-payment level annually as part of the legislative budget  
5 process.

6 (5) Out-of-pocket maximums shall be set at \$800.00 for an individual,  
7 \$1,200.00 for a two-person group, and \$1,600.00 for a family for in-network  
8 services and \$1,500.00 for an individual, \$2,250.00 for a two-person group,  
9 and \$3,000.00 for a family for out-of-network services. Out-of-pocket  
10 maximums shall include all funds expended on co-payments for prescription  
11 drugs.

12 (6) There shall be a waiver of the deductible and other cost-sharing  
13 payments for chronic care for individuals participating in chronic care  
14 management and for primary and preventive care.

15 (7) There shall be no annual or lifetime maximum limit on benefits  
16 available to a covered individual or his or her dependent.

17 § 1808. ADMINISTRATION

18 (a) The agency of human services shall implement Green Mountain Care to  
19 provide Vermont residents with coverage beginning on January 1, 2014. The  
20 agency shall provide options for individuals to enroll in an individual, a

1 two-person, or a family plan with a sliding-scale premium established in  
2 section 1806 of this chapter.

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

8 (c) The agency shall use a single, uniform, simple one-page form to  
9 determine eligibility for Green Mountain Care to ensure individuals have the  
10 opportunity to enroll easily at the point of service. This form shall be available  
11 online.

12 (d) Upon an individual's enrollment in Green Mountain Care, the agency  
13 shall issue a member benefits handbook and Green Mountain Care  
14 membership cards to the individual and his or her dependents.

15 (e)(1) The agency shall establish by rule a process to allow health care  
16 professionals to presume that an individual is eligible based on the information  
17 provided on the simplified form and to provide the individual immediately  
18 with a card for the program.

19 (2) The agency shall collect additional information necessary to  
20 determine the individual's premium and cost-sharing amounts and  
21 requirements necessary to determine if Medicaid or CHIP funds are available

1 for that individual or family after submission of the application, but shall  
2 provide payment for any services received by the individual at the time the  
3 application is submitted. Coverage for individuals ineligible for Medicaid  
4 shall be from the date of application. Coverage for individuals eligible for  
5 Medicaid shall be retroactive for three months.

6 (3) An individual who has been found presumptively eligible for Green  
7 Mountain Care pursuant to this section on three or more occasions but has  
8 failed to pay the required premiums and cost-sharing amounts subsequent to  
9 each such finding of eligibility may continue to receive services under Green  
10 Mountain Care but shall be subject to the assessment established in section  
11 1852 of this title for the applicable calendar year as though the individual  
12 failed to comply with the individual mandate, regardless of the individual's  
13 coverage status or whether the individual would otherwise be eligible for an  
14 exemption from the assessment.

15 (f) Nothing in this subchapter shall require an individual covered by health  
16 insurance to terminate that insurance. An individual enrolled in Green  
17 Mountain Care may elect to maintain supplemental health insurance if the  
18 individual so chooses, provided that after January 1, 2014, the supplemental  
19 insurance shall cover only services that are not already covered by Green  
20 Mountain Care.

1       (g) Vermonters shall not be billed by a health care provider any additional  
2 amount for health services covered by Green Mountain Care.

3       (h) The secretary of human services may adopt rules pursuant to chapter 25  
4 of Title 3 in order to carry out the purposes of this chapter.

5       (i) Green Mountain Care shall be the secondary payer with respect to any  
6 health service that may be covered in whole or in part by Title XVIII of the  
7 Social Security Act (Medicare) or by any other health benefit plan funded  
8 solely with federal funds, such as federal health benefit plans offered by the  
9 Veterans' Administration or to federal employees.

10       (j) An individual aggrieved by an adverse decision of the agency or plan  
11 administrator may appeal to the human services board.

12       § 1809. BUDGET FOR PACKAGE OF HEALTH SERVICES

13       (a) The agency shall develop a budget for Green Mountain Care based on  
14 the payment methodologies established in section 1810 of this title, payment  
15 amounts established in section 1811 of this title, and the hospital budgeting  
16 and payment provisions provided for in subchapter 4 of this chapter.

17       (b) For each state fiscal year, beginning with state fiscal year 2014, the  
18 agency shall propose its budget for Green Mountain Care to the general  
19 assembly on or before January 15 of each year, including recommended  
20 expenditures during the next succeeding state fiscal year broken down by

1 services in each health care sector and region and anticipated revenues  
2 available to support such expenditures.

3 § 1810. PAYMENTS TO HEALTH CARE PROFESSIONALS

4 (a) No later than January 1, 2013, the agency shall determine by rule  
5 pursuant to chapter 25 of Title 3 the type of payment method to be used for  
6 health services under Green Mountain Care. The payment methods shall  
7 encourage cost-containment; provision of high-quality, evidence-based health  
8 services in an integrated setting; patient self-management; and healthy  
9 lifestyles. In developing the payment methods, the agency shall consult with  
10 health care professionals prior to filing draft rules for comment.

11 (b) The agency shall consider the following payment methods:

12 (1) periodic payments based on approved annual global hospital budgets  
13 as provided for in subchapter 4 of this chapter;

14 (2) capitated payments;

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

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

4           (5) fee-for-service.

5           (c) To the extent Green Mountain Care provides coverage for any particular  
6 type of health service or for any particular health condition, it shall cover those  
7 health services and conditions when they are provided by any type of health  
8 care professional acting within the scope of practice authorized by law. Green  
9 Mountain Care may establish a term or condition that places a greater financial  
10 burden on an individual for access to treatment by the type of health care  
11 professional only if it is related to the efficacy or cost-effectiveness of the type  
12 of service.

13           § 1811. PAYMENT AMOUNTS

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

18           (b)(1) When providing payment by fee-for-service, the agency shall pay a  
19 health care professional the lower of:

20                   (A) the health care professional's billed charges; or

1           (B)(i) for primary or preventive care or chronic care management, the  
2 rate derived from the Medicare fee schedule at an amount 10 percent greater  
3 than fee schedule amounts paid under the Medicare program in 2010; and

4           (ii) for services other than those described in subdivision (1)(B)(i)  
5 of this subsection, the applicable rate for the service under the Medicare fee  
6 schedule.

7           (2) Payments based on Medicare methodologies under this subsection  
8 shall be indexed to the Medicare economic index developed annually by the  
9 Centers for Medicare and Medicaid Services.

10          (c) Payment amounts for hospital services shall be established as provided  
11 in subchapter 4 of this chapter.

12          (d) For other payment methods, the agency shall establish by rule a  
13 methodology for setting rates, which may include negotiations with health care  
14 providers.

15          § 1812. GREEN MOUNTAIN CARE TRUST FUND

16          (a) The Green Mountain Care trust fund is established in the state treasury  
17 for the purpose of financing health care coverage for beneficiaries of Green  
18 Mountain Care as established under this subchapter. Monies from this fund  
19 may be transferred to the Global Commitment fund for the purposes of  
20 establishing the federal Medicaid match for eligible individuals and to the

1 Vermont hospital security trust fund for the Green Mountain Care hospital  
2 payment established in subchapter 4 of this chapter.

3 (b) Into the fund shall be deposited:

4 (1) the payroll tax established in chapter 27 of Title 21;

5 (2) the candy and soft drink tax allocated in 32 V.S.A. § 9820;

6 (3) 15.5 percent of the revenue from the cigarette tax levied pursuant to  
7 chapter 205 of Title 32;

8 (4) premiums paid by individuals enrolled in Green Mountain Care;

9 (5) assessments for failure to comply with the individual responsibility  
10 requirement established in subchapter 5 of this chapter;

11 (6) transfers or appropriations from the general fund authorized by the  
12 general assembly; and

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

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

19 (d) All monies received by or generated to the fund shall be used only for  
20 the administration and delivery of health care covered through the Green  
21 Mountain Care program administered by the agency under this subchapter.

1                   Subchapter 3. Pharmacy Best Practices and Cost-Containment

2                   § 1821. PHARMACY BEST PRACTICES

3                   The agency of human services or its designee shall establish and maintain a  
4                   pharmacy best-practices and cost-control program designed to reduce the cost  
5                   of providing prescription drugs while maintaining high quality in prescription  
6                   drug therapies in Green Mountain Care. The program shall include:

7                   (1) Use of an evidence-based preferred list of covered prescription drugs  
8                   that identifies preferred choices within therapeutic classes for particular  
9                   diseases and conditions, including generic alternatives and over-the-counter  
10                  drugs.

11                  (2) Utilization review procedures, including a prior authorization review  
12                  process.

13                  (3) Any strategy designed for negotiations with pharmaceutical  
14                  manufacturers to lower the cost of prescription drugs for program participants,  
15                  including:

16                         (A) a supplemental rebate program; and

17                         (B) joint purchasing agreements or other contracts with any  
18                         participating health benefit plan or organization within or outside the state  
19                         which the agency determines will lower the cost of prescription drugs for  
20                         Vermonters while maintaining high quality in prescription drug therapies.

1           (4) Alternative pricing mechanisms, including consideration of using  
2           maximum allowable cost pricing for generic and other prescription drugs.

3           (5) Alternative coverage terms, including consideration of providing  
4           coverage of over-the-counter drugs when cost-effective in comparison to  
5           prescription drugs and authorizing coverage of dosages capable of permitting  
6           the consumer to split each pill if cost-effective and medically appropriate for  
7           the consumer.

8           (6) A simple, uniform prescription form designed to implement the  
9           preferred drug list and to enable prescribers and consumers to request an  
10           exception to the preferred drug list choice with a minimum of cost and time to  
11           prescribers, pharmacists, and consumers.

12           (7) Any other cost-containment activity adopted, by rule, by the agency,  
13           which is designed to reduce the cost of providing prescription drugs while  
14           maintaining high quality in prescription drug therapies.

15           § 1822. PREFERRED DRUG LIST

16           (a)(1) The drug utilization review board established in connection with  
17           Vermont's Medicaid program shall make recommendations to the secretary for  
18           the adoption of the preferred drug list. The board's recommendations shall be  
19           based upon evidence-based considerations of clinical efficacy, adverse  
20           side-effects, safety, appropriate clinical trials, and cost-effectiveness.  
21           "Evidence-based" shall have the same meaning as in 18 V.S.A. § 4622. The

1 secretary shall provide the board with evidence-based information about  
2 clinical efficacy, adverse side-effects, safety, and appropriate clinical trials and  
3 shall provide information about cost-effectiveness of available drugs in the  
4 same therapeutic class.

5 (2) The board shall meet at least quarterly. The board shall comply with  
6 the requirements of subchapter 2 of chapter 5 of Title 1 (open meetings) and  
7 subchapter 3 of chapter 5 of Title 1 (open records), except that the board may  
8 go into executive session to discuss drug alternatives and receive information  
9 on the relative price, net of any rebates, of a drug under discussion and the  
10 drug price in comparison to the prices, net of any rebates, of alternative drugs  
11 available in the same class to determine cost-effectiveness and in order to  
12 comply with subsection 1826(c) of this title to consider information relating to  
13 a pharmaceutical rebate or to supplemental rebate agreements, which  
14 information is protected from disclosure by federal law or the terms and  
15 conditions required by the Centers for Medicare and Medicaid Services as a  
16 condition of rebate authorization under the Medicaid program.

17 (3) To the extent feasible, the board shall review all drug classes  
18 included in the preferred drug list at least every 12 months and may  
19 recommend that the secretary make additions to or deletions from the preferred  
20 drug list.

1           (4) The board shall establish board procedures for the timely review of  
2 prescription drugs newly approved by the federal Food and Drug  
3 Administration, including procedures for the review of newly approved  
4 prescription drugs in emergency circumstances.

5           (5) Members of the board shall receive per diem compensation and  
6 reimbursement of expenses in accordance with 32 V.S.A. § 1010.

7           (6) The secretary shall encourage participation in a joint purchasing  
8 consortium by inviting representatives of health insurers and other purchasers  
9 to participate as observers or nonvoting members of the drug utilization review  
10 board and by inviting the representatives to use the preferred drug list in  
11 connection with the plans' prescription drug coverage.

12           (b) The agency shall seek assistance from entities conducting independent  
13 research into the effectiveness of prescription drugs to provide technical and  
14 clinical support in the development and the administration of the preferred  
15 drug list and the evidence-based education program established in subchapter 2  
16 of Title 18.

17           § 1823. PHARMACY MAIL ORDER

18           The agency shall require consumers to purchase prescription drugs using  
19 mail order for selected pharmacy products.

1        § 1824. CONSUMER PROTECTION RULES; PRIOR AUTHORIZATION

2            (a)(1) The agency shall authorize pharmacy benefit coverage in Green  
3        Mountain Care when a patient's health care provider prescribes a prescription  
4        drug not on the preferred drug list or a prescription drug which is not the list's  
5        preferred choice if either of the circumstances set forth in subdivision (2) of  
6        this subsection applies.

7            (2)(A) The agency shall authorize coverage under the same terms as  
8        coverage for preferred choice drugs if the prescriber determines, after  
9        consultation with the pharmacist, that:

10            (i) the preferred choice has not been effective or with reasonable  
11        certainty is not expected to be effective in treating the patient's condition; or

12            (ii) the preferred choice causes or is reasonably expected to cause  
13        adverse or harmful reactions in the patient.

14            (B) The prescriber's determination concerning whether the standards  
15        established in this subdivision (2) have been demonstrated shall be final if any  
16        documentation required at the direction of the drug utilization board has been  
17        provided.

18            (b) The agency shall provide information on how prescribers, pharmacists,  
19        beneficiaries, and other interested parties can obtain a copy of the preferred  
20        drug list, whether any change has been made to the preferred drug list since it

1 was last issued, and the process by which exceptions to the preferred list may  
2 be made.

3 (c) For HIV- and AIDS-related medications used by individuals with HIV  
4 or AIDS, the preferred drug list and any utilization review procedures shall not  
5 be more restrictive than the drug list and the application of the list used for the  
6 state of Vermont AIDS medication assistance program.

7 (d)(1) The prior authorization process shall be designed to minimize  
8 administrative burdens on prescribers, pharmacists, and consumers.

9 (2) The prior authorization process shall ensure real-time receipt of  
10 requests by telephone, voice mail, facsimile, electronic transmission, or mail  
11 on a 24-hour basis seven days a week.

12 (3) The prior authorization process shall provide an in-person response  
13 to emergency requests by a prescriber with telephone answering queues that do  
14 not exceed 10 minutes.

15 (4) If a prescriber indicates in a request for authorization or approval of  
16 a drug that the drug is for an emergency or urgent condition, the agency shall  
17 respond to the request within four hours of the time the agency receives the  
18 request.

19 (5) In emergency circumstances, or if the response to a request for prior  
20 authorization is not provided within the time period established in subdivision  
21 (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed

1 to be authorized by the agency, provided it is a prescription drug approved by  
2 the Food and Drug Administration and provided, for drugs dispensed to a  
3 Medicaid-funded enrollee in Green Mountain Care, it is subject to a rebate  
4 agreement with the Centers for Medicare and Medicaid Services.

5 (6) The agency shall provide to participating providers a prior  
6 authorization request form for each enrollee in Green Mountain Care known to  
7 be a patient of the provider designed to permit the prescriber to make prior  
8 authorization requests in advance of the need to fill the prescription and  
9 designed to be completed without unnecessary delay. The form shall be  
10 capable of being stamped with information relating to the participating  
11 provider and, if feasible, at least one form capable of being copied shall  
12 contain known patient information.

13 (e) The agency's prior authorization process shall require that the  
14 prescriber, not the pharmacy, request a prior authorization exemption to the  
15 requirements of this section.

16 § 1825. PHARMACY BENEFIT MANAGEMENT

17 The secretary may implement all or a portion of the pharmacy best-practices  
18 and cost-control program through a contract with a third party with expertise in  
19 the management of pharmacy benefits.

1     § 1826. SUPPLEMENTAL REBATES

2           (a) The agency of human services or its designee shall use the preferred  
3     drug list authorized by the pharmacy best-practices and cost-control program  
4     to negotiate with pharmaceutical companies for the payment to the agency of  
5     supplemental rebates or price discounts for Green Mountain Care and VPharm,  
6     pursuant to section 2073 of this title, including Medicaid as required by Title  
7     XIX of the Social Security Act. The agency may also use the preferred drug  
8     list to negotiate for the payment of rebates or price discounts in connection  
9     with drugs covered under any other participating health benefit plan within or  
10    outside this state, provided that such negotiations and any subsequent  
11    agreement shall comply with the provisions of 42 U.S.C. § 1396r-8. The  
12    program or such portions of the program as the secretary shall designate shall  
13    constitute a state pharmaceutical assistance program under 42 U.S.C.  
14    § 1396r-8(c)(1)(C).

15           (b) The agency shall negotiate supplemental rebates, price discounts, and  
16    other mechanisms to reduce net prescription drug costs by means of any  
17    negotiation strategy which the secretary determines will result in the maximum  
18    economic benefit to the program and to consumers in this state, while  
19    maintaining access to high-quality prescription drug therapies. The agency  
20    may negotiate through a purchasing pool or directly with manufacturers. The  
21    provisions of this subsection do not authorize agreements with pharmaceutical

1 manufacturers when financial support for medical services covered by the  
2 Medicaid program is accepted as consideration for placement of one or more  
3 prescription drugs on the preferred drug list.

4 (c) The agency shall prohibit the public disclosure of information revealing  
5 company-identifiable trade secrets (including rebate and supplemental rebate  
6 amounts and manufacturer's pricing) obtained by the agency or by any officer,  
7 employee, or contractor of the agency in the course of negotiations conducted  
8 pursuant to this section. Such confidential information shall be exempt from  
9 public disclosure under subchapter 3 of chapter 5 of Title 1 (open records law).

10 Subchapter 4. Hospital Cost Containment

11 § 1831. PURPOSE

12 The purpose of this subchapter is to provide the opportunity to reduce  
13 hospital and related administrative costs in order to ensure the sustainability of  
14 providing access to payment for health services under Green Mountain Care.

15 The general assembly recognizes that the health care system is in crisis, and  
16 that all Vermonters do not have the financial ability to pay for increasing  
17 health insurance premiums or for the rising costs of health care. Vermonters  
18 need access to care, regardless of ability to pay or insurance coverage.

19 Additionally, the state must seek financial sustainability of the health care  
20 system, including reducing health care spending and transaction costs.

1     § 1832. VERMONT HOSPITAL SECURITY PLAN

2           (a) The agency of human services or its designee shall administer the  
3     Vermont hospital security plan in consultation with the department of banking,  
4     insurance, securities, and health care administration.

5           (b) The Vermont hospital security plan shall:

6           (1) provide each hospital in the state with an annual, negotiated  
7     inclusive hospital payment based upon the hospital's share of the global  
8     hospital budget for health services provided by that hospital to all patients,  
9     including patients who are not Vermont residents and patients enrolled in  
10    Green Mountain Care;

11          (2) provide for the collection of payments for health services provided  
12    by hospitals in the state to patients who are not residents of the state or who are  
13    not enrolled in Green Mountain Care, which collection may be by the agency  
14    or by a third-party administrator under contract with the agency for this  
15    purpose; and

16          (3) provide for payments for health services to hospitals not located in  
17    the state provided by them to Vermont residents enrolled in Green Mountain  
18    Care.

19     § 1833. GLOBAL HOSPITAL BUDGETS

20          (a) Annually beginning with hospital fiscal year 2014, the commissioner of  
21    banking, insurance, securities, and health care administration, in collaboration

1 with the secretary of human services, shall develop a global hospital budget for  
2 the state and individual negotiated inclusive hospital budgets for each hospital  
3 located in Vermont. The commissioner shall consider the portions of the  
4 health resource allocation plan under 18 V.S.A. § 9405 applicable to hospitals;  
5 the portions of the unified health care budget under 18 V.S.A. § 9406  
6 applicable to hospitals; the hospital budgets reviewed under 18 V.S.A. § 9456;  
7 the negotiated inclusive hospital payments under section 1835 of this title; and  
8 all other revenue received by hospitals in the development of the global  
9 hospital budget. The global hospital budget for the state shall be reported  
10 annually to the general assembly on or before January 15 for the following  
11 fiscal year.

12 (b) The global hospital budget for the state shall serve as a spending cap  
13 within which hospital costs may be controlled, resources directed, and quality  
14 and access assured. The global hospital budget shall limit the total annual  
15 growth of hospital costs to the Consumer Price Index plus three percent. The  
16 commissioner shall ensure that the review of individual hospital budgets under  
17 subchapter 7 of chapter 221 of Title 18 and the certificate of need requests  
18 under subchapter 5 of chapter 221 of Title 18 are consistent with the global  
19 hospital budget.

20 (c) The commissioner shall adopt by rule standards and procedures  
21 necessary to implement this section.

1     § 1834. GREEN MOUNTAIN CARE HOSPITAL PAYMENTS

2         The agency shall negotiate with each Vermont hospital for a capitated  
3     hospital payment for health services provided to individuals enrolled in Green  
4     Mountain Care by that hospital. The payment amount shall be based upon the  
5     hospital's share of the global hospital budget developed under section 1833 of  
6     this title, the expected population, and other information necessary to the  
7     determination of the appropriate payment, including all other revenue received  
8     from other sources. The payment amount shall not include any sums to be  
9     expended for hospital advertising purposes. The agency shall adopt by rule  
10    standards and procedures necessary to implement this section.

11    § 1835. NEGOTIATED INCLUSIVE HOSPITAL PAYMENTS

12        The commissioner shall negotiate with each Vermont hospital for an  
13    inclusive hospital payment for specified health services provided to all  
14    individuals by that hospital. The payment amount shall be based upon the  
15    hospital's share of the global hospital budget developed under section 1833 of  
16    this title, the Green Mountain Care hospital payment, and other information  
17    necessary to the determination of the appropriate payment, including all other  
18    revenue received from other sources. The payment amount shall not include  
19    any sums to be expended for hospital advertising purposes. The agency shall  
20    adopt by rule standards and procedures necessary to implement this section.

1     § 1836. PAYMENTS TO OUT-OF-STATE HOSPITALS

2         (a) The agency shall negotiate a contract including payment methods and  
3         amounts with any out-of-state hospital that regularly treats a sufficient volume  
4         of Vermont residents to provide health services under Green Mountain Care.  
5         The agency may also contract with out-of-state hospitals for the provision of  
6         specialized health services under Green Mountain Care that are not available  
7         locally to Vermonters.

8         (b) The agency shall pay to an out-of-state hospital with which the agency  
9         has not established a contract the amount charged for a medically necessary  
10        health service for which the individual received a referral or for an emergency  
11        health service customarily covered by Green Mountain Care. The agency shall  
12        develop a reference pricing system for nonemergency health services usually  
13        covered by Green Mountain Care which are received in an out-of-state hospital  
14        with which the agency has not contracted.

15     § 1837. VERMONT HOSPITAL SECURITY TRUST FUND

16        (a) The Vermont hospital security trust fund is established as a special fund  
17        in the state treasury for the purpose of financing health care services provided  
18        by hospitals to all individuals.

19        (b) Into the fund shall be deposited:

20            (1) transfers from other funds, including the Green Mountain Care trust  
21            fund and the Global Commitment fund, authorized by the general assembly;

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

3           (3) transfers of all Medicare receipts upon federal approval; and

4           (4) payments from other sources for health services provided by  
5 hospitals in the state to patients who are not residents of the state or who are  
6 not enrolled in Green Mountain Care.

7           (c) The fund shall be administered by the secretary pursuant to subchapter  
8 5 of chapter 7 of Title 32, except that interest earned on the fund and any  
9 remaining balance shall be retained in the fund. The secretary shall maintain  
10 records indicating the amount of money in the fund at any time.

11           (d) All monies received by or generated to the fund shall be used only for  
12 the administration and delivery of health care services provided by hospitals  
13 covered through state health care assistance programs administered by the  
14 agency, including the Vermont hospital security plan.

15                   Subchapter 5. Individual Responsibility Requirement

16           § 1851. DEFINITIONS

17           Notwithstanding section 1801 of this title, as used in this subchapter:

18           (1) “Benchmark benefit plan” means a health benefit plan that provides  
19 coverage for preventive services and provides additional coverage that is at  
20 least equivalent to the actuarial value of Green Mountain Care. The term does  
21 not include a high deductible plan unless such plan is offered by an employer

1 and the employer pays into the employee's health savings account an amount  
2 of funds sufficient to enable the employee to receive first-dollar coverage  
3 under the plan.

4 (2) "Vermont resident" means an individual who meets one or more of  
5 the following criteria:

6 (A) is domiciled in Vermont as evidenced by an intent to maintain a  
7 principal dwelling place in Vermont indefinitely and to return to Vermont if  
8 temporarily absent, coupled with an act or acts consistent with that intent;

9 (B) both maintains a permanent place of abode in this state and is  
10 present in this state for more than an aggregate of 183 days of the taxable year;

11 (C) filed a Vermont resident income tax return pursuant to chapter  
12 151 of Title 32;

13 (D) made a declaration of homestead pursuant to 32 V.S.A. § 5410;

14 (E) submitted a claim pursuant to 32 V.S.A. § 6066(b) (income  
15 sensitivity adjustment);

16 (F) declared in a home mortgage settlement document that the  
17 mortgaged property located in this state would be occupied as the individual's  
18 principal residence;

19 (G) obtained homeowner's liability insurance coverage on property  
20 that was declared to be occupied as a principal residence;

1           (H) filed a certificate of residency and identified the individual's  
2 place of residence in a city or town in this state in order to comply with a  
3 residency requirement as a prerequisite for employment with a governmental  
4 entity;

5           (I) paid on the individual's own behalf or on the behalf of a child or  
6 dependent of whom the individual has custody resident in-state tuition rates to  
7 attend a state-sponsored institution of higher education located in this state;

8           (J) applied for and received public assistance from this state for the  
9 individual or his or her child or dependent of whom the individual has custody;

10           (K) has a child or dependent, of whom the individual has custody,  
11 who is enrolled in a public school in a city or town in this state, unless the cost  
12 of such education is paid for by such individual, the child, or dependent, or by  
13 another education jurisdiction;

14           (L) is registered to vote in this state;

15           (M) obtained any benefit, exemption, deduction, entitlement, license,  
16 permit, or privilege by claiming principal residence in this state; or

17           (N) is a resident under any other written criteria under which the  
18 commissioner of taxes may determine residency in this state.

1     § 1852. HEALTH COVERAGE MANDATE; REPORTING;

2             ASSESSMENTS

3             (a) As of January 1, 2014, the following individuals age 18 and over shall  
4             obtain and maintain health coverage at least equivalent to the benchmark  
5             benefit plan:

6                 (1) Vermont residents; and

7                 (2) individuals who become Vermont residents within 63 days of  
8             meeting any one or more of the criteria specified in subdivision 1851(2) of this  
9             title.

10            (b)(1) Every person who files or is required to file an individual return as a  
11            Vermont resident, either separately or jointly with a spouse, shall indicate on  
12            the return, in a manner prescribed by the commissioner of taxes, whether such  
13            person:

14                 (A) had health coverage at least equivalent to the benchmark benefit  
15                 plan in force for each of the 12 months of the taxable year for which the return  
16                 is filed as required under subsection (a) of this section, whether covered as an  
17                 individual or as a named beneficiary of a policy covering multiple individuals;  
18                 or

19                 (B) claims an exemption under section 1853 of this title based on  
20                 sincerely held religious beliefs.

1           (2) If the person either fails to indicate or indicates that he or she did not  
2           have such coverage in force, then an assessment shall be imposed on the return  
3           as provided in subsection (c) of this section.

4           (3) If the person indicates that he or she had such coverage in force but  
5           the commissioner determines, based on the information available to the  
6           commissioner, that the coverage requirement in subsection (a) of this section  
7           was not met, then the commissioner shall impose an assessment as provided in  
8           subsection (c) of this section.

9           (c)(1) If in any taxable year, in whole or in part, a taxpayer does not  
10           comply with the coverage requirement in subsection (b) of this section, the  
11           commissioner of taxes shall retain any amount overpaid by the taxpayer for  
12           purposes of making payments to the Green Mountain Care trust fund  
13           established pursuant to section 1812 of this title; provided, however, that the  
14           amount retained shall not exceed 50 percent of the highest premium available  
15           under Green Mountain Care.

16           (2) The assessment shall be imposed for each of the months for which  
17           the individual did not meet the coverage requirement in subsection (a) of this  
18           section; provided, however, that any lapse in coverage of 63 days or fewer  
19           shall not be counted in calculating the assessment; and provided further that  
20           nothing in this subsection shall be deemed to authorize the commissioner of  
21           taxes to retain any amount for such purposes that otherwise would be paid to a

1 claimant, agency, or agencies as debts pursuant to subchapter 12 of chapter  
2 151 of Title 32.

3 (3) If the amount retained by the commissioner of taxes is insufficient to  
4 meet the assessment imposed, the commissioner of taxes shall notify the  
5 taxpayer of the balance due on the assessment and related interest.

6 (d) The state shall have all enforcement and collection procedures available  
7 under chapter 103 of Title 32 to collect any assessments imposed pursuant to  
8 this section. Individuals shall have all appeal rights available under chapter  
9 103 of Title 32.

10 (e) The commissioner of taxes shall deposit all assessments collected  
11 pursuant to this section into the Green Mountain Care trust fund, established  
12 pursuant to section 1812 of this title.

13 § 1853. EXEMPTION FOR REFUSAL OF COVERAGE BASED ON

14 SINCERELY HELD RELIGIOUS BELIEFS

15 (a) An individual shall be exempt from the coverage requirement pursuant  
16 to subsection 1852(a) of this title if the individual files a sworn affidavit with  
17 his or her income tax return stating that such individual did not have creditable  
18 coverage, and that his or her sincerely held religious beliefs are the basis of his  
19 or her refusal to obtain and maintain the required coverage during the 12  
20 months of the taxable year for which the return was filed.

1        (b) Any individual who claimed an exemption but received medical care  
2        during the taxable year for which the return is filed shall be liable for providing  
3        or arranging for full payment for the medical care and be subject to the  
4        assessment under subsection 1852(c) of this title.

5        (c) The agency of human services and the department of taxes shall  
6        coordinate procedures to identify individuals who are subject to an assessment  
7        pursuant to subsection (b) of this section and may make rules pursuant to  
8        chapter 25 of Title 3 to carry out the purposes of this section.

9        Sec. 2. 18 V.S.A. § 9437(1) is amended to read:

10        (1) the application is consistent with the health resource allocation plan  
11        and, as applicable, the financial parameters set by the global hospital budget  
12        established under 33 V.S.A. § 1833;

13        Sec. 3. 18 V.S.A. § 9456(c) is amended to read:

14        (c) Individual hospital budgets established under this section shall:

15        (1) be consistent with the health resource allocation plan;

16        (2) take into consideration national, regional, or instate peer group  
17        norms, according to indicators, ratios, and statistics established by the  
18        commissioner;

19        (3) promote efficient and economic operation of the hospital;

20        (4) reflect budget performances for prior years; ~~and~~

1           (5) include a finding that the analysis provided in subdivision (b)(9) of  
2 this section is a reasonable methodology for reflecting a reduction in net  
3 revenues for non-Medicaid payers;

4           (6) take into consideration co-payments imposed on consumers for  
5 hospital services under public and private health benefit plans;

6           (7) not include sums to be expended for advertising purposes; and

7           (8) be consistent with the global hospital budget established under  
8 33 V.S.A. § 1833.

9       Sec. 4. FEDERAL WAIVERS

10       (a) The secretary of human services shall apply for a federal Medicare  
11 waiver no later than September 30, 2012, to allow the state to modify the  
12 payment standards or amounts in order to include Medicare funds in the global  
13 hospital budget established under 33 V.S.A. § 1833.

14       (b) The secretary of human services shall apply for a Medicaid Section  
15 1115 waiver to take effect no later than January 1, 2014 to allow the state to  
16 modify the payment standards or amounts in order to include Medicaid funds  
17 in the global hospital budget established under 33 V.S.A. § 1833.

18       (c)(1) The secretary shall also apply for a Medicaid Section 1115 waiver to  
19 take effect no later than January 1, 2014 to provide benefits to individuals and  
20 families through Green Mountain Care.

1           (2) At minimum, this waiver shall request federal participation for  
2 individuals up to 300 percent of the federal poverty level and request that there  
3 be no asset eligibility requirement.

4           (3) The waiver request shall continue the managed care organization  
5 (MCO) structure established in Vermont's Global Commitment to Health  
6 waiver, allowing the office of Vermont health access to be a public MCO and  
7 maintaining the ability to provide MCO investments for reducing the rate of  
8 uninsured or underinsured in Vermont; increasing the access of quality health  
9 care to uninsured, underinsured, and Green Mountain Care beneficiaries;  
10 providing public health approaches to improve the health outcomes and the  
11 quality of life for Medicaid-eligible individuals and Green Mountain Care  
12 enrollees in Vermont; and encouraging the formation and maintenance of  
13 government and community partnerships in health care.

14           (d) If the waiver amendments are denied, the secretary may continue  
15 provide medical assistance to eligible and enrolled individuals under the  
16 provisions of any other Medicaid waiver or waivers, if any, in effect on  
17 January 1, 2014.

18                                   \* \* \* Medicaid Provisions \* \* \*

19           Sec. 5. 33 V.S.A. § 1901(b) and (c) are amended to read:

20           (b) The secretary may charge a ~~monthly~~ Green Mountain Care premium, in  
21 amounts set by the general assembly as provided for in section 1806 of this

1 ~~title, to each an individual 18 years or older who is eligible for enrollment in~~  
2 ~~the health access program, as authorized by section 1973 of this title and as~~  
3 ~~implemented by rules. All premiums collected by the agency of human~~  
4 ~~services or designee for enrollment in the health access program shall be~~  
5 ~~deposited in the state health care resources fund established in section 1901d of~~  
6 ~~this title~~ benefits paid for with Medicaid funds under the amended Global  
7 Commitment to Health waiver. Individuals eligible for Medicaid as defined in  
8 section 1801 of this title shall not be charged a premium unless specifically  
9 authorized by this section. Any Green Mountain Care co-payments,  
10 coinsurance, or other cost sharing to be charged to individuals whose benefits  
11 are paid for with Medicaid funds shall also be authorized and set by the general  
12 assembly.

13 (c) The secretary may charge a ~~monthly~~ Green Mountain Care premium, in  
14 amounts set by the general assembly, ~~per~~ for an individual, two-person group,  
15 or family for pregnant women and children eligible for medical assistance  
16 under sections Sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title  
17 XIX of the Social Security Act, whose family income exceeds 185 percent of  
18 the federal poverty level, as permitted under section Section 1902(r)(2) of that  
19 act. Fees collected under this subsection shall be credited to the state health  
20 care resources fund established in section 1901d of this title and shall be  
21 available to the agency to offset the costs of providing Medicaid services. Any

1 Green Mountain Care co-payments, coinsurance, or other cost sharing to be  
2 charged to individuals or families whose benefits are paid for with Medicaid or  
3 the Children's Health Insurance Program (CHIP) funds as defined in section  
4 1801 of this title shall also be authorized and set by the general assembly.

5 Sec. 6. 33 V.S.A. § 1901(e) and (f) are amended to read:

6 ~~(e)(1) The department for children and families and the department of~~  
7 ~~Vermont health access shall monitor and evaluate and report quarterly~~  
8 ~~beginning July 1, 2006 on the disenrollment in each of the Medicaid or~~  
9 ~~Medicaid waiver programs subject to premiums, including:~~

10 ~~(A) The number of beneficiaries receiving termination notices for~~  
11 ~~failure to pay premiums;~~

12 ~~(B) The number of beneficiaries terminated from coverage as a result~~  
13 ~~of failure to pay premiums as of the second business day of the month~~  
14 ~~following the termination notice. The number of beneficiaries terminated from~~  
15 ~~coverage for nonpayment of premiums shall be reported by program and~~  
16 ~~income level within each program; and~~

17 ~~(C) The number of beneficiaries terminated from coverage as a result~~  
18 ~~of failure to pay premiums whose coverage is not restored three months after~~  
19 ~~the termination notice.~~

20 ~~(2) The department for children and families and the department of~~  
21 ~~Vermont health access shall submit reports at the end of each quarter required~~

1 ~~by subdivision (1) of this subsection to the house and senate committees on~~  
2 ~~appropriations, the senate committee on health and welfare, the house~~  
3 ~~committee on human services, the health access oversight committee, and the~~  
4 ~~Medicaid advisory board.~~

5       ~~(f)~~ The secretary shall not impose a prescription co-payment for individuals  
6 under age 21 enrolled in Green Mountain Care and paid for with Medicaid or  
7 ~~Dr. Dynasaur~~ CHIP funds, as defined in section 1801 of this title.

8 Sec. 7. TRANSITIONAL PROVISIONS

9       (a) Premiums, deductibles, co-payments, and out-of-pocket maximums for  
10 individuals and families whose health services are paid for with Medicaid or  
11 CHIP funds shall be the same amount as in effect upon passage of this act,  
12 except that individuals, two-person groups, and families with incomes under  
13 100 percent of the federal poverty level shall not be charged a premium or a  
14 deductible.

15       (b) If the Centers for Medicare and Medicaid Services grant the waiver  
16 amendment requested in Sec. 4 of this act, beginning January 1, 2014, the  
17 agency of human services shall provide individuals currently eligible for  
18 Medicaid, the Vermont health access plan, the employer-sponsored insurance  
19 program, Catamount Health Assistance, Dr. Dynasaur, or other coverage  
20 funded with Medicaid or the Children's Health Insurance Program (CHIP), as

1 defined in section 1801 of this title, with a Green Mountain Care card at the  
2 time of the individual's or family's recertification for current coverage.

3 (c) At least 30 days in advance of the transition, the agency shall provide  
4 notice of the change, new options available for coverage on a two-person or  
5 family plan, and any adjustments to premiums and cost-sharing requirements  
6 to the individual. The agency shall assist the individual in changing from  
7 individual coverage to coverage for two people or a family upon request of the  
8 individual.

9 (d) Health insurers offering Catamount Health pursuant to 8 V.S.A. § 4080f  
10 shall inform the agency of human services monthly of the Catamount enrollees  
11 with approaching anniversary dates in order to ensure a smooth transition from  
12 Catamount coverage to Green Mountain Care. The insurer shall notify the  
13 individual that his or her coverage through Catamount Health will terminate,  
14 and that the individual will be provided with coverage through Green  
15 Mountain Care. The agency shall notify individuals of their eligibility for  
16 Green Mountain Care and request the information necessary to determine the  
17 applicable premium amount.

18 (e) The agency shall make reasonable efforts to ensure that individuals do  
19 not lose health care coverage during the transition to Green Mountain Care.

1                   \* \* \* Additional Green Mountain Care Provisions \* \* \*

2           Sec. 8. APPLICABILITY TO COLLECTIVE BARGAINING

3                   AGREEMENTS

4           Individuals insured through health benefit plans entered into as the result of  
5           a collective bargaining agreement shall not be subject to the benchmark benefit  
6           plan requirement of the individual coverage mandate in 33 V.S.A. § 1852(a)  
7           until after the first renegotiation of the employment contract following April 1,  
8           2014.

9           Sec. 9. HEALTH BENEFIT EXCHANGE ELIGIBILITY

10           No later than January 15, 2012, the commissioner of banking, insurance,  
11           securities, and health care administration shall recommend to the house  
12           committees on health care and on human services and the senate committees  
13           on health and welfare and on finance a method by which Green Mountain Care  
14           may obtain an insurance license and offer the public option through Vermont's  
15           health benefit exchange pursuant to the Patient Protection and Affordable Care  
16           Act of 2010, Public Law 111-148, as amended by the Health Care and  
17           Education Reconciliation Act of 2010, Public Law 111-152.

18                           \* \* \* Tax Financing \* \* \*

19           Sec. 10. 32 V.S.A. § 9701(48) and (49) are added to read:

20                   (48) Candy: means a preparation of sugar, honey, or other natural or  
21           artificial sweeteners in combination with chocolate, fruits, nuts, or other

1 ingredients or flavorings in the form of bars, drops, or pieces. “Candy” shall  
2 not include any preparation containing flour and shall require no refrigeration.

3 (49) Soft drinks: means nonalcoholic beverages that contain natural or  
4 artificial sweeteners. “Soft drinks” do not include beverages that contain milk  
5 or milk products, soy, rice, or similar milk substitutes, or greater than 50  
6 percent of vegetable or fruit juice by volume.

7 Sec. 11. 32 V.S.A. § 9741(13) is amended to read:

8 (13) Sales of food, ~~food stamps, purchases made with food stamps,~~ food  
9 products, and beverages (other than candy and soft drinks) sold for human  
10 consumption off the premises where sold; food stamps, purchases made with  
11 food stamps.

12 Sec. 12. 32 V.S.A. § 9820 is added to read:

13 § 9820. REALLOCATION OF RECEIPTS FROM TAX ON CANDY AND  
14 SOFT DRINKS

15 (a) The commissioner shall allocate annually receipts from the tax on  
16 candy and soft drinks, currently estimated at \$7,000,000.00, to the Green  
17 Mountain Care trust fund established pursuant to 33 V.S.A. § 1812.

18 (b) Amounts due the education fund pursuant to 16 V.S.A. § 4025 shall be  
19 calculated after the allocation set forth in subsection (a) of this section.

1 Sec. 13. 32 V.S.A. § 7823 is amended to read:

2 § 7823. DEPOSIT OF REVENUE

3 The revenue generated by the taxes imposed under this chapter shall be  
4 credited to the state health care resources fund established by  
5 33 V.S.A. § 1901d and the ~~Catamount fund established by section 1986 of~~  
6 ~~Title 33~~ Green Mountain Care trust fund established by 33 V.S.A. § 1812.

7 Sec. 14. 21 V.S.A. chapter 27 is added to read:

8 CHAPTER 27. GREEN MOUNTAIN CARE CONTRIBUTIONS

9 § 2101. ADMINISTRATION AND ENFORCEMENT OF CHAPTER

10 (a) The administration of this chapter is vested in the commissioner of the  
11 department of labor. All forms necessary and proper for the administration and  
12 enforcement of this chapter shall be prescribed and furnished by the  
13 commissioner. The commissioner shall appoint such agents, clerks,  
14 stenographers and other assistants as he or she may deem necessary for  
15 effecting the purposes of this chapter, but their salaries shall be fixed by the  
16 commissioner with the approval of the governor. The commissioner may  
17 require any such agent, clerk, stenographer, or other assistant to execute a bond  
18 in such sum as such commissioner shall determine for the faithful discharge of  
19 his or her duties. Any such agent, clerk, stenographer, or other assistant may  
20 be removed by the commissioner. The commissioner may prescribe  
21 regulations and rulings not inconsistent with law to carry into effect the

1 provisions of this chapter, which regulations and rulings, when reasonably  
2 designed to carry out the intent and purpose of this chapter, shall be prima  
3 facie evidence of its proper interpretation. The commissioner, from time to  
4 time, shall publish for distribution such regulations prescribed by him or her  
5 and such rulings as he or she shall deem to be of general interest.

6 (b) The commissioner shall enforce this chapter in the same manner as  
7 provided for in the enforcement provisions of chapter 17 of this title, and all  
8 assessments, penalties, interest, collections, liens, reporting requirements,  
9 penalties for failure to follow the reporting and contribution requirements, and  
10 appeal rights shall be in accordance with chapter 17 of this title.

11 § 2102. DEFINITIONS

12 For purposes of this chapter, all terms not defined in this chapter shall have  
13 their respective meanings as defined in chapter 17 of this title.

14 § 2103. EMPLOYER CONTRIBUTION

15 (a) Each employer in this state that employs five or more employees shall  
16 pay to the commissioner a Green Mountain Care employer contribution equal  
17 to 10 percent of the employer's gross wages paid for employment; provided,  
18 however, that the amount of the employer contribution shall be reduced by any  
19 increase in the federal payroll tax directly related to federal health care reform  
20 legislation.

1       (b) The Green Mountain Care employer contribution shall accrue and  
2       become payable by each employer at such time and in such installments as the  
3       commissioner, in consultation with the secretary of human services, prescribes.

4       (c) For purposes of this section, "employee" means an individual who  
5       works for the employer for at least 30 hours per week and at least 30 weeks per  
6       year.

7       § 2104. EMPLOYEE PREMIUM PAYMENT

8       (a) Each employer in this state upon request shall deduct from an  
9       employee's gross wages a sum equal to the premium payment for the  
10       employee's individual, two-person, or family coverage under Green Mountain  
11       Care established pursuant to chapter 18 of Title 33 at such time and in such  
12       installments as the commissioner, in consultation with the secretary of human  
13       services, prescribes.

14       (b) Each employer in this state upon request shall deduct from an  
15       employee's gross wages a sum equal to the premium payment for the  
16       employee's individual, two-person, or family coverage under any individual or  
17       group health benefit plan at such time and in such installments as the  
18       commissioner, in consultation with the commissioner of banking, insurance,  
19       securities, and health care administration, prescribes.

20       (c) Every employer required to deduct the Green Mountain Care or other  
21       health benefit plan premium pursuant to subsection (a) or (b) of this section

1 shall be liable for the payment of the premium and shall be indemnified against  
2 the claims and demands of any person for the amount of the payment made by  
3 the employer.

4 \* \* \* Insurance Provisions \* \* \*

5 Sec. 15. 8 V.S.A. § 4080a(g) is amended to read:

6 (g) ~~For a 12-month period from the effective date of coverage, a registered~~  
7 ~~small group carrier may limit coverage of preexisting conditions which exist~~  
8 ~~during the six-month period before the effective date of coverage; provided~~  
9 ~~that a registered small group carrier shall waive any preexisting condition~~  
10 ~~provisions for all new employees or members of a small group, and their~~  
11 ~~dependents, who produce evidence of continuous health benefit coverage~~  
12 ~~during the previous nine months substantially equivalent to the common health~~  
13 ~~care plan of the carrier approved by the commissioner. Credit shall be given~~  
14 ~~for prior coverage that occurred without a break in coverage of 90 days or~~  
15 ~~more. Notwithstanding any provision of law to the contrary, a registered small~~  
16 group carrier shall not limit coverage of preexisting conditions which existed  
17 prior to the enrollment of an employee or a member, or his or her dependents  
18 in the plan.

19 Sec. 16. 8 V.S.A. § 4080b is amended to read:

20 § 4080b. NONGROUP HEALTH BENEFIT PLANS

21 (a) As used in this section:

1           (1) ~~“Individual” means a person who is not eligible for coverage by~~  
2 ~~group health insurance as defined by section 4079 of this title.~~

3           (2) “Nongroup plan” means a health insurance policy, a nonprofit  
4 hospital or medical service corporation service contract or a health  
5 maintenance organization health benefit plan offered or issued to an individual,  
6 including but not limited to common health care plans approved by the  
7 commissioner under subsection (e) of this section. The term does not include  
8 disability insurance policies, accident indemnity or expense policies, long-term  
9 care insurance policies, student or athletic expense or indemnity policies,  
10 Medicare supplemental policies, and dental policies. The term also does not  
11 include hospital indemnity policies or specified disease indemnity or expense  
12 policies, provided such policies are sold only as supplemental coverage when a  
13 common health care plan or other comprehensive health care policy is in  
14 effect. By July 1, 1993, the commissioner shall review and approve or  
15 disapprove, according to the provisions of section 4062 of this title, any  
16 supplemental health insurance policy form offered or issued to an individual  
17 within the state of Vermont.

18           (3)(2) “Registered nongroup carrier” means any person, except an  
19 insurance agent, broker, appraiser, or adjuster, who issues a nongroup plan and  
20 who has a registration in effect with the commissioner as required by this  
21 section.

1 \* \* \*

2 (g) ~~For a 12-month period from the effective date of coverage, a registered~~  
3 ~~nongroup carrier may limit coverage of preexisting conditions which exist~~  
4 ~~during the 12-month period before the effective date of coverage; provided that~~  
5 ~~a registered nongroup carrier shall waive any preexisting condition provisions~~  
6 ~~for all individuals, and their dependents, who produce evidence of continuous~~  
7 ~~health benefit coverage during the previous nine months substantially~~  
8 ~~equivalent to the common health care plan of the carrier approved by the~~  
9 ~~commissioner. If an individual has a preexisting condition excluded under a~~  
10 ~~subsequent policy, such exclusion shall not continue longer than the period~~  
11 ~~required under the original contract, or 12 months, whichever is less. Credit~~  
12 ~~shall be given for prior coverage that occurred without a break in coverage of~~  
13 ~~63 days or more. For an eligible individual, as such term is defined in Section~~  
14 ~~2741 of Title XXVII of the Public Health Service Act, a registered nongroup~~  
15 ~~carrier shall not limit coverage of preexisting conditions. Notwithstanding any~~  
16 ~~provision of law to the contrary, a registered nongroup carrier shall not limit~~  
17 ~~coverage of preexisting conditions which existed prior to the enrollment of an~~  
18 ~~individual or his or her dependents in the plan.~~

19 \* \* \*



1       Sec. 19. HEALTH CARE OMBUDSMAN

2           The agency of human services shall consult with the office of the health  
3       care ombudsman to ascertain the increased demand on the office's services as  
4       a result of the creation of Green Mountain Care and the individual  
5       responsibility requirement. As part of its fiscal year 2013 budget proposal, the  
6       agency shall propose increased funding for the office as needed to ensure  
7       adequate staffing and the provision of necessary consumer services.

8       Sec. 20. FEDERAL PREMIUM TAX CREDIT AND COST-SHARING

9                       SUBSIDY STUDY

10          The department of Vermont health access shall analyze the federal premium  
11       tax credits and cost-sharing subsidies for which individuals may be eligible  
12       under the Patient Protection and Affordable Care Act of 2010, Public Law  
13       111-148, as amended by the Health Care and Education Reconciliation Act of  
14       2010, Public Law 111-152 to determine the impact of the credits and subsidies  
15       on the premium and cost-sharing amounts applicable to each income increment  
16       as established in 33 V.S.A. § 1806. No later than January 15, 2013, the  
17       department shall report the results of its analysis to the house committees on  
18       appropriations, on health care, and on human services and the senate  
19       committees on appropriations and on health care.



1           (4) 33 V.S.A. § 1998a (pharmacy mail order).

2           (5) 33 V.S.A. § 1999 (pharmacy consumer protection and prior  
3 authorization).

4           (6) 33 V.S.A. § 2000 (pharmacy benefit management).

5           (7) 33 V.S.A. § 2001 (report to legislature).

6           (8) 33 V.S.A. § 2002 (supplemental rebate).

7           (c) Chapter 25 of Title 2 (joint legislative commission on health care  
8 reform) is repealed effective July 1, 2011.

9           (d) The following provisions are repealed effective December 31, 2013:

10           (1) 8 V.S.A. § 4080c (health insurance safety net).

11           (2) 8 V.S.A. § 4080f (Catamount Health).

12           (3) 21 V.S.A. § 2003 (health care fund employer assessment).

13       Sec. 23. APPROPRIATION

14           In fiscal year 2013, the sum of \$500,000.00 is appropriated to the  
15 department of health from the Green Mountain Care trust fund to be deposited  
16 in the Vermont health care educational loan repayment fund pursuant to  
17 18 V.S.A. § 10a.

18       Sec. 24. EFFECTIVE DATES

19           (a) Sec. 1 (establishing Green Mountain Care) shall take effect January 1,  
20 2014, except that:

1           (1) The commissioner of banking, insurance, securities, and health care  
2           administration and the secretary of human services may take steps beginning  
3           January 1, 2013, including rulemaking and collection of funds from insurers  
4           and from the Green Mountain Care trust fund, to ensure that the hospital global  
5           budget process established pursuant to subchapter 4 of chapter 18 of Title 33  
6           will be operational for hospital fiscal year 2014.

7           (2) Green Mountain Care shall be implemented no later than January 1,  
8           2014.

9           (3) The individual responsibility requirement established in subchapter 5  
10          of chapter 18 of Title 33 shall take effect on January 1, 2014.

11          (b) Secs. 2 (certificate of need criteria) and 3 (hospital budget review) of  
12          this act shall take effect January 1, 2014.

13          (c) Sec. 4 (federal waivers) shall take effect upon passage.

14          (d) Secs. 5 (Medicaid program changes) and 6 (repeal of Medicaid reports;  
15          prohibition on prescription co-payments) shall take effect upon the approval of  
16          the Medicaid Section 1115 waiver pursuant to Sec. 4(c) of this act.

17          (e) Sec. 7 (transitional provisions) shall take effect upon the approval of the  
18          Medicaid Section 1115 waiver pursuant to Sec. 4(c) of this act, except that  
19          subsection (d) of Sec. 7 (Catamount Health transition) shall take effect  
20          January 1, 2014 for individuals who are not receiving Catamount Health  
21          Assistance.

1       (f) Sec. 8 (applicability to collective bargaining agreements) shall take  
2 effect January 1, 2014.

3       (g) Sec. 9 (exchange analysis) shall take effect upon passage.

4       (h) Secs. 10 (definitions of candy and soft drink), 11 (exclusion of candy  
5 and soft drinks from sales tax exemption), 12 (allocation of tax on candy and  
6 soft drinks) 13 (allocation of cigarette taxes), and 14 (employer and employee  
7 contributions) shall take effect January 1, 2013.

8       (i) Secs. 15 (ban on preexisting condition exclusion for small group plans),  
9 16 (amendments to nongroup health plans), and 17 (composition of health  
10 access oversight committee) shall take effect upon passage.

11       (j) Sec. 18 (health access oversight committee charge) shall take effect  
12 July 1, 2013.

13       (k) Sec. 19 (health care ombudsman staffing) shall take effect July 1, 2011.

14       (l) Secs. 20 (premium tax credit and cost-sharing subsidy analysis), 21  
15 (statutory revision authority), and 22 (repeals) shall take effect upon passage.

16       (m) Sec. 23 (loan repayment appropriation) shall take effect July 1, 2011.

17       (n) This section shall take effect on passage.