

1 H.202

2 Introduced by Representative Larson of Burlington

3 Referred to Committee on

4 Date:

5 Subject: Health; health insurance; Medicaid; Vermont health benefit

6 exchange; single-payer; public health; payment reform; prescription

7 drugs; health information technology; medical malpractice

8 Statement of purpose: This bill proposes to set forth a strategic plan for
9 creating a single-payer and unified health system. It would establish a board to
10 ensure cost-containment in health care, to create system-wide budgets, and to
11 pursue payment reform; establish a health benefit exchange for Vermont as
12 required under federal health care reform laws; create a public-private
13 single-payer health care system to provide coverage for all Vermonters after
14 receipt of federal waivers; create a consumer and health care professional
15 advisory board; examine reforms to Vermont's medical malpractice system;
16 modify the insurance rate review process; and create a statewide drug
17 formulary.

18 ~~An act relating to a single-payer and unified health system~~ *An act relating*
19 *to a universal and unified health system*

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

1 Sec. 1. PRINCIPLES

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

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

11 (2) Health care spending growth in Vermont must be consistent with
12 growth in the state's economy and spending capacity.

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

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

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

3 (6) Vermonters should be aware of the total cost of the health services
4 they receive. Costs should be transparent and readily understood, and
5 individuals should have a personal responsibility to maintain their own health
6 and to use health resources wisely.

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

10 (8) Vermont's health delivery system must model continuous
11 improvement of health care quality and safety, and the system therefore must
12 be evaluated for improvement in access, quality, and reliability and for
13 reductions in cost.

14 (9) A system must be implemented for containing all system costs and
15 eliminating unnecessary expenditures, including by reducing administrative
16 costs; reducing costs that do not contribute to efficient, high-quality health
17 services; and reducing care that does not improve health outcomes.

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

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

1 * * * Road Map to a Single-Payer and a Unified Health Care System * * *

2 Sec. 2. STRATEGIC PLAN; SINGLE-PAYER AND UNIFIED HEALTH
3 SYSTEM

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

13 (b) The Vermont health reform board is created to develop mechanisms to
14 reduce the rate of growth in health care through cost-containment,
15 establishment of budgets, and payment reform.

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

19 (1) No later than November 1, 2013, the Vermont health benefit
20 exchange established in subchapter 1 of chapter 18 of Title 33 shall begin
21 enrolling individuals and employers with 100 employees or fewer for coverage

1 beginning January 1, 2014. The intent of the general assembly is to establish
2 the Vermont health benefit exchange in a manner such that it may become the
3 foundation for a single-payer health system.

4 (2) No later than November 1, 2016, the Vermont health benefit
5 exchange established in subchapter 1 of chapter 18 of Title 33 shall begin
6 enrolling employers with more than 100 employees for coverage beginning
7 January 1, 2017.

8 (3) No later than January 1, 2014, the commissioner of banking,
9 insurance, securities, and health care administration shall require that all
10 individual and small group health insurance products be sold only through the
11 Vermont health benefit exchange and shall require all large group insurance
12 products to be aligned with the administrative requirements and essential
13 benefits required in the Vermont health benefit exchange. The commissioner
14 shall provide recommendations for statutory changes as part of the integration
15 plan established in Sec. 8 of this act.

16 (4) The secretary shall supervise the planning efforts, reports of which
17 are due on January 15, 2012, as provided in Sec. 8 and Secs. 10 through 14 of
18 this act, including integration of multiple payers into the Vermont health
19 benefit exchange; a continuation of the planning necessary to ensure an
20 adequate, well-trained primary care workforce; necessary retraining for any
21 employees dislocated from health care professionals or from health insurers

1 due to the simplification in the administration of health care; and unification of
2 health system planning, regulation, and public health.

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

8 (d) The secretary of administration or designee shall obtain waivers,
9 exemptions, agreements, legislation, or a combination thereof to ensure that all
10 federal payments provided within the state for health services are paid directly
11 to Green Mountain Care. Green Mountain Care shall assume responsibility for
12 the benefits and services previously paid for by the federal programs, including
13 Medicaid, Medicare, and, after implementation, the Vermont health benefit
14 exchange. In obtaining the waivers, exemptions, agreements, legislation, or
15 combination thereof, the secretary shall negotiate with the federal government
16 a federal contribution for health care services in Vermont that reflects medical
17 inflation, the state gross domestic product, the size and age of the population,
18 the number of residents living below the poverty level, and the number of
19 Medicare-eligible individuals and that does not decrease in relation to the
20 federal contribution to other states as a result of the waivers, exemptions,
21 agreements, or savings from implementation of Green Mountain Care.

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

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

3 CHAPTER 220. VERMONT HEALTH REFORM BOARD

4 § 9371. PURPOSE

5 It is the intent of the general assembly to create an independent board to
6 develop mechanisms to reduce the per capita rate of growth in health care
7 expenditures in Vermont across all payers for health services.

8 § 9372. DEFINITIONS

9 As used in this chapter:

10 (1) "Board" means the Vermont health reform board established in this
11 chapter.

12 (2) "Green Mountain Care" means the public-private single-payer
13 health system established in 33 V.S.A. chapter 18, subchapter 2.

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

17 (4) "Health services" means any medically necessary treatment or
18 procedure to maintain, diagnose, or treat an individual's physical or mental
19 condition, including services ordered by a health care professional and
20 medically necessary services to assist in activities of daily living.

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

3 § 9373. BOARD MEMBERSHIP

4 (a) On July 1, 2011, a Vermont health reform board is created and shall
5 consist of a chair and four members. The chair shall be a full-time state
6 employee and the four other members shall be part-time state employees. All
7 members shall be exempt from the state classified system.

8 (b) The chair and the four members shall be appointed by the governor
9 with the advice and consent of the senate. The governor shall appoint one
10 member who is an expert in health policy or health financing, one member
11 who is a practicing physician, one member who has experience in or who
12 represents hospitals, one member representing employers who purchase health
13 insurance, and one member who represents consumers. The governor shall
14 name the chair.

15 (c) The term of each member shall be six years; except that of the members
16 first appointed, two shall serve for a term of two years and two shall serve for a
17 term of four years. Members of the board may be removed only for cause.

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

20 § 9374. DUTIES

21 (a) In carrying out its duties, the board shall have the following objectives:

- 1 (1) Improve the health of the population;
- 2 (2) Enhance the patient experience of care, including quality, access,
3 and reliability;
- 4 (3) reduce or control the total cost of health care in order to contain
5 costs consistent with appropriate measures of economic growth and the state's
6 capacity to fund the system; and
- 7 (4) in carrying out the planning duties in this subsection, to the extent
8 feasible:
- 9 (A) improve health care delivery and health outcomes, including by
10 promoting integrated care, care coordination, prevention and wellness, and
11 quality and efficiency improvement;
- 12 (B) protect and improve individuals' access to necessary and
13 evidence-based health care;
- 14 (C) target reductions in costs to sources of excess cost growth;
- 15 (D) consider the effects on individuals of any changes in payments to
16 health care professionals and suppliers;
- 17 (E) consider the effects of payment reform on health care
18 professionals; and
- 19 (F) consider the unique needs of individuals who are eligible for both
20 Medicare and Medicaid.

1 (b) Beginning on October 1, 2011, the board shall have the following
2 duties:

3 (1) review and recommend statutory modifications to the following
4 regulatory duties of the department of banking, insurance, securities, and
5 health care administration: the hospital budget review process provided in
6 chapter 221, subchapter 7 of this title and the certificate of need process
7 provided in chapter 221, subchapter 5 of this title.

8 (2) develop and approve the payment reform pilot projects set forth in
9 section 9376 of this title to manage total health care costs, improve health care
10 outcomes, and provide a positive health care experience for patients and health
11 care professionals.

12 (3) develop methodologies for health care professional cost-containment
13 targets, global budgets, and uniform payment methods and amounts pursuant
14 to section 9375 of this title.

15 (4) review and approve recommendations from the commissioner of
16 banking, insurance, securities, and health care administration on any insurance
17 rate increases pursuant to 8 V.S.A. chapter 107, taking into consideration
18 changes in health care delivery, changes in payment methods and amounts, and
19 other issues at the discretion of the board.

20 (c) Beginning on July 1, 2013, the board shall have the following duties in
21 addition to the duties described in subsection (b) of this section:

1 (1) establish cost-containment targets and global budgets for each sector
2 of the health care system.

3 (2) review and approve global payments or capitated payments to
4 accountable care organizations, health care professionals, or other provider
5 arrangements.

6 (3) review and approve of any fee-for-service payment amounts
7 provided outside of the global payment or capitated payment.

8 (4) negotiate with health care professionals pursuant to section 9475 of
9 this title.

10 (5) provide information and recommendations to the deputy
11 commissioner of the department of Vermont health access for the Vermont
12 health benefit exchange established in chapter 18, subchapter 1 of Title 33
13 necessary to contract with health insurers to provide qualified health benefit
14 plans in the Vermont health benefit exchange.

15 (6) review and approve, with recommendations from the deputy
16 commissioner for the Vermont health benefit exchange, the benefit package for
17 qualified health benefit plans pursuant to chapter 18, subchapter 1 of Title 33.

18 (7) evaluate system-wide performance, including by identifying the
19 appropriate outcome measures:

20 (A) for utilization of health services;

1 (B) in consultation with the department of health, for quality of
2 health services and the effectiveness of prevention and health promotion
3 programs;

4 (C) for cost-containment and limiting the growth in health care
5 expenditures; and

6 (D) for other measures as determined by the board.

7 (d) Upon implementation of Green Mountain Care, the board shall have the
8 following duties in addition to the duties described in subsections (b) and (c) of
9 this section:

10 (1) review and approve, upon recommendation from the agency of
11 human services, the initial Green Mountain Care benefit package within the
12 parameters established in chapter 18, subchapter 2 of Title 33.

13 (2) review and approve the Green Mountain Care budget, including any
14 modifications to the benefit package.

15 (3) recommend appropriation estimates for Green Mountain Care
16 pursuant to 32 V.S.A. chapter 5.

17 § 9375. PAYMENT AMOUNTS; METHODS

18 (a) It is the intent of the general assembly to ensure reasonable payments to
19 health care professionals and to eliminate the shift of costs between the payers
20 of health services by ensuring that the amount paid to health care professionals
21 is sufficient and distributed equitably.

1 (b) The board shall negotiate payment amounts with health care
2 professionals, manufacturers of prescribed products, medical supply
3 companies, and other companies providing health services or health supplies in
4 order to have a consistent reimbursement amount accepted by these persons.

5 (c) The board shall establish payment methodologies for health services,
6 including using innovative payment methodologies consistent with any
7 payment reform pilot projects and with evidence-based practices. The
8 payment methods shall encourage cost containment; provision of high-quality,
9 evidence-based health services in an integrated setting; patient
10 self-management; and healthy lifestyles.

11 § 9376. PAYMENT REFORM; PILOTS

12 (a)(1) The board shall be responsible for developing pilot projects to test
13 payment reform methodologies as provided in this section. The director of
14 payment reform shall oversee the development, implementation, and
15 evaluation of the payment reform pilot projects. Whenever health insurers are
16 involved, the director shall collaborate with the commissioner of banking,
17 insurance, securities, and health care administration. The terms used in this
18 section shall have the same meanings as in chapter 13 of this title.

19 (2) The director of payment reform in the department of Vermont health
20 access shall convene a broad-based group of stakeholders, including health
21 care professionals who provide health services, health insurers, professional

1 organizations, community and nonprofit groups, consumers, businesses, school
2 districts, and state and local governments to advise the director in developing
3 and implementing the pilot projects.

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

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

11 (B) health care professionals should coordinate patient care through a
12 local entity or organization facilitating this coordination or another structure
13 which results in the coordination of patient care;

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

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

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

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

10 (B) with input from long-term care providers, whether to include
11 home health services and long-term care services as part of capitated
12 payments.

13 (b) Health insurer participation.

14 (1)(A) Health insurers shall participate in the development of the
15 payment reform strategic plan for the pilot projects and in the implementation
16 of the pilot projects, including by providing incentives or fees, as required in
17 this section. This requirement may be enforced by the department of banking,
18 insurance, securities, and health care administration to the same extent as the
19 requirement to participate in the Blueprint for Health pursuant to 8 V.S.A.
20 § 4088h.

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

10 (C) After the pilot projects are implemented, health insurers shall
11 have the same appeal rights as provided in section 706 of this title for
12 participation in the Blueprint for Health.

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

18 (c) To the extent required to avoid federal antitrust violations, the board
19 shall facilitate and supervise the participation of health care professionals,
20 health care facilities, and insurers in the planning and implementation of the
21 payment reform pilot projects, including by creating a shared incentive pool if

1 appropriate. The department shall ensure that the process and implementation
2 include sufficient state supervision over these entities to comply with federal
3 antitrust provisions.

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

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

9 § 9377. AGENCY COOPERATION

10 The secretary of administration shall ensure that the Vermont health reform
11 board has access to data and analysis held by any executive branch agency
12 which is necessary to carry out the board's duties as described in this chapter.

13 § 9378. RULES

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

* * * Public-Private Single-Payer System * * *

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

CHAPTER 18. PUBLIC-PRIVATE SINGLE-PAYER SYSTEM

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

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

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

(1) “Affordable Care Act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health

1 Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as
2 further amended.

3 (2) “Deputy commissioner” means the deputy commissioner of the
4 department of Vermont health access for the Vermont health benefit exchange.

5 (3) “Health benefit plan” means a policy, contract, certificate, or
6 agreement offered or issued by a health insurer to provide, deliver, arrange for,
7 pay for, or reimburse any of the costs of health services. This term does not
8 include coverage only for accident or disability income insurance, liability
9 insurance, coverage issued as a supplement to liability insurance, workers’
10 compensation or similar insurance, automobile medical payment insurance,
11 credit-only insurance, coverage for on-site medical clinics, or other similar
12 insurance coverage where benefits for health services are secondary or
13 incidental to other insurance benefits as provided under the Affordable Care
14 Act. The term also does not include stand-alone dental or vision benefits;
15 long-term care insurance; specific disease or other limited benefit coverage,
16 Medicare supplemental health benefits, Medicare Advantage plans, and other
17 similar benefits excluded under the Affordable Care Act.

18 (4) “Health insurer” shall have the same meaning as in 18 V.S.A.
19 § 9402.

20 (5) “Qualified employer” means:

1 (A) an entity which employed an average of not more than 100
2 employees during the preceding calendar year and which:

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

6 (ii) elects to provide coverage through the Vermont health benefit
7 exchange for all of its eligible employees who are principally employed in this
8 state.

9 (B) After January 1, 2017, the term “qualified employer” shall
10 include employers who meet these requirements regardless of size.

11 (6) “Qualified health benefit plan” means a health benefit plan which
12 meets the requirements set forth in section 1806 of this title.

13 (7) “Qualified individual” means an individual, including a minor, who
14 is a Vermont resident and, at the time of enrollment:

15 (A) is not incarcerated, or is only incarcerated awaiting disposition of
16 charges; and

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

1 § 1803. VERMONT HEALTH BENEFIT EXCHANGE

2 (a)(1) The department of Vermont health access shall establish the
3 Vermont health benefit exchange, which shall be administered by the
4 department in consultation with the advisory board established in section 402
5 of this title.

6 (2) The Vermont health benefit exchange shall be considered a division
7 within the department of Vermont health access and shall be headed by a
8 deputy commissioner as provided in chapter 53 of Title 3.

9 (b)(1)(A) The Vermont health benefit exchange shall provide qualified
10 individuals and qualified employers with qualified health plans with effective
11 dates beginning on or before January 1, 2014. The Vermont health benefit
12 exchange may contract with qualified entities or enter into intergovernmental
13 agreements to facilitate the functions provided by the Vermont health benefit
14 exchange.

15 (B) Prior to contracting with a health insurer, the Vermont health
16 benefit exchange shall consider the insurer's historic rate increase information
17 required under section 1806 of this title, along with the information and the
18 recommendations provided to the Vermont health benefit exchange by the
19 commissioner of banking, insurance, securities, and health care administration
20 under section 2794(b)(1)(B) of the federal Public Health Service Act.

1 (2) To the extent allowable under federal law, the Vermont health
2 benefit exchange may offer health benefits to populations in addition to those
3 eligible under Subtitle D of Title I of the Affordable Care Act, including:
4 (A) comprehensive health benefits to individuals and employers who
5 are not qualified individual or qualified employers as defined by this
6 subchapter and by the Affordable Care Act;
7 (B) Medicaid benefits to individuals who are eligible, upon approval
8 by the Centers for Medicare and Medicaid Services and provided that
9 including these individuals in the health benefit exchange would not reduce
10 their Medicaid benefits;
11 (C) Medicare benefits to individuals who are eligible, upon approval
12 by the Centers for Medicare and Medicaid Services and provided that
13 including these individuals in the health benefit exchange would not reduce
14 their Medicare benefits; and
15 (D) state employees and municipal employees.
16 (3) To the extent allowable under federal law, the Vermont health
17 benefit exchange may offer health benefits to employees for injuries arising out
18 of or in the course of employment in lieu of medical benefits provided pursuant
19 to chapter 9 of Title 21 (workers' compensation).
20 (c) If the Vermont health benefit exchange is required by the secretary of
21 the U.S. Department of Health and Human Services to contract with more than

1 one health insurer, the Vermont health benefit exchange shall determine the
2 appropriate method to provide a unified, simplified claims administration,
3 benefit management, and billing system for any health insurer offering a
4 qualified health benefit plan. The Vermont health benefit exchange may offer
5 this service to other health insurers, workers' compensation insurers,
6 employers, or other entities in order to simplify administrative requirements for
7 health benefits.

8 (d) The Vermont health benefit exchange may enter into
9 information-sharing agreements with federal and state agencies and other state
10 exchanges to carry out its responsibilities under this subchapter provided such
11 agreements include adequate protections with respect to the confidentiality of
12 the information to be shared and provided such agreements comply with all
13 applicable state and federal laws and regulations.

14 § 1804. QUALIFIED EMPLOYERS

15 (a) A qualified employer shall be an employer who, on at least 50 percent
16 of its working days during the preceding calendar quarter, employed at least
17 one and no more than 100 employees, and the term "qualified employer"
18 includes self-employed persons. Calculation of the number of employees of a
19 qualified employer shall not include a part-time employee who works less than
20 30 hours per week.

1 (b) An employer with 100 or fewer employees that offers a qualified health
2 benefit plan to its employees through the Vermont health benefit exchange
3 may continue to participate in the exchange even if the employer's size grows
4 beyond 100 employees as long as the employer continuously makes qualified
5 health benefit plans in the Vermont health benefit exchange available to its
6 employees.

7 § 1805. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

3 (2) Determining eligibility for and enrolling individuals in Medicaid,
4 Dr. Dynasaur, VPharm, and VermontRx pursuant to chapter 19 of this title.

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

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

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

17 (6) Determining enrollee premiums and subsidies as required by the
18 secretary of the U.S. Treasury or of the U.S. Department of Health and Human
19 Services and informing consumers of eligibility for premiums and subsidies,
20 including by providing an electronic calculator to determine the actual cost of
21 coverage after application of any premium tax credit under section 36B of the

1 Internal Revenue Code of 1986 and any cost-sharing reduction under section
2 1402 of the Affordable Care Act.

3 (7) Transferring to the federal secretary of the Treasury the name and
4 taxpayer identification number of each individual who was an employee of an
5 employer but who was determined to be eligible for the premium tax credit
6 under section 36B of the Internal Revenue Code of 1986 for the following
7 reasons:

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

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

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

17 (A) Granting a certification attesting that an individual is exempt
18 from the individual responsibility requirement or from the penalty for violating
19 that requirement, if there is no affordable qualified health plan available
20 through the Vermont health benefit exchange or the individual's employer for
21 that individual or if the individual meets the requirements for any exemption

1 from the individual responsibility requirement or from the penalty pursuant to
2 section 5000A of the Internal Revenue Code of 1986; and

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

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

12 (B) Communicating to each employer the name of each of its
13 employees and the effective date of the cessation reported to the Treasury
14 under this subdivision.

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

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

19 (12) Crediting the amount of any free choice voucher to the monthly
20 premium of the plan in which a qualified employee is enrolled and collecting
21 the amount credited from the offering employer.

1 (13) Providing consumers with satisfaction surveys and other
2 mechanisms for evaluating and informing the deputy commissioner and the
3 commissioner of banking, insurance, securities, and health care administration
4 of the performance of qualified health benefit plans.

5 (14) Ensuring consumers have easy and simple access to the relevant
6 grievance and appeals processes pursuant to 8 V.S.A. chapter 107 and 3 V.S.A.
7 § 3090 (human services board).

8 (15) Consulting with the advisory board established in section 402 of
9 this title to obtain information and advice as necessary to fulfill the duties
10 outlined in this subchapter.

11 § 1806. QUALIFIED HEALTH BENEFIT PLANS

12 (a) Prior to contracting with a qualified health benefit plan, the deputy
13 commissioner shall determine that making the plan available through the
14 Vermont health benefit exchange is in the best interest of individuals and
15 qualified employers in this state.

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

17 (1)(A) The essential benefits package required by section 1302(a) of the
18 Affordable Care Act and any additional benefits required by the deputy
19 commissioner by rule after consultation with the advisory board established in
20 section 402 of this title and after approval from the Vermont health reform
21 board established in chapter 220 of Title 18.

1 (B) Notwithstanding subdivision (1)(A) of this subsection, a health
2 insurer may offer a plan that provides more limited dental benefits if such plan
3 meets the requirements of section 9832(c)(2)(A) of the Internal Revenue Code
4 and provides pediatric dental benefits meeting the requirements of section
5 1302(b)(1)(J) of the Affordable Care Act either separately or in conjunction
6 with a qualified health plan.

7 (2) At least the silver level of coverage as defined by section 1302 of the
8 Affordable Care Act and the cost-sharing limitations for individuals provided
9 in section 1302 of the Affordable Care Act, as well as any more restrictive
10 requirements specified by the deputy commissioner by rule after consultation
11 with the advisory board established in section 402 of this title and after
12 approval from the Vermont health reform board established in chapter 220 of
13 Title 18.

14 (3) For qualified health benefit plans offered to employers, a deductible
15 which meets the limitations provided in section 1302 of the Affordable Care
16 Act and any more restrictive requirements required by the deputy
17 commissioner by rule after consultation with the advisory board and after
18 approval from the Vermont health reform board established in chapter 220 of
19 Title 18.

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

1 (1) standards for marketing practices, network adequacy, essential
2 community providers in underserved areas, accreditation, quality
3 improvement, and information on quality measures for health benefit plan
4 performance as provided in section 1311 of the Affordable Care Act and more
5 restrictive requirements provided by 8 V.S.A. chapter 107;

6 (2) quality and wellness standards as specified in rule by the deputy
7 commissioner, after consultation with the commissioners of health and of
8 banking, insurance, securities, and health care administration and with the
9 advisory board established in section 402 of this title; and

10 (3) standards for participation in the Blueprint for Health as provided in
11 18 V.S.A. chapter 13.

12 (d) A qualified health benefit plan shall provide uniform enrollment forms
13 and descriptions of coverage as determined by the deputy commissioner and
14 the commissioner of banking, insurance, securities, and health care
15 administration.

16 (e)(1) A qualified health benefit plan shall comply with the following
17 insurance and consumer information requirements:

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

20 (ii) Submit to the commissioner of banking, insurance, securities,
21 and health care administration a justification for any premium increase before

1 implementation of that increase and prominently post this information on the
2 health insurer's website.

3 (B) Offer at least one qualified health plan at the silver level and at
4 least one qualified health plan at the gold level, as defined in section 1302 of
5 the Affordable Care Act.

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

10 (D) Provide accurate and timely disclosure of information to the
11 public and to the Vermont health benefit exchange relating to claims denials,
12 enrollment data, rating practices, out-of-network coverage, enrollee and
13 participant rights provided by Title I of the Affordable Care Act, and other
14 information as required by the deputy commissioner or by the commissioner of
15 banking, insurance, securities, and health care administration.

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

19 (2) A qualified health benefit plan shall comply with all other insurance
20 requirements for health insurers as provided in 8 V.S.A. chapter 107, including

1 licensure or solvency requirements, and as specified by the commissioner of
2 banking, insurance, securities, and health care administration.

3 (f) The Vermont health benefit exchange shall not exclude a health benefit
4 plan:

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

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

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

11 § 1807. NAVIGATORS

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

18 (b) Navigators shall have the following duties:

19 (1) Conduct public education activities to raise awareness of the
20 availability of qualified health plans;

1 (2) Distribute fair and impartial information concerning enrollment in
2 qualified health plans and concerning the availability of premium tax credits
3 and cost sharing reductions;

4 (3) Facilitate enrollment in qualified health plans, Medicaid,
5 Dr. Dynasaur, VPharm, and VermontRx;

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

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

13 (6) Distribute information to health care professionals, community
14 organizations, and others to facilitate the enrollment of individuals who are
15 eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRx, or the Vermont
16 health benefit exchange in order to ensure that all eligible individuals are
17 enrolled.

18 § 1808. FINANCIAL INTEGRITY

19 (a) The Vermont health benefit exchange shall:

20 (1) Keep an accurate accounting of all activities, receipts, and
21 expenditures and submit this information annually as required by federal law.

1 (2) Cooperate with the secretary of the U.S. Department of Health and
2 Human Services or the inspector general of the U.S. Department of Health and
3 Human Services in any investigation into the affairs of the Vermont health
4 benefit exchange, examination of the properties and records of the Vermont
5 health benefit exchange, or requirement for periodic reports in relation to the
6 activities undertaken by the Vermont health benefit exchange.

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

12 § 1809. PUBLICATION OF COSTS

13 The Vermont health benefit exchange shall publish the average costs of
14 licensing, regulatory fees, and any other payments required by the exchange
15 and shall publish the administrative costs of the exchange on a website
16 intended to educate consumers about such costs. This information shall
17 include information on monies lost to waste, fraud, and abuse.

18 § 1810. RULES

19 The secretary of human services may adopt rules pursuant to chapter 25 of
20 Title 3 as needed to carry out the duties and functions established in this
21 subchapter.

Subchapter 2. Green Mountain Care

§ 1821. PURPOSE

The purpose of Green Mountain Care is to provide comprehensive, affordable, high-quality health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health insurance. Green Mountain Care shall contain costs: by providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits; by innovative payment mechanisms to health care professionals, such as global payments; and by encouraging the management of health services through the Blueprint for Health.

§ 1822. DEFINITIONS

For purposes of this subchapter:

(1) "Agency" means the agency of human services.

(2) "CHIP funds" means federal funds available under Title XXI of the Social Security Act.

(3) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last one year or more and that requires ongoing clinical management, health services that attempt to restore the individual to highest function and that minimize the negative effects of the condition and prevent complications related to chronic

1 conditions. Examples of chronic conditions include diabetes, hypertension,
2 cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse,
3 mental illness, spinal cord injury, and hyperlipidemia.

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

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

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

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

19 (8) "Primary care" means health services provided by health care
20 professionals specifically trained for and skilled in first-contact and continuing
21 care for individuals with signs, symptoms, or health concerns, not limited by

1 problem origin, organ system, or diagnosis, and shall include prenatal care and
2 mental health and substance abuse treatment.

3 (9) "Secretary" means the secretary of human services.

4 (10) "Smart card" means a card to authenticate patient identity which,
5 consistent with the privacy and security standards provided in the state's health
6 information technology plan established under 18 V.S.A. chapter 219, enables
7 a health care professional or provider to access patients' health records and
8 facilitates payment for health services.

9 (11) "Vermont resident" means an individual domiciled in Vermont as
10 evidenced by an intent to maintain a principal dwelling place in Vermont
11 indefinitely and to return to Vermont if temporarily absent, coupled with an act
12 or acts consistent with that intent.

13 § 1823. ELIGIBILITY

14 (a) Upon implementation, all Vermont residents shall be eligible for Green
15 Mountain Care. The agency shall establish standards for the verification of
16 residency.

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

1 (c) The agency shall establish a procedure to enroll residents and shall
2 provide each with a smart card that may be used by health care professionals
3 for payment.

4 (d)(1) The agency shall establish by rule a process to allow health care
5 professionals to presume an individual is eligible based on the information
6 provided on a simplified application.

7 (2) After submission of the application, the agency shall collect
8 additional information as necessary to determine whether Medicaid or CHIP
9 funds may be applied toward the cost of the health services provided, but shall
10 provide payment for any health services received by the individual from the
11 time the application is submitted.

12 (e) Vermont residents who are temporarily out of the state on a short-term
13 basis and who intend to return and reside in Vermont shall remain eligible for
14 Green Mountain Care while outside Vermont.

15 (f) A nonresident visiting Vermont, or his or her insurer, shall be billed for
16 all services received. The agency may enter into intergovernmental
17 arrangements or contracts with other states and countries to provide reciprocal
18 coverage for temporary visitors.

19 (g) An employer with an existing retiree benefit program may elect to
20 provide retiree benefits through Green Mountain Care. However, if an
21 employer does not elect to provide retiree benefits through Green Mountain

1 Care, Green Mountain Care shall be the secondary payer to the retiree's health
2 benefit plan.

3 (h) Green Mountain Care shall maintain a robust and adequate network of
4 health care professionals, including mental health professionals.

5 § 1824. HEALTH BENEFITS

6 (a)(1) Green Mountain Care shall provide coverage at least as
7 comprehensive as the essential benefit package provided for the Vermont
8 health benefit exchange established in subchapter 1 of this chapter, which shall
9 include primary care, preventive care, chronic care, acute episodic care, and
10 hospital services. The Vermont health reform board established in 18 V.S.A.
11 chapter 220 shall approve the scope of the benefit package as part of its review
12 of the Green Mountain Care budget.

13 (2) If funds allow, Green Mountain Care shall provide a basic dental and
14 vision benefit modeled on common benefits offered in stand-alone dental and
15 vision plans available in this state.

16 (b) Green Mountain Care shall include cost-sharing and out-of-pocket
17 limitations as determined by the Vermont health reform board, after
18 recommendations from the agency, as part of its review of the Green Mountain
19 Care budget. There shall be a waiver of the cost-sharing requirement for
20 chronic care for individuals participating in chronic care management and for
21 primary and preventive care.

1 (c)(1) For individuals eligible for Medicaid, the benefit package shall
2 include the scope of benefits provided to these individuals on January 1, 2014,
3 except that, consistent with federal law, the Vermont health reform board may
4 modify benefits to these individuals; provided that individuals whose benefits
5 are paid for with Medicaid or CHIP funds shall receive, at a minimum, the
6 Green Mountain Care benefit package.

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

10 (3) For individuals eligible for Medicare, the benefit package shall
11 include, at a minimum, the scope of benefits provided to these individuals on
12 January 1, 2014.

13 § 1825. BLUEPRINT FOR HEALTH

14 (a) All individuals enrolled in Green Mountain Care shall have a primary
15 health care professional who is involved with the Blueprint for Health
16 established in 18 V.S.A. chapter 13, which includes patient-centered medical
17 homes and multi-disciplinary community health teams to support
18 well-coordinated health services. The agency shall determine a method to
19 approve a specialist as a patient's primary health care professional for the
20 purposes of establishing a medical home for the patient.

1 (b) The Blueprint for Health established in 18 V.S.A. chapter 13 shall be
2 integrated with Green Mountain Care.

3 § 1826. ADMINISTRATION; ENROLLMENT

4 (a) The agency may, under an open bidding process, solicit and receive
5 bids from insurance carriers or third-party administrators for administration of
6 certain elements of Green Mountain Care.

7 (b)(1) Nothing in this subchapter shall require an individual covered by
8 health insurance to terminate that insurance.

9 (2) Notwithstanding the provisions of subdivision (1) of this subsection,
10 after implementation of Green Mountain Care, private insurance companies
11 shall be prohibited from selling health insurance policies in Vermont that cover
12 services also covered by Green Mountain Care.

13 (c) An individual may elect to maintain supplemental health insurance if
14 the individual so chooses, provided that after implementation of Green
15 Mountain Care, the supplemental insurance shall cover only services that are
16 not also covered by Green Mountain Care.

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

19 (e) The agency shall seek permission from the Centers for Medicare and
20 Medicaid Services to be the administrator for the Medicare program in
21 Vermont. If the agency is unsuccessful in obtaining such permission, Green

1 Mountain Care shall be the secondary payer with respect to any health service
2 that may be covered in whole or in part by Title XVIII of the Social Security
3 Act (Medicare).

4 (f) Green Mountain Care shall be the secondary payer with respect to any
5 health service that may be covered in whole or in part by any other health
6 benefit plan funded solely with federal funds, such as federal health benefit
7 plans offered by the Veterans' Administration, by the military, or to federal
8 employees.

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

16 (h) Any prescription drug coverage offered by Green Mountain Care shall
17 be consistent with the standards and procedures applicable to the pharmacy
18 best practices and cost control program established in sections 1996 and 1998
19 of this title and the state drug formulary established in chapter 91, subchapter 4
20 of Title 18.

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

5 (j) An individual aggrieved by an adverse decision of the agency or plan
6 administrator may appeal to the human services board as provided in 3 V.S.A.
7 § 3090.

8 § 1827. BUDGET PROPOSAL; COST-CONTAINMENT

9 For each state fiscal year, the agency shall develop a budget for Green
10 Mountain Care based on the payment methodologies, payment amounts, and
11 cost-containment targets established by the Vermont health reform board. The
12 agency shall propose its budget for Green Mountain Care to the Vermont
13 health reform board at such time as required by the board for its consideration.

14 § 1828. GREEN MOUNTAIN CARE FUND

15 (a) The Green Mountain Care fund is established in the state treasury as a
16 special fund to be the single source to finance health care coverage for all
17 Vermonters.

18 (b) Into the fund shall be deposited:

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

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

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

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

10 (d) All monies received by or generated to the fund shall be used only for
11 the administration and delivery of health services covered by Green Mountain
12 Care as provided in this subchapter.

13 § 1829. IMPLEMENTATION

14 Green Mountain Care shall be implemented upon receipt of a waiver
15 pursuant to Section 1332 of the Affordable Care Act. As soon as available
16 under federal law, the secretary of administration shall seek a waiver to allow
17 the state to suspend operation of the Vermont health benefit exchange and to
18 enable Vermont to receive the appropriate federal fund contribution in lieu of
19 the federal premium tax credits, cost-sharing subsidies, and small business tax
20 credits provided in the Affordable Care Act. The secretary may seek a waiver

1 from other provisions of the Affordable Care Act as necessary to ensure the
2 operation of Green Mountain Care.

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

4 § 401. COMPOSITION OF DEPARTMENT

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

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

11 UNIT

12 Effective October 1, 2011, the secretary of administration shall transfer to
13 and place under the supervision of the commissioner of Vermont health access
14 all employees, professional and support staff, consultants, positions, and all
15 balances of all appropriation amounts for personal services and operating
16 expenses for the administration of health care eligibility currently contained in
17 the department for children and families.

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

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

3 § 402. CONSUMER AND HEALTH CARE PROFESSIONAL ADVISORY
4 BOARD

5 (a)(1) A consumer and health care professional advisory board is created
6 for the purpose of advising the commissioner of Vermont health access with
7 respect to policy development and program administration for the Vermont
8 health benefit exchange, Medicaid, the Vermont health access plan, VPharm,
9 and VermontRx.

10 (2) The board shall have an opportunity to review and comment upon
11 agency policy initiatives pertaining to quality improvement initiatives and to
12 health care benefits and eligibility for individuals receiving services through
13 Medicaid, programs funded with Medicaid funds under a Section 1115 waiver,
14 or the Vermont health benefit exchange. It also shall have the opportunity to
15 comment on proposed rules prior to commencement of the rulemaking process
16 pursuant to chapter 25 of Title 3 and on waiver or waiver amendment
17 applications prior to submission to the Centers for Medicare and Medicaid
18 Services.

19 (3) Prior to the annual budget development process, the department of
20 Vermont health access shall engage the advisory committee in setting

1 priorities, including consideration of scope of benefits, beneficiary eligibility,
2 funding outlook, financing options, and possible budget recommendations.

3 (b) The advisory committee shall make policy recommendations on
4 proposals of the department of Vermont health access to the department, the
5 health access oversight committee, the senate committee on health and welfare,
6 and the house committees on health care and on human services. When the
7 general assembly is not in session, the commissioner shall respond in writing
8 to these recommendations, a copy of which shall be provided to each of the
9 legislative committees of jurisdiction.

10 (c) During the legislative session, the commissioner shall provide the
11 committee at regularly scheduled meetings with updates on the status of policy
12 and budget proposals.

13 (d) The commissioner shall convene the advisory committee at least six
14 times during each calendar year.

15 (e)(1) At least one-third of the members of the advisory committee shall be
16 recipients of Medicaid, VHAP, VPharm, VermontRx, or enrollees in the
17 Vermont health benefit exchange. Such members shall receive per diem
18 compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010,
19 including costs of travel, child care, personal assistance services, and any other
20 service necessary for participation on the committee and approved by the
21 commissioner.

1 (2) The commissioner shall ensure broad representation from health care
2 professionals.

3 (f) The commissioner shall appoint members of the advisory committee,
4 who shall serve staggered three-year terms. The commissioner may remove
5 members of the committee who fail to attend three consecutive meetings and
6 may appoint replacements.

7 * * * Planning Initiatives * * *

8 Sec. 8. INTEGRATION PLAN

9 No later than January 15, 2012, the secretary of administration or designee
10 shall make recommendations to the house committee on health care and the
11 senate committee on health and welfare on the following issues:

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

16 (A) Whether it is necessary to establish a basic health program for
17 individuals with incomes above 133 percent of the federal poverty level (FPL)
18 and at or below 200 percent of FPL pursuant to Section 1331 of the Patient
19 Protection and Affordable Care Act (Public Law 111-148), as amended by the
20 federal Health Care and Education Reconciliation Act of 2010 (Public Law

1 11-152), and as further amended (“Affordable Care Act”), to ensure that the
2 health coverage is affordable for this population.

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

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

19 (2) Once Green Mountain Care is implemented, whether to allow
20 employers and individuals to purchase coverage for supplemental health

1 services from Green Mountain Care or to allow private insurers to provide
2 supplemental insurance plans.

3 Sec. 9. FINANCING PLANS

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

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

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

1 (b) In developing both financing plans, the secretary shall consider the
2 following:
3 (1) financing sources, including adjustments to the income tax, a payroll
4 tax, consumption taxes, provider assessments required under 33 V.S.A. chapter
5 19, the employer assessment required by 21 V.S.A. chapter 25, other new or
6 existing taxes, and additional options as determined by the secretary;
7 (2) the impacts of the various financing sources, including levels of
8 deductibility of any tax or assessment system contemplated;
9 (3) issues involving federal law and taxation;
10 (4) impacts of tax system changes:
11 (A) on individuals, households, businesses, public sector entities, and
12 the nonprofit community;
13 (B) over time, on changing revenue needs; and
14 (C) for the transitional period, while the tax system and health care
15 cost structure are changing, strategies may be needed to avoid double
16 payments, such as premiums and tax obligations;
17 (5) growth in health care spending relative to needs and capacity to pay;
18 (6) the costs of maintaining existing state insurance mandates and other
19 appropriate considerations in order to determine the state contribution required
20 under the Affordable Care Act;

1 (7) additional funds needed to support recruitment and retention
2 programs for primary care health professionals in order to address the primary
3 care shortage;

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

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

9 Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

10 (a) The secretary of administration or designee, in consultation with the
11 Vermont health reform board and the commissioner of Vermont health access,
12 shall review the health information technology plan required by 18 V.S.A.
13 § 9351 to ensure that the plan reflects the creation of the Vermont health
14 benefit exchange; the transition to a public-private single payer health system
15 pursuant to 33 V.S.A. chapter 18, subchapter 2; and any necessary
16 development or modifications to public health information technology and data
17 and to public health surveillance systems, to ensure that there is progress
18 toward full implementation.

19 (b) In conducting this review, the secretary of administration may issue a
20 request for proposals for an independent design and implementation plan
21 which would describe how to integrate existing health information systems to

1 carry out the purposes of this act, detail how to develop the necessary capacity
2 in health information systems, determine the funding needed for such
3 development, and quantify the existing funding sources available for such
4 development. The health information technology plan or design and
5 implementation plan shall also include:

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

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

12 (3) other systems analysis as specified by the secretary.

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

16 Sec. 11. HEALTH SYSTEM PLANNING, REGULATION, AND PUBLIC

17 HEALTH

18 No later than January 15, 2012, the secretary of administration or designee
19 shall make recommendations to the house committee on health care and the
20 senate committee on health and welfare on how to unify Vermont's current
21 efforts around health system planning, regulation, and public health, including:

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

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

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

11 (B) recommending whether to institute a public health audit process
12 to ensure appropriate consideration of the impacts on public health resulting
13 from major policy or planning decisions made by municipalities, local entities,
14 and state agencies.

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

20 (4) Provide a progress report on payment reform planning and other
21 activities authorized in 18 V.S.A. chapter 220.

1 Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

2 No later than January 15, 2012, the Vermont health reform board
3 established in chapter 220 of Title 18, in consultation with the commissioner of
4 banking, insurance, securities, and health care administration and the
5 commissioner of Vermont health access, shall recommend to the house
6 committee on health care and the senate committee on health and welfare any
7 necessary modifications to the regulatory processes for health care
8 professionals and managed care organizations in order to align these processes
9 with the payment reform strategic plan.

10 Sec. 13. WORKFORCE ISSUES

11 (a)(1) Currently, Vermont has a shortage of primary care professionals, and
12 many practices are closed to new patients. In order to ensure sufficient patient
13 access now and in the future, it is necessary to plan for the implementation of
14 Green Mountain Care and utilize Vermont's health care professionals to the
15 fullest extent of their professional competence.

16 (2) The board of nursing, the board of medical practice, and the office of
17 professional regulation shall collaborate to determine how to optimize the
18 primary care workforce by reviewing the licensure process, scope of practice
19 requirements, reciprocity of licensure, and efficiency of the licensing process,
20 and by identifying any other barriers to augmenting Vermont's primary care
21 workforce. No later than January 15, 2012, the boards and office shall provide

1 to the house committee on health care and the senate committee on health and
2 welfare joint recommendations for improving the primary care workforce
3 through the boards' and office's rules and procedures.

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

16 Sec. 14. MEDICAL MALPRACTICE STUDY

17 (a) The secretary of administration or designee shall study

18 (1) the feasibility of creating a no-fault medical malpractice system in
19 Vermont;

20 (2) medical malpractice insurance reform in other states;

1 (3) opportunities for captive insurance to expand into the area of
2 malpractice; and

3 (4) the impacts in Vermont and other states of the SorryWorks program.

4 (b) The secretary shall also consider the impacts of the medical malpractice
5 reforms reviewed in subdivisions (a)(1) through (4) of this section on health
6 care professionals and on patients, including the impacts on patient safety and
7 the costs associated with preventable medical errors, on health care
8 professionals who may currently practice defensive medicine and any savings
9 attributable to a decline in this practice, on the availability of compensation for
10 patients, on medical malpractice insurance availability and premium rates, and
11 such other issues as the secretary deems appropriate.

12 (c) The secretary shall report his or her findings to the house committees on
13 health care and on judiciary and the senate committees on health and welfare
14 and on judiciary no later than January 15, 2012.

15 * * * Rate Review * * *

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

17 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

18 No policy of health insurance or certificate under a policy not exempted by
19 subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in
20 this state nor shall any endorsement, rider, or application which becomes a part
21 of any such policy be used, until a copy of the form, premium rates, and rules

1 for the classification of risks pertaining thereto have been filed with the
2 commissioner of banking, insurance, securities, and health care administration;
3 nor shall any such form, premium rate, or rule be so used until the expiration of
4 ~~30~~ 60 days after having been filed, or in the case of a request for a rate
5 increase, until a decision by the Vermont health reform board as provided
6 herein, unless the commissioner shall sooner give his or her written approval
7 thereto. The commissioner shall review policies and rates to determine
8 whether a policy or rate is affordable, promotes quality care, and promotes
9 access to health care. Prior to approving a rate, the commissioner shall seek
10 approval for any rate increase from the Vermont health reform board
11 established in 18 V.S.A. chapter 220, which shall approve or disapprove the
12 rate increase within 10 business days. The commissioner shall notify in
13 writing the insurer which has filed any such form, premium rate, or rule if it
14 contains any provision which is unjust, unfair, inequitable, misleading, or
15 contrary to the law of this state or if it does not meet the standards expressed in
16 this section. In such notice, the commissioner shall state that a hearing will be
17 granted within 20 days upon written request of the insurer. ~~In all other cases,~~
18 ~~the commissioner shall give his or her approval.~~ After the expiration of such
19 ~~30 days from the filing of any such form, premium rate or rule,~~ the review
20 period provided herein or at any time after having given written approval, the
21 commissioner may, after a hearing of which at least 20 ~~days~~ days' written

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

6 * * * Employer Benefit Information * * *

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

8 § 2004. HEALTH BENEFIT COSTS

9 Employers shall provide their employees with an annual statement
10 indicating the total monthly premium cost paid for any employer-sponsored
11 health benefit plan and the employee's share of the cost. The department shall
12 develop a simple form for employers to use for this annual statement.

13 * * * Single Formulary * * *

14 Sec. 17. 18 V.S.A. chapter 91, subchapter 4 is added to read:

15 Subchapter 4. Statewide Prescription Drug Formulary

16 § 4635. STATEWIDE PREFERRED DRUG LIST

17 (a) The drug utilization review board established in connection with
18 Vermont's Medicaid program shall develop and maintain a preferred drug list
19 applicable to all health benefit plans covering Vermont lives.

20 (b)(1) The drug utilization review board's selection of drugs for inclusion
21 on the preferred drug list shall be based upon evidence-based considerations of

1 clinical efficacy, adverse side-effects, safety, appropriate clinical trials, and
2 cost-effectiveness. In this subchapter, "evidence-based" shall have the same
3 meaning as in section 4622 of this title. The commissioner of Vermont health
4 access shall provide the board with evidence-based information about clinical
5 efficacy, adverse side-effects, safety, and appropriate clinical trials, and shall
6 provide information about cost-effectiveness of available drugs in the same
7 therapeutic class. Health benefit plans covering Vermont lives may also
8 submit evidence-based information listed in this subdivision to the board for its
9 consideration.

10 (2) The board may identify different drugs within the same therapeutic
11 class as preferred for health insurance plans and for state public assistance
12 programs to reflect differences in available manufacturer rebates and
13 discounts.

14 (3) The board shall meet at least quarterly. The board shall comply with
15 the requirements of subchapter 2 of chapter 5 of Title 1 (open meetings) and
16 subchapter 3 of chapter 5 of Title 1 (open records), except that the board may
17 go into executive session to discuss drug alternatives and receive information
18 on the relative price, net of any rebates or discounts, of a drug under discussion
19 and the drug price in comparison to the prices, net of any rebates or discounts,
20 of alternative drugs available in the same class to determine cost-effectiveness,
21 and in order to comply with 33 V.S.A. § 2002(c) to consider information

1 relating to a pharmaceutical rebate, supplemental rebate, or Section 340b
2 discount, which is protected from disclosure by federal law or the terms and
3 conditions required by the Centers for Medicare and Medicaid Services or the
4 federal Health Resources and Service Administration as a condition of rebate
5 authorization under the Medicaid program.

6 (4) To the extent feasible, the board shall review all drug classes
7 included in the preferred drug list at least every 24 months, and may make
8 additions to or modifications of the preferred drug list.

9 (5) The program shall establish board procedures for the timely review
10 of prescription drugs newly approved by the federal Food and Drug
11 Administration, including procedures for the review of newly approved
12 prescription drugs in emergency circumstances.

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

15 (c) As used in this section:

16 (1) "Health benefit plan" means a health benefit plan with prescription
17 drug coverage offered or administered by a health insurer, as defined by
18 section 9402 of this title. The term includes:

19 (A) any state public assistance program with a health benefit plan
20 that provides coverage of prescription drugs;

1 (B) any health benefit plan offered by or on behalf of the state of
2 Vermont or any instrumentality of the state providing coverage for government
3 employees and their dependents; and

4 (C) any self-insured health benefit plan that agrees to participate in
5 the preferred drug list.

6 (2) "State public assistance program" includes the Medicaid program,
7 the Vermont health access plan, VPharm, VermontRx, the state children's
8 health insurance program, the state of Vermont AIDS medication assistance
9 program, the general assistance program, the pharmacy discount plan program,
10 and the out-of-state counterparts to such programs.

11 Sec. 18. 1 V.S.A. § 313(a)(9) is amended to read:

12 (9) Information relating to a pharmaceutical rebate or to supplemental
13 rebate agreements, which is protected from disclosure by federal law or the
14 terms and conditions required by the Centers for Medicare and Medicaid
15 Services as a condition of rebate authorization or discounts under the Medicaid
16 program, considered pursuant to ~~33 V.S.A. §§ 1998(f)(2)~~ 18 V.S.A.
17 § 4635(b)(3) and 2002(e) 33 V.S.A. § 2002(c).

18 Sec. 19. 8 V.S.A. § 4088e is amended to read:

19 § 4088e. NOTICE OF PREFERRED DRUG LIST CHANGES

20 On a periodic basis, no less than once per calendar year, a health insurer as
21 defined in ~~subdivisions~~ 18 V.S.A. § 9471(2)(A), (C), and (D) of Title 18 shall

1 notify beneficiaries of changes in pharmaceutical coverage and provide access
2 to the preferred drug list established and maintained by the insurer pursuant to
3 18 V.S.A. § 4635.

4 Sec. 20. 33 V.S.A. § 1998 is amended to read:

5 § 1998. PHARMACY BEST PRACTICES AND COST CONTROL

6 PROGRAM ESTABLISHED

7 (a) The commissioner of Vermont health access shall establish and
8 maintain a pharmacy best practices and cost control program designed to
9 reduce the cost of providing prescription drugs, while maintaining high quality
10 in prescription drug therapies. The program shall include:

11 ~~(1) Use of an evidence based preferred list of covered prescription drugs~~
12 ~~that identifies preferred choices within therapeutic classes for particular~~
13 ~~diseases and conditions, including generic alternatives and over the counter~~
14 ~~drugs.~~

15 ~~(2) Utilization review procedures, including a prior authorization review~~
16 ~~process.~~

17 ~~(3)(2) Any strategy designed to negotiate with pharmaceutical~~
18 ~~manufacturers to lower the cost of prescription drugs for program participants,~~
19 ~~including a supplemental purchasing agreement, discounts, and rebate program~~
20 ~~programs.~~

1 ~~commissioner shall directly or by contract implement the program through a~~
2 ~~joint pharmaceuticals purchasing consortium. The joint pharmaceuticals~~
3 ~~purchasing consortium shall be offered on a voluntary basis no later than~~
4 ~~January 1, 2008, with mandatory participation by state or publicly funded,~~
5 ~~administered, or subsidized purchasers to the extent practicable and consistent~~
6 ~~with the purposes of this chapter, by January 1, 2010. If necessary, the~~
7 ~~department of Vermont health access shall seek authorization from the Centers~~
8 ~~for Medicare and Medicaid to include purchases funded by Medicaid. "State~~
9 ~~or publicly funded purchasers" shall include the department of corrections, the~~
10 ~~department of mental health, Medicaid, the Vermont Health Access Program~~
11 ~~(VHAP), Dr. Dynasaur, Vermont Rx, VPharm, Healthy Vermonters, workers'~~
12 ~~compensation, and any other state or publicly funded purchaser of prescription~~
13 ~~drugs.~~

14 ~~(2) The commissioner of Vermont health access and the secretary of~~
15 ~~administration shall take all steps necessary to enable Vermont's participation~~
16 ~~in joint prescription drug purchasing agreements with any other health benefit~~
17 ~~plan or organization within or outside this state that agrees to participate with~~
18 ~~Vermont in such joint purchasing agreements.~~

19 ~~(3) The commissioner of human resources shall take all steps necessary~~
20 ~~to enable the state of Vermont to participate in joint prescription drug~~
21 ~~purchasing agreements with any other health benefit plan or organization~~

1 ~~within or outside this state that agrees to participate in such joint purchasing~~
2 ~~agreements, as may be agreed to through the bargaining process between the~~
3 ~~state of Vermont and the authorized representatives of the employees of the~~
4 ~~state of Vermont.~~

5 (4) The actions of the commissioners and the secretary shall include:

6 (A)(1) active collaboration with the National Legislative Association
7 on Prescription Drug Prices;

8 (B)(2) active collaboration with the ~~Pharmacy RFP Issuing States~~
9 ~~initiative organized by the West Virginia Public Employees Insurance Agency~~
10 multi-state purchasing pools; and

11 (C)(3) the execution of any joint purchasing agreements or other
12 contracts with any participating health benefit plan or organization within or
13 outside the state which the commissioner of Vermont health access determines
14 will lower the cost of prescription drugs for Vermonters while maintaining
15 high quality in prescription drug therapies; and

16 (D) ~~with regard to participation by the state employees health benefit~~
17 ~~plan, the execution of any joint purchasing agreements or other contracts with~~
18 ~~any health benefit plan or organization within or outside the state which the~~
19 ~~commissioner of Vermont health access determines will lower the cost of~~
20 ~~prescription drugs and provide overall quality of integrated health care services~~
21 ~~to the state employees health benefit plan and the beneficiaries of the plan, and~~

1 ~~which is negotiated through the bargaining process between the state of~~
2 ~~Vermont and the authorized representatives of the employees of the state of~~
3 ~~Vermont.~~

4 ~~(5)(d)~~ The commissioners of human resources and of Vermont health
5 access may renegotiate and amend existing contracts to which the departments
6 of Vermont health access and of human resources are parties if such
7 renegotiation and amendment will be of economic benefit to the health benefit
8 plans subject to such contracts, and to the beneficiaries of such plans. Any
9 renegotiated or substituted contract shall be designed to improve the overall
10 quality of integrated health care services provided to beneficiaries of such
11 plans.

12 ~~(6)(e)~~ The commissioners and the secretary shall report quarterly to the
13 health access oversight committee and the joint fiscal committee on their
14 progress in securing Vermont's participation in such joint purchasing
15 agreements.

16 ~~(7)(f)~~ The commissioner of Vermont health access, the commissioner of
17 human resources, the commissioner of banking, insurance, securities, and
18 health care administration, and the secretary of human services shall establish a
19 collaborative process with the Vermont medical society, pharmacists, health
20 insurers, consumers, employer organizations and other health benefit plan
21 sponsors, the National Legislative Association on Prescription Drug Prices,

1 pharmaceutical manufacturer organizations, and other interested parties
2 designed to consider and make recommendations to reduce the cost of
3 prescription drugs for all Vermonters.

4 ~~(d) A participating health benefit plan other than a state public~~
5 ~~assistance program may agree with the director to limit the plan's participation~~
6 ~~to one or more program components. The commissioner shall supervise the~~
7 ~~implementation and operation of the pharmacy best practices and cost control~~
8 ~~program, including developing and maintaining the preferred drug list, to carry~~
9 ~~out the provisions of the subchapter. The director may include such insured or~~
10 ~~self insured health benefit plans as agree to use the preferred drug list or~~
11 ~~otherwise participate in the provisions of this subchapter. The purpose of this~~
12 ~~subchapter is to reduce the cost of providing prescription drugs while~~
13 ~~maintaining high quality in prescription drug therapies.~~

14 * * *

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

1 ~~appropriate clinical trials and shall provide information about cost-~~
2 ~~effectiveness of available drugs in the same therapeutic class.~~

3 ~~(2) The board shall meet at least quarterly. The board shall comply with~~
4 ~~the requirements of subchapter 2 of chapter 5 of Title 1 (open meetings) and~~
5 ~~subchapter 3 of chapter 5 of Title 1 (open records), except that the board may~~
6 ~~go into executive session to discuss drug alternatives and receive information~~
7 ~~on the relative price, net of any rebates, of a drug under discussion and the~~
8 ~~drug price in comparison to the prices, net of any rebates, of alternative drugs~~
9 ~~available in the same class to determine cost effectiveness, and in order to~~
10 ~~comply with subsection 2002(c) of this title to consider information relating to~~
11 ~~a pharmaceutical rebate or to supplemental rebate agreements, which is~~
12 ~~protected from disclosure by federal law or the terms and conditions required~~
13 ~~by the Centers for Medicare and Medicaid Services as a condition of rebate~~
14 ~~authorization under the Medicaid program.~~

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

19 ~~(4) The program shall establish board procedures for the timely review~~
20 ~~of prescription drugs newly approved by the federal Food and Drug~~

1 ~~Administration, including procedures for the review of newly approved~~
2 ~~prescription drugs in emergency circumstances.~~

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

5 ~~(6) The commissioner shall encourage participation in the joint~~
6 ~~purchasing consortium by inviting representatives of the programs and entities~~
7 ~~specified in subdivision (c)(1) of this section to participate as observers or~~
8 ~~nonvoting members in the drug utilization review board and by inviting the~~
9 ~~representatives to use the preferred drug list in connection with the plans'~~
10 ~~prescription drug coverage.~~

11 (g) The department shall seek assistance from entities conducting
12 independent research into the safety and effectiveness of prescription drugs to
13 provide technical and clinical support in the development and the
14 administration of the preferred drug list pursuant to 18 V.S.A. § 4635 and the
15 evidence-based education program established in subchapter 2 of chapter 91 of
16 Title 18.

17 Sec. 21. 33 V.S.A. § 1999(a)(1) is amended to read:

18 (a)(1) The pharmacy best practices and cost control program shall authorize
19 pharmacy benefit coverage when a patient's health care provider prescribes a
20 prescription drug not on the preferred drug list established pursuant to
21 18 V.S.A. § 4635, or a prescription drug which is not the list's preferred

1 choice, if either of the circumstances set forth in subdivision (2) or (3) of this
2 subsection applies.

3 Sec. 22. 33 V.S.A. § 2001 is amended to read:

4 § 2001. LEGISLATIVE OVERSIGHT

5 (a) In connection with the pharmacy best practices and cost control
6 program pursuant to this subchapter and the statewide preferred drug list
7 pursuant to subchapter 4 of chapter 91 of Title 18, the commissioner of
8 Vermont health access shall report for review by the health access oversight
9 committee, prior to initial implementation, and prior to any subsequent
10 modifications:

11 * * *

12 (c) The commissioner of Vermont health access shall report quarterly to the
13 health access oversight committee concerning the following aspects of the
14 pharmacy best practices and cost control program and the statewide preferred
15 drug list:

16 * * *

17 Sec. 23. 33 V.S.A. § 2002(a) is amended to read:

18 (a) The commissioner of Vermont health access, ~~separately or in concert~~
19 ~~with the authorized representatives of any participating health benefit plan, or~~
20 designee shall use the preferred drug list ~~authorized by the pharmacy best~~
21 ~~practices and cost control program~~ established pursuant to 18 V.S.A. § 4635 to

1 negotiate with pharmaceutical companies for the payment to the commissioner
2 of supplemental rebates or price discounts, including 340B discounts, for
3 Medicaid and for any other state public assistance health benefit plans
4 designated by the commissioner, in addition to those required by Title XIX of
5 the Social Security Act. The commissioner may also use the preferred drug list
6 to negotiate for the payment of rebates or price discounts in connection with
7 drugs covered under any other participating health benefit plan within or
8 outside this state, provided that such negotiations and any subsequent
9 agreement shall comply with the provisions of 42 U.S.C. § 1396r-8. The
10 program, or such portions of the program as the commissioner shall designate,
11 shall constitute a state pharmaceutical assistance program under 42 U.S.C.
12 § 1396r-8(c)(1)(C).

13 Sec. 24. 33 V.S.A. § 2076(a) is amended to read:

14 (a) All public pharmaceutical assistance programs shall provide coverage
15 for those over-the-counter pharmaceuticals on the preferred drug list developed
16 ~~under section 1998 of this title pursuant to 18 V.S.A. § 4635~~, provided the
17 pharmaceuticals are authorized as part of the medical treatment of a specific
18 disease or condition, and they are a less costly, medically appropriate substitute
19 for or an alternative to currently covered pharmaceuticals.

1 (3) The multi-payer data collection project pursuant to 18 V.S.A.
2 § 9410.

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

5 (5) The consumer price and quality information system pursuant to
6 18 V.S.A. § 9410.

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

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

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

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

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

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

20 ~~(e) The secretary of administration or designee shall provide information~~
21 ~~and testimony on the activities included in this section to the health access~~

1 oversight committee, the commission on health care reform, and to any
2 legislative committee upon request.

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

4 § 5. DUTIES OF DEPARTMENT OF HEALTH

5 The department of health is hereby designated as the sole state agency for
6 the purposes of shall:

7 (1) ~~Conducting~~ Conduct studies, ~~developing~~ develop state plans, and
8 ~~administering~~ administer programs and state plans for hospital survey and
9 construction, hospital operation and maintenance, medical care, treatment of
10 alcoholics, and alcoholic rehabilitation.

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

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

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

1 (5) Obtain and maintain accreditation through the Public Health
2 Accreditation Board.

3 (6) Create a state health improvement plan and facilitate local health
4 improvement plans in order to encourage the design of healthy communities
5 and to promote policy initiatives that contribute to community, school, and
6 workplace wellness.

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

8 (a)(1) The commissioner shall establish and maintain a unified health care
9 data base to enable the commissioner and the Vermont health reform board to
10 carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title
11 8, including:

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

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

14 (C) Evaluating the effectiveness of intervention programs on
15 improving patient outcomes.

16 (D) Comparing costs between various treatment settings and
17 approaches.

18 (E) Providing information to consumers and purchasers of health
19 care.

20 (F) Improving the quality and affordability of patient health care and
21 health care coverage.

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

3 Sec. 10. IMPLEMENTATION OF CERTAIN FEDERAL HEALTH
4 CARE REFORM PROVISIONS

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

11 (b) From the effective date of this act through July 1, ~~2014~~ 2014, the
12 commissioner of Vermont health access shall undertake such planning steps as
13 are necessary to ensure Vermont's participation in beneficial opportunities
14 created by the Patient Protection and Affordable Care Act of 2010, Public Law
15 111-148, as amended by the Health Care and Education Reconciliation Act of
16 2010, Public Law 111-152.

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

19 (d) Term of committee. The committee shall cease to exist on January 31,
20 ~~2014~~ 2012.

1 Sec. 30. REPEAL

2 (a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective
3 December 31, 2013.

4 (b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective
5 June 30, 2011.

6 Sec. 31. EFFECTIVE DATES

7 (a) Secs. 1 (principles), 2 (strategic plan), 8 (integration plan), 9 (financing
8 plans), 10 (HIT), 11 (health planning), 12 (regulatory process), 13 (workforce),
9 14 (medical malpractice), 25 (health care reform), 26 (department of health),
10 28 (ACA grants), and 29 (primary care workforce committee) of this act and
11 this section shall take effect on passage.

12 (b) Secs. 3 (Vermont health care reform), 5 (DVHA), 6 (Health care
13 eligibility), and 30 (repeal) shall take effect on July 1, 2011.

14 (c) Sec. 4 (Vermont health benefit exchange; Green Mountain Care) shall
15 take effect on July 1, 2011. The Vermont health benefit exchange shall begin
16 enrolling individuals no later than November 1, 2013 and shall be fully
17 operational no later than January 1, 2014. Green Mountain Care shall be
18 implemented upon approval by the U.S. Department of Health and Human
19 Services of a waiver under Section 1332 of Affordable Care Act.

20 (d) Sec. 7, 3 V.S.A. § 402 (patient and health care professionals advisory
21 board), shall take effect on January 1, 2014.

1 (e) Sec. 15 (rate review) shall take effect on October 1, 2011 and shall
2 apply to all filings on and after October 1, 2011.

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

5 (g) Secs. 17–24 (drug formulary) shall take effect on October 1, 2011,
6 except the provisions in Sec. 17 of this act (18 V.S.A. § 4635, statewide
7 preferred drug list), allowing the drug utilization and review board to develop
8 the statewide preferred drug list, shall take effect immediately upon passage to
9 ensure implementation on October 1, 2011.

Sec. 1. [Deleted.]

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

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

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

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

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

(1) No later than November 1, 2013, the Vermont health benefit
exchange established in subchapter 1 of chapter 18 of Title 33 shall begin
enrolling individuals and small employers for coverage beginning January 1,

2014. The intent of the general assembly is to establish the Vermont health benefit exchange in a manner such that it may become the foundation for a Green Mountain Care.

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

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

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

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

(d) The secretary of administration or designee shall obtain waivers, exemptions, agreements, legislation, or a combination thereof to ensure that, to the extent possible under federal law, all federal payments provided within the state for health services are paid directly to Green Mountain Care. Green Mountain Care shall assume responsibility for the benefits and services previously paid for by the federal programs, including Medicaid, Medicare, and, after implementation, the Vermont health benefit exchange. In obtaining the waivers, exemptions, agreements, legislation, or combination thereof, the secretary shall negotiate with the federal government a federal contribution for health care services in Vermont that reflects medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, the number of Medicare-eligible

individuals, and other factors that may be advantageous to Vermont and that does not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of Green Mountain Care.

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

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

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

CHAPTER 220. GREEN MOUNTAIN CARE BOARD

Subchapter 1. Green Mountain Care Board

§ 9371. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(3) 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 of the health care system.

(4) 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, including the educational and research missions of the state's academic medical center, must be supported in such a way that all Vermonters have access to necessary health services and

that these health services are sustainable.

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

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

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

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

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

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

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

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

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

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

§ 9372. PURPOSE

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

(1) improve the health of the population;

(2) enhance the patient experience of care; and

(3) reduce the per capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised.

§ 9373. DEFINITIONS

As used in this chapter:

(1) "Board" means the Green Mountain Care board established in this chapter.

(2) "Green Mountain Care" means the public-private universal health care program designed to provide health benefits through a simplified, uniform, single administrative system pursuant to 33 V.S.A. chapter 18, subchapter 2.

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

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

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

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

§ 9374. BOARD MEMBERSHIP; AUTHORITY

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair shall be a full-time state employee and the four other members shall be part-time state employees. The chair and all of the members shall be exempt from the state classified system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 9375. DUTIES

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

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

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

(2)(A) Develop by rule, pursuant to chapter 25 of Title 3, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for accountable care organizations, health care professionals, or other provider arrangements.

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

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

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

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

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

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

(2) Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business days of receipt of such recommendations, on any insurance rate increases pursuant to 8 V.S.A. chapter 107, on hospital budgets pursuant to chapter 221, subchapter 7 of this title, and on certificates of need pursuant to chapter 221, subchapter 5 of this title, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board.

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

(4) Review and approve, with recommendations from the commissioner of Vermont health access, the benefit package for qualified health benefit plans pursuant to chapter 18, subchapter 1 of Title 33. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

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

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

(ii) for utilization of health services;

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

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

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

(B) The board shall develop the evaluation method pursuant to subdivision (A) of this subdivision (5) by October 15, 2013 and shall report the

results of its evaluations and any resulting recommendations in its annual report as required by subsection (d) of this section.

(6)(A)(i) In preparation for implementing Green Mountain Care, develop and approve, upon recommendation from the agency of human services, the Green Mountain Care benefit package within the parameters established in chapter 18, subchapter 2 of Title 33.

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

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

(7) In preparation for implementing Green Mountain Care and every three years after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

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

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include

any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the status of efforts to implement the health care workforce development strategic plan pursuant to subdivision (b)(4) of this section, any substantive changes to the benefit package for qualified health benefit plans pursuant to subdivision (c)(3) of this section, the results of the systemwide performance and quality evaluations required by subdivision (c)(4) of this section, the rationale for any decision to impose or alter cost-sharing requirements for Green Mountain Care pursuant to subdivision (c)(6) of this section, and the extent and impacts of migration to Vermont for health services as described in subdivision (c)(8) of this section.

§ 9376. PAYMENT AMOUNTS; METHODS

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

(b)(1) The board shall ensure that health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies receive reasonable rates, as determined by the board based on the methodologies developed pursuant to section 9375 of this title and after consultation with the affected parties, in order to have a consistent reimbursement amount accepted by these persons.

(2) The board shall consider compensating health care providers for the completion of requests for prior authorization.

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

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

§ 9377. PAYMENT REFORM; PILOTS

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for oversight of the pilot projects to test payment reform methodologies as provided in this section. The director of payment reform in the department of Vermont health access shall develop and implement the payment reform pilot projects and the board shall evaluate their effectiveness. Whenever health insurers are involved, the director and the board shall collaborate with the commissioner of banking, insurance, securities, and health care administration. The terms used in this section shall have the same meanings as in chapter 13 of this title.

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

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

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

(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another

structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

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

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

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

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

(B) with input from long-term care providers, whether to include home health services and long-term care services as part of capitated payments.

(c) Health insurer participation.

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

(B) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of banking, insurance, securities, and health care administration. Health insurers shall be exempt from participation if the

insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

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

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

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

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

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

§ 9378. PUBLIC PROCESS

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

§ 9379. AGENCY COOPERATION

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

§ 9380. RULES

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

§ 9381. APPEALS

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

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

Subchapter 2. Green Mountain Care Board Nominating Committee

§ 9390. GREEN MOUNTAIN CARE BOARD NOMINATING COMMITTEE
CREATED; COMPOSITION

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

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

(A) Two members appointed by the governor.

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

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

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

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

(F) One member representing home health services, to be appointed by the Vermont Association of Home Health Agencies.

(G) One member representing nurses, to be appointed by the Vermont State Nurses Association.

(H) The state health care ombudsman.

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

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

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

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

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

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

§ 9391. NOMINATION AND APPOINTMENT PROCESS

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

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

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

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

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

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

(b) The health care ombudsman office shall:

* * *

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

* * *

Sec. 3b. GREEN MOUNTAIN CARE BOARD AND EXCHANGE POSITIONS

(a) On July 1, 2011, five exempt positions are created on the Green Mountain Care board, including:

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

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

(b) By October 1, 2011, nine positions and appropriate amounts for personal services and operating expenses shall be transferred from the division of health care administration in the department of banking, insurance, securities, and health care administration to the Green Mountain Care board. In addition, one exempt attorney position shall be transferred from the administrative division in the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

(c) On or after January 1, 2012, one exempt deputy commissioner position is created in the department of Vermont health access to support the functions provided for in Sec. 4 of this act establishing 33 V.S.A. chapter 18, subchapter 1. The salary and benefits for this position shall be funded from federal funds provided to establish the Vermont health benefit exchange.

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

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(5) "Gift" means:

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

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

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

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

* * *

(b)(1) It is unlawful for any manufacturer of a prescribed product or any wholesale distributor of medical devices, or any agent thereof, to offer or give any gift to a health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title.

* * *

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

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

(a)(1) Annually on or before October 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the

fiscal year ending the previous June 30th the value, nature, purpose, and recipient information of:

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

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

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

(iii) payments for clinical trials as described in subdivision 4631a(a)(1)(C) of this title, which shall be disclosed after the earlier of the date of the approval or clearance of the prescribed product by the Food and Drug Administration or two calendar years after the date the payment was made. For a clinical trial for which disclosure is delayed under this subdivision (iii), the manufacturer shall identify to the attorney general the clinical trial, the start date, and the web link to the clinical trial registration on the national clinical trials registry;

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

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

** * **

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

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

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

(6) After issuance of the report required by subdivision (5) of this subsection and except as otherwise provided in subdivision (2)(A)(i) of this

subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

** * **

** * * Public-Private Universal Health Care System * * **

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

*CHAPTER 18. PUBLIC-PRIVATE UNIVERSAL
HEALTH CARE SYSTEM*

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

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

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

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

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

(2) "Commissioner" means the commissioner of the department of Vermont health access.

(3) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. This term does not include coverage only for accident or disability income insurance, liability

insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage where benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

(4) "Health insurer" shall have the same meaning as in 18 V.S.A. § 9402.

(5) "Qualified employer" means an employer that:

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

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

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

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

(8) "Qualified individual" means an individual, including a minor, who is a Vermont resident and, at the time of enrollment,

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

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

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

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

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

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

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

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

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

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

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

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

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

(c)(1) If the Vermont health benefit exchange is required by the secretary of the U.S. Department of Health and Human Services to contract with more than one health insurer, the Vermont health benefit exchange may determine an

appropriate method to provide a unified, simplified administration system for health insurers offering qualified health benefit plans. The exchange may include claims administration, benefit management, billing, or other components in the unified system and may achieve simplification by contracting with a single entity for administration and management of all qualified health benefit plans, by licensing or requiring the use of particular software, by requiring health insurers to conform to a standard set of systems and rules, or by another method determined by the commissioner.

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

(d) The Vermont health benefit exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this subchapter provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and provided such agreements comply with all applicable state and federal laws and regulations.

§ 1804. QUALIFIED EMPLOYERS

[Reserved.]

§ 1805. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

(6) Determining enrollee premiums and subsidies as required by the secretary of the U.S. Treasury or of the U.S. Department of Health and Human Services and informing consumers of eligibility for premiums and subsidies, including by providing an electronic calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the Affordable Care Act.

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

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

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

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

(A) Granting a certification attesting that an individual is exempt from the individual responsibility requirement or from the penalty for violating that requirement, if there is no affordable qualified health benefit plan available through the Vermont health benefit exchange or the individual's employer for that individual or if the individual meets the requirements for any exemption from the individual responsibility requirement or from the penalty pursuant to Section 5000A of the Internal Revenue Code of 1986; and

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

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

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

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

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

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

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

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

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

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

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

(a) Prior to contracting with a health insurer to offer a qualified health benefit plan, the commissioner shall determine that making the plan available through the Vermont health benefit exchange is in the best interest of individuals and qualified employers in this state. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.

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

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

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

(2) At least the silver level of coverage as defined by Section 1302 of the Affordable Care Act and the cost-sharing limitations for individuals provided in Section 1302 of the Affordable Care Act, as well as any more restrictive cost-sharing requirements specified by the secretary of human services by rule after consultation with the advisory board established in section 402 of this title and after approval from the Green Mountain Care board established in chapter 220 of Title 18.

(3) For qualified health benefit plans offered to employers, a deductible which meets the limitations provided in Section 1302 of the Affordable Care Act and any more restrictive deductible requirements specified by the secretary of human services by rule after consultation with the advisory board and after

approval from the Green Mountain Care board established in chapter 220 of Title 18.

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

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

(2) quality and wellness standards as specified in rule by the secretary of human services, after consultation with the commissioners of health and of banking, insurance, securities, and health care administration and with the advisory board established in section 402 of this title; and

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

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

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

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

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

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

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

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

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

(2) A health insurer offering a qualified health benefit plan shall comply with all other insurance requirements for health insurers as provided in 8 V.S.A. chapter 107 and as specified by rule by the commissioner of banking, insurance, securities, and health care administration.

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

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

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

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

§ 1807. NAVIGATORS

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

(2) The Vermont health benefit exchange shall ensure that navigators are available to provide in-person assistance to individuals in all regions of the state.

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

(b) Navigators shall have the following duties:

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

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

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

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

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

(6) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRx, other public health benefit programs, or the Vermont health benefit exchange in order to ensure that all eligible individuals are enrolled.

§ 1808. FINANCIAL INTEGRITY

(a) The Vermont health benefit exchange shall:

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

(2) Cooperate with the secretary of the U.S. Department of Health and Human Services or the inspector general of the U.S. Department of Health and Human Services in any investigation into the affairs of the Vermont health benefit exchange, any examination of the properties and records of the

Vermont health benefit exchange, or any requirement for periodic reports in relation to the activities undertaken by the Vermont health benefit exchange.

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

§ 1809. PUBLICATION OF COSTS AND SATISFACTION SURVEYS

(a) The Vermont health benefit exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, as well as the administrative costs of the exchange on a website intended to educate consumers about such costs. This information shall include information on monies lost to waste, fraud, and abuse.

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

§ 1810. RULES

The secretary of human services may adopt rules pursuant to chapter 25 of Title 3 as needed to carry out the duties and functions established in this subchapter.

Subchapter 2. Green Mountain Care

§ 1821. PURPOSE

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

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

(2) establishing innovative payment mechanisms to health care professionals, such as global payments;

(3) encouraging the management of health services through the Blueprint for Health; and

(4) reducing unnecessary administrative expenditures.

§ 1822. DEFINITIONS

For purposes of this subchapter:

- (1) "Agency" means the agency of human services.
- (2) "CHIP funds" means federal funds available under Title XXI of the Social Security Act.
- (3) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last one year or more; that requires ongoing clinical management; and that requires health services that attempt to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.
- (4) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or otherwise authorized by Vermont law to provide professional health services.
- (5) "Health service" means any medically necessary treatment or procedure to maintain an individual's physical or mental health or to diagnose or treat an individual's physical or mental health condition, including services ordered by a health care professional and medically necessary services to assist in activities of daily living.
- (6) "Hospital" shall have the same meaning as in 18 V.S.A. § 1902 and may include hospitals located outside the state.
- (7) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.
- (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, and shall include prenatal care and mental health and substance abuse treatment.
- (9) "Secretary" means the secretary of human services.

(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. An individual shall not be considered to be a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state.

§ 1823. ELIGIBILITY

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

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

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

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

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

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

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

(2) After submission of the application, the agency shall collect additional information as necessary to determine whether Medicaid, Medicare, CHIP, or other federal funds may be applied toward the cost of the health

services provided, but shall provide payment for any health services received by the individual from the time the application is submitted.

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

(d) The agency shall adopt rules pursuant to chapter 25 of Title 3 to ensure that Vermont residents who are temporarily out of the state on a short-term basis and who intend to return and reside in Vermont remain eligible for Green Mountain Care while outside Vermont.

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

§ 1824. HEALTH BENEFITS

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

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

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

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

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

(B) Upon implementation of Green Mountain Care, the benefit package for individuals eligible for Medicaid or CHIP shall also include any optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services

covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc for which these individuals are eligible on January 1, 2014. Beginning with the second year of Green Mountain Care and going forward, the Green Mountain Care board may, consistent with federal law, modify these optional benefits, as long as at all times the benefit package for these individuals contains at least the benefits described in subdivision (A) of this subdivision (b)(1).

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

(3) For individuals eligible for Medicare, the benefit package shall include, at a minimum, the benefits provided to these individuals under federal law.

§ 1825. BLUEPRINT FOR HEALTH

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

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

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

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

§ 1826. ADMINISTRATION; ENROLLMENT

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

(2) The agency shall ensure that entities awarded contracts pursuant to this subsection do not have a financial incentive to restrict individuals' access

to health services. The agency may establish performance measures that provide incentives for contractors to provide timely, accurate, transparent, and courteous services to individuals enrolled in Green Mountain Care and to health care professionals, where applicable.

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

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

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

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

(e) The agency shall seek permission from the Centers for Medicare and Medicaid Services to be the administrator for the Medicare program in Vermont. If the agency is unsuccessful in obtaining such permission, Green Mountain Care 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).

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

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

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

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

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

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

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

§ 1827. BUDGET PROPOSAL

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

§ 1828. GREEN MOUNTAIN CARE FUND

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

(b) Into the fund shall be deposited:

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

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

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

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

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

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

§ 1829. IMPLEMENTATION; WAIVER

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

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

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

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

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

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

§ 1830. COLLECTIVE BARGAINING RIGHTS

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

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

§ 401. COMPOSITION OF DEPARTMENT

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

Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY

UNIT

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

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

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

§ 402. MEDICAID AND EXCHANGE ADVISORY BOARD

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

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

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

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

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

(C) advocates for consumer organizations.

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

(3) Members whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, including costs of travel, child care, personal assistance services, and any other service

necessary for participation in the advisory group and approved by the commissioner.

(c)(1) The advisory board shall have an opportunity to review and comment on agency policy initiatives pertaining to quality improvement initiatives and to health care benefits and eligibility for individuals receiving services through Medicaid, programs funded with Medicaid funds under a Section 1115 waiver, or the Vermont health benefit exchange. It also shall have the opportunity to comment on proposed rules prior to commencement of the rulemaking process pursuant to chapter 25 of Title 3 and on waiver or waiver amendment applications prior to submission to the Centers for Medicare and Medicaid Services.

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

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

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

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

** * * Planning Initiatives * * **

Sec. 8. INTEGRATION PLAN

(a) No later than January 15, 2012, the secretary of administration or designee shall make recommendations to the house

committee on health care and the senate committee on health and welfare on the following issues:

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

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

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

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

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

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

(2) Once Green Mountain Care is implemented, whether to allow employers and individuals to purchase coverage for supplemental health

services from Green Mountain Care or to allow private insurers to provide supplemental insurance plans.

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

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

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

(b) The commissioner of labor, in consultation with the commissioner of Vermont health access, the commissioner of banking, insurance, securities, and health care administration, and interested stakeholders, shall evaluate the feasibility of integrating or aligning Vermont's workers' compensation system with Green Mountain Care, including providing any covered services in addition to those in the Green Mountain Care benefit package that may be appropriate for injuries arising out of and in the course of employment. No later than January 15, 2012, the commissioner of labor shall report the results of the evaluation and, if integration or alignment has been found to be feasible, make recommendations on how to achieve it.

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

Sec. 9. FINANCING PLANS

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

(1) One plan shall recommend the amounts and necessary mechanisms to finance any initiatives which must be implemented by January 1, 2014 in order to provide coverage to all Vermonters in the absence of a waiver from certain federal health care reform provisions established in Section 1332 of

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

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

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

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

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

(3) issues involving federal law and taxation;

(4) impacts of tax system changes:

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

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

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

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

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

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

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

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

(10) whether to require eligible individuals to enroll in Medicare in order to become eligible or maintain eligibility for Green Mountain Care;

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

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

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

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

Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

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

(b) In conducting this review, the secretary of administration may issue a request for proposals for an independent design and implementation plan.

which would describe how to integrate existing health information systems to carry out the purposes of this act, detail how to develop the necessary capacity in health information systems, determine the funding needed for such development, and quantify the existing funding sources available for such development. The health information technology plan or design and implementation plan shall also include a review of the multi-payer database established in 18 V.S.A. § 9410 to determine whether there are systems modifications needed to use the database to reduce fraud, waste, and abuse; and shall include other systems analysis as specified by the secretary.

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

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

HEALTH

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

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

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

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

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

(3) In collaboration with the director of the Blueprint for Health established in 18 V.S.A. chapter 13 and health care professionals, how to coordinate quality efforts across state government and private payers; optimize quality assurance programs; and ensure that health care

professionals in Vermont utilize, are informed of, and engage in evidence-based practice.

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

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

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall review the hospital budget review process provided in 18 V.S.A. chapter 221, subchapter 7, and the certificate of need process provided in 18 V.S.A. chapter 221, subchapter 5 and recommend to the house committee on health care and the senate committee on health and welfare statutory modifications needed to enable the participation of the Green Mountain Care board as set forth in 18 V.S.A. § 9375.

Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

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

Sec. 13. WORKFORCE ISSUES

(a)(1) Currently, Vermont has a shortage of primary care professionals, and many practices are closed to new patients. It also experiences periodic and geographic shortages of specialty care professionals necessary to ensure that Vermonters have reasonable access to a broad range of health services within the state. In order to ensure sufficient patient access now and in the future, it is necessary to plan for the implementation of Green Mountain Care and utilize Vermont's health care professionals to the fullest extent of their professional competence.

(2) The board of nursing, the board of medical practice, and the office of professional regulation, in consultation with the primary care workforce development committee established in Sec. 31 of No. 128 of the Acts of the 2009 Adj. Sess. (2010), shall collaborate to determine how to optimize the

primary care workforce by reviewing the licensure process, scope of practice requirements, reciprocity of licensure, and efficiency of the licensing process, and by identifying any other barriers to augmenting Vermont's primary care workforce. No later than January 15, 2012, the boards and office shall provide to the house committee on health care and the senate committee on health and welfare joint recommendations for improving the primary care workforce through the boards' and office's rules and procedures.

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

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

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

(d) The department of Vermont health access, in consultation with the area health education centers, shall provide the Green Mountain Care board with data on the extent to which individual health care professionals begin and cease to practice in their applicable fields in Vermont for inclusion in the board's health care workforce strategic plan pursuant to 18 V.S.A. §9375.

(e) The board shall consider exempting from any prior authorization requirement those health care professionals whose prior authorization requests are routinely granted.

**** Cost Estimates ****

Sec. 14. COST ESTIMATES

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

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

**** Rate Review ****

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

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

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

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the law of this state. The commissioner shall notify in writing the insurer

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

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

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

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

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

comments prior to the expiration of the review period pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for their consideration in approving any rate increases.

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

(b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate, or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

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

§ 4515a. FORM AND RATE FILING; FILING FEES

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

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

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the commissioner of banking, insurance, securities, and health care administration under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by such commissioner. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the commissioner of a

nonrefundable fee of \$50.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

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

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

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

** * * Employer Benefit Information * * **

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

§ 2004. HEALTH BENEFIT COSTS

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

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

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

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

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

* * * Consumer Protection * * *

Sec. 17. REVIEW OF BAN ON DISCRETIONARY CLAUSES

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting a National Association of Insurance Commissioners (NAIC) model act prohibiting insurers from using discretionary clauses in their health benefit contracts. The purpose of the NAIC model act is to prohibit insurance clauses that purport to reserve discretion to the insurer to interpret the terms of the policy, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

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

* * * Single Formulary * * *

Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

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

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

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

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

Secs. 19-24. [Deleted.]

* * * Conforming Revisions * * *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(10) The uniform hospital uncompensated care policies. A strategic approach to workforce needs, including retraining programs for workers displaced through increased efficiency and reduced administration in the health care system and ensuring an adequate health care workforce to provide access to health care for all Vermonters.~~

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

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

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

~~§ 5. DUTIES OF DEPARTMENT OF HEALTH~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

*Sec. 10. IMPLEMENTATION OF CERTAIN FEDERAL HEALTH
CARE REFORM PROVISIONS*

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

(b) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of Vermont health access shall undertake such planning steps as are necessary to ensure Vermont's participation in beneficial opportunities created by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

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

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

Sec. 30. REPEAL

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

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

Sec. 31. APPROPRIATIONS

(a) In fiscal year 2012, the sum of \$807,182.00 in general funds and \$355,727.00 in federal funds is appropriated to the Green Mountain Care board to carry out its functions.

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

Sec. 32. EFFECTIVE DATES

(a) Sec. 2 (strategic plan); Sec. 3, 18 V.S.A. chapter 220, subchapter 2 (Green Mountain Care board nominating committee); Secs. 8 (integration plan), 9 (financing plans); 10 (HIT); 11 (health planning); 12 (regulatory process); 13 (workforce); 14 (cost estimates); 17 (discretionary clauses); 18 (single formulary); 25 (health care reform); 26 (department of health); 28 (ACA grants); and 29 (primary care workforce committee) of this act and this section shall take effect on passage.

(b) Sec. 3, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Care board) and Secs. 3a (health care ombudsman), 3b (positions), 3c and 3d (manufacturers of prescribed products), 5 (DVHA), 6 (Health care eligibility), 30 (repeal), and 31 (appropriations) shall take effect on July 1, 2011.

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

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

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

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

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

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

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

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

(e) Sec. 15 (rate review) shall take effect on October 1, 2011 and shall apply to all filings on and after October 1, 2011, except that the amendments

~~to § 4962(c)(2) shall take effect on January 1, 2012 and shall apply to all filings on and after that date.~~

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

Sec. 1. INTENT

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

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

Sec. 1a. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(3) 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 of the health care system.

(4) 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, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) The public health promotion programs of the agency of human services, including primary prevention for chronic disease, community assessments, school wellness programs, public health information technology,

data and surveillance systems, healthy retailers, healthy community design, and alcohol and substance abuse treatment and prevention programs.

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

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

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

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

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

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

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

~~Sec. 2. STRATEGIC PLAN; UNIVERSAL AND UNIFIED HEALTH SYSTEM~~

~~(a) Vermont must begin to plan now for health care reform, including simplified administration processes, payment reform, and delivery reform, in order to have a publicly financed program of universal and unified health care~~

operational after the occurrence of specific events, including the receipt of a waiver from the federal Exchange requirement from the U.S. Department of Health and Human Services. A waiver will be available in 2017 under the provisions of existing law in the Patient Protection and Affordable Care Act (Public Law 111-148) ("Affordable Care Act"), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and may be available in 2014 under the provisions of two bills, H.R. 844 and S.248, introduced in the 112th Congress. In order to begin the planning efforts, the director of health care reform in the agency of administration shall establish a strategic plan, which shall include time lines and allocations of the responsibilities associated with health care system reform, to further the containment of health care costs, to further Vermont's existing health care system reform efforts as described in 3 V.S.A. § 2222a and to further the following:

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

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

(B) No later than February 15, 2012, the director of health care reform or designee shall provide the house committee on health care and the

senate committees on finance and on health and welfare the following information related to the Vermont health benefit exchange, to the extent available:

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

(ii) a comparison of the federal health benefits with the Vermont health insurance benefit requirements provided for in 8 V.S.A. chapter 107;

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

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

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

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

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

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

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

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

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

(4) The director shall supervise and oversee, as appropriate, the planning efforts, reports of which are due on January 15, 2012, as provided in Secs. 8 and 10 through 13 of this act, including integration of multiple payers into the Vermont health benefit exchange; a continuation of the planning

necessary to ensure an adequate, well-trained primary care workforce; necessary retraining for any employees dislocated from health care professionals or from health insurers due to the simplification in the administration of health care; and unification of health system planning, regulation, and public health.

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

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

(7) No later than January 15, 2012, the secretary of administration or designee shall submit to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary a proposal for potential improvement or reforms to the medical malpractice system for Vermont. The proposal shall be designed to address any findings of defensive medicine, reduce health care costs and medical errors, and protect patients' rights, and shall include the secretary's or designee's consideration of a no-fault system and of confidential pre-suit mediation. In designing the proposal, the secretary or designee shall consider the findings and recommendations contained in the majority and minority reports of the medical malpractice study committee established by Sec. 292 of No. 122 of the Acts of the 2003 Adj. Sess. (2004).

(b) The Green Mountain Care board established in 18 V.S.A. chapter 220, in collaboration with the director of health care reform in the agency of

administration, shall develop a work plan for the board, which may include any necessary processes for implementation of the board's duties, a time line for implementation of the board's duties, and a plan for ensuring sufficient staff to implement the board's duties. The work plan shall be provided to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.

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

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

CHAPTER 220. GREEN MOUNTAIN CARE BOARD

Subchapter 1. Green Mountain Care Board

§ 9371. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(3) 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 of the health care system.

(4) 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, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

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

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

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

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

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

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

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

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

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

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

§ 9372. PURPOSE

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

(1) improving the health of the population;

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

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

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

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

§ 9373. DEFINITIONS

As used in this chapter:

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

(2) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care.

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

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

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

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

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

(8) “Health insurer” means any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of a health benefit plan offered by a public or a private entity. The term does not include Medicaid, the Vermont health access plan, or any other state health care assistance program financed in whole or in part through a federal program.

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

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

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

(12) “Payment reform” means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

(13) “Preventive care” means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and

medication determined by scientific evidence to be effective in preventing or detecting a condition.

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

§ 9374. BOARD MEMBERSHIP; AUTHORITY

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair and all of the members shall be state employees and shall be exempt from the state classified system. The chair shall receive compensation equal to that of a superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the chair.

(2) The chair and the members of the board shall be nominated by the Green Mountain Care board nominating committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a superior judge. The governor shall not appoint a nominee who was denied confirmation by the senate within the past six years.

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

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

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

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

(c)(1) No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.

(2) No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member.

individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.

(3) The prohibitions contained in subdivisions (1) and (2) of this subsection shall not be construed to prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

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

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

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

(4) No board member shall, during his or her term or terms on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board.

(5) No board member may appear before the board or any other state agency on behalf of a person subject to supervision or regulation by the board for a period of one year following his or her last day as a member of the Green Mountain Care board.

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

(e)(1) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. Members of such advisory group who are not state employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed \$5,000.00 per year.

(2) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

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

§ 9375. DUTIES

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

(b) The board shall have the following duties:

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

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

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

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

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

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

(3) Review and approve the health care workforce development strategic plan created in chapter 222 of this title.

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

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

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

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

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

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

(7) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

(8) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

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

(D) for cost-containment and limiting the growth in health care expenditures;

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

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the board.

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

(1) Prior to implementing Green Mountain Care, consider recommendations from the agency of human services, and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the agency by rule.

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

(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision

(b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the board comports with the principles expressed in section 9371 of this title.

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

§ 9376. PAYMENT AMOUNTS; METHODS

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

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

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

(c) The board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy

lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the board determines such payments to be appropriate.

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

§ 9377. PAYMENT REFORM; PILOTS

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for payment and delivery system reform, including setting the overall policy goals for the pilot projects established in chapter 13, subchapter 2 of this title.

(2) The director of payment reform in the department of Vermont health access shall develop and implement the payment reform pilot projects in accordance with policies established by the board, and the board shall evaluate the effectiveness of such pilot projects in order to inform the payment and delivery system reform.

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

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

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

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

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

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

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

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

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

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

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

§ 9378. PUBLIC PROCESS

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

§ 9379. AGENCY COOPERATION

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

§ 9380. RULES

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

§ 9381. APPEALS

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

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

Subchapter 2. Green Mountain Care Board Nominating Committee

§ 9390. GREEN MOUNTAIN CARE BOARD NOMINATING COMMITTEE CREATED; COMPOSITION

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

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

(A) Two members appointed by the governor.

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

(C) Two members of the house of representatives, who shall not be members of the same party, to be appointed by the speaker of the house of representatives.

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

(2) The members of the committee shall serve for terms of two years and may serve for no more than three consecutive terms. All appointments shall be made between January 1 and February 1 of each odd-numbered year, except to fill a vacancy. Members shall serve until their successors are appointed.

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

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

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

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

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

§ 9391. NOMINATION AND APPOINTMENT PROCESS

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

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

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

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

§ 9392. QUALIFICATIONS FOR NOMINEES

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

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

(2) knowledge of or expertise in health care policy, health care delivery, or health care financing, and openness to alternative approaches to health care.

(3) possession of desirable personal characteristics, including integrity, impartiality, health, empathy, experience, diligence, neutrality, administrative and communication skills, social consciousness, public service, and regard for the public good.

(4) knowledge, expertise, and characteristics that complement those of the remaining members of the board.

(5) impartiality and the ability to remain free from undue influence by a personal, business, or professional relationship with any person subject to supervision or regulation by the board.

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

(b) The health care ombudsman office shall:

* * *

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

* * *

Sec. 3b. GREEN MOUNTAIN CARE BOARD AND EXCHANGE POSITIONS

(a) On July 1, 2011, five exempt positions are created on the Green Mountain Care board, including:

(1) one chair, Green Mountain Care board; and

(2) four members, Green Mountain Care board.

(b)(1) On or before January 1, 2012, up to nine positions and appropriate amounts for personal services and operating expenses shall be transferred from the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

(2) One exempt attorney position shall be transferred from the administrative division in the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

(c) On July 1, 2011, one classified administrative assistant position is created for the Green Mountain Care board.

(d) On or after November 1, 2011, one exempt deputy commissioner position is created in the department of Vermont health access to support the functions provided for in Sec. 4 of this act establishing 33 V.S.A. chapter 18, subchapter 1. The salary and benefits for this position shall be funded from federal funds provided to establish the Vermont health benefit exchange.

(e) On July 1, 2011, one exempt position, director of health care reform, is created in the agency of administration.

* * *

Sec. 3c. 18 V.S.A. chapter 13 is amended to read:

**CHAPTER 13. CHRONIC CARE INFRASTRUCTURE
AND PREVENTION MEASURES**

§ 701. DEFINITIONS

For the purposes of this chapter:

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

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

(3) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year

or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, hyperlipidemia, and chronic pain.

~~(3)~~(4) “Chronic care information system” means the electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.

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

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

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

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

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

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

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

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

(13) “Payment reform” means modifying the method of payment from a fee for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies, for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

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

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

Subchapter 1. Blueprint for Health

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

* * *

Subchapter 2. Payment Reform

§ 721. PURPOSE

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

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

§ 722. PILOT PROJECTS

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

(b) The director of payment reform shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments to advise the director in developing and implementing the pilot projects and the Green Mountain Care board in setting overall policy goals.

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

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

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

(3) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health

outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

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

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

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

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

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

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

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

§ 723. HEALTH INSURER PARTICIPATION

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

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of banking, insurance, securities, and health care administration. Health insurers shall be exempt from participation if the

insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

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

§ 724. ANTITRUST PROTECTION

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

§ 725. ADMINISTRATION; RULES

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

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

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

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

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(5) "Gift" means:

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

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

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

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

* * *

(b)(1) It is unlawful for any manufacturer of a prescribed product or any wholesale distributor of medical devices, or any agent thereof, to offer or give any gift to a health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title.

* * *

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

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

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

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

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

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

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

Drug Administration or two calendar years after the date the payment was made. For a clinical trial for which disclosure is delayed under this subdivision (iii), the manufacturer shall identify to the attorney general the clinical trial, the start date, and the web link to the clinical trial registration on the national clinical trials registry;

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

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

* * *

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

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

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

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

* * *

** * * Public-Private Universal Health Care System * * **

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

*CHAPTER 18. PUBLIC-PRIVATE UNIVERSAL
HEALTH CARE SYSTEM*

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

(a) It is the intent of the general assembly to establish a Vermont health benefit exchange which meets the policy established in 18 V.S.A. § 9401 and,

to the extent allowable under federal law or a waiver of federal law, becomes the mechanism to create Green Mountain Care.

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

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

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

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

(3) “Health benefit plan” means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. This term does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers’ compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage where benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

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

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

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

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

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

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

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

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

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

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

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

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

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

(B) Prior to contracting with any health insurer, the Vermont health benefit exchange shall consider the insurer's historic rate increase information required under section 1806 of this title, along with the information and the recommendations provided to the Vermont health benefit exchange by the

commissioner of banking, insurance, securities, and health care administration under Section 2794(b)(1)(B) of the federal Public Health Service Act.

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

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

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

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

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

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

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

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

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

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

§ 1804. QUALIFIED EMPLOYERS

[Reserved.]

§ 1805. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

(5) Assigning a quality and wellness rating to each qualified health benefit plan offered through the Vermont health benefit exchange and

determining each qualified health benefit plan's level of coverage in accordance with regulations issued by the U.S. Department of Health and Human Services.

(6) Determining enrollee premiums and subsidies as required by the secretary of the U.S. Treasury or of the U.S. Department of Health and Human Services and informing consumers of eligibility for premiums and subsidies, including by providing an electronic calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the Affordable Care Act.

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

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

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

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

(A) Granting a certification attesting that an individual is exempt from the individual responsibility requirement or from the penalty for violating that requirement, if there is no affordable qualified health benefit plan available through the Vermont health benefit exchange or the individual's employer for that individual or if the individual meets the requirements for any exemption from the individual responsibility requirement or from the penalty pursuant to Section 5000A of the Internal Revenue Code of 1986; and

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

(9)(A) Transferring to the secretary of the U.S. Department of the Treasury the name and taxpayer identification number of each individual who notifies the Vermont health benefit exchange that he or she has changed

employers and of each individual who ceases coverage under a qualified health benefit plan during a plan year and the effective date of that cessation; and

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

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

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

(12) Consistent with federal law, crediting the amount of any free choice voucher provided pursuant to Section 10108 of the Affordable Care Act to the monthly premium of the plan in which a qualified employee is enrolled and collecting the amount credited from the offering employer.

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

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

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

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

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

(a) Prior to contracting with a health insurer to offer a qualified health benefit plan, the commissioner shall determine that making the plan available through the Vermont health benefit exchange is in the best interest of individuals and qualified employers in this state. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.

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

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

(B) Notwithstanding subdivision (1)(A) of this subsection, a health insurer or a stand-alone dental insurer, including a nonprofit dental service corporation, may offer a plan that provides only limited dental benefits, either separately or in conjunction with a qualified health benefit plan, if it meets the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code and provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act.

(2) At least the silver level of coverage as defined by Section 1302 of the Affordable Care Act and the cost-sharing limitations for individuals provided in Section 1302 of the Affordable Care Act, as well as any more restrictive cost-sharing requirements specified by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

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

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

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

(2) quality and wellness standards, including a requirement for joint quality improvement activities with other plans, as specified in rule by the secretary of human services, after consultation with the commissioners of

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

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

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

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

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

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

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

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

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

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

(2) A health insurer offering a qualified health benefit plan shall comply with all other insurance requirements for health insurers as provided in 8 V.S.A. chapter 107 and as specified by rule by the commissioner of banking, insurance, securities, and health care administration.

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

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

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

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

§ 1807. NAVIGATORS

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

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

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

(b) Navigators shall have the following duties:

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

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

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

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

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

(6) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRx, other public health benefit programs, or the Vermont health benefit exchange in order to ensure that all eligible individuals are enrolled.

§ 1808. FINANCIAL INTEGRITY

(a) The Vermont health benefit exchange shall:

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

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

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

§ 1809. PUBLICATION OF COSTS AND SATISFACTION SURVEYS

(a) The Vermont health benefit exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, as well as the administrative costs of the exchange on a website intended to educate consumers about such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(b) The Vermont health benefit exchange shall publish the deidentified results of the satisfaction surveys and other evaluation mechanisms required

pursuant to subdivision 1805(13) of this title on a website intended to enable consumers to compare the qualified health benefit plans offered through the exchange.

§ 1810. RULES

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

Subchapter 2. Green Mountain Care

§ 1821. PURPOSE

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

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

(2) establishing innovative payment mechanisms to health care professionals, such as global payments;

(3) encouraging the management of health services through the Blueprint for Health; and

(4) reducing unnecessary administrative expenditures.

§ 1822. IMPLEMENTATION; WAIVER

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

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

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

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

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

(5) A determination by the Green Mountain Care Board that each of the following conditions will be met:

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

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.

(C) The financing for Green Mountain Care is sustainable.

(D) Administrative expenses will be reduced.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.

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

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

§ 1823. DEFINITIONS

For purposes of this subchapter:

(1) "Agency" means the agency of human services.

(2) "Board" means the Green Mountain Care board established in 18 V.S.A. chapter 220.

(3) "CHIP funds" means federal funds available under Title XXI of the Social Security Act.

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

(5) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic

conditions, including significant patient self-care efforts, systemic supports for licensed health care practitioners and their patients, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

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

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

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

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

(10) “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, and shall include family planning, prenatal care, and mental health and substance abuse treatment.

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

(12) “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. An individual shall not be considered to be a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state.

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

§ 1824. ELIGIBILITY

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

(2)(A) Except as otherwise provided in subdivision (C) of this subdivision (2), if an individual is determined to be eligible for Green Mountain Care based on information later found to be false, the agency shall make reasonable efforts to recover from the individual the amounts expended for his or her care. In addition, if the individual knowingly provided the false information, he or she shall be assessed an administrative penalty of not more than \$5,000.00.

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

(C) An individual determined to be eligible for Green Mountain Care whose health services are paid in whole or in part by Medicaid funds who commits fraud shall be subject to the provisions of chapter 1, subchapter 5 of this title in lieu of the administrative penalty described in subdivision (A) of this subdivision (2).

(D) Nothing in this section shall be construed to limit or restrict prosecutions under any applicable provision of law.

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

(B) Except as otherwise provided in subdivision (C) of this subdivision (3), an individual covered under Green Mountain Care shall inform the agency within 60 days of becoming a resident of another state. An individual who obtains or attempts to obtain health services through Green Mountain Care more than 60 days after becoming a resident of another state shall reimburse the agency for the amounts expended for his or her care and shall be assessed an administrative penalty of not more than \$1,000.00 for a first violation and not more than \$2,000.00 for any subsequent violation.

(C) An individual whose health services are paid in whole or in part by Medicaid funds who obtains or attempts to obtain health services through Green Mountain Care more than 60 days after becoming a resident of another state shall be subject to the provisions of chapter 1, subchapter 5 of this title in

lieu of the administrative penalty described in subdivision (B) of this subdivision (3).

(D) Nothing in this section shall be construed to limit or restrict prosecutions under any applicable provision of law.

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

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

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

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

(d) The agency shall adopt rules pursuant to 3 V.S.A. chapter 25 to ensure that Vermont residents who are temporarily out of the state and who intend to return and reside in Vermont remain eligible for Green Mountain Care while outside Vermont.

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

§ 1825. HEALTH BENEFITS

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

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

(3) The Green Mountain Care board shall consider whether to impose cost-sharing requirements; if so, whether to make the cost-sharing requirements income-sensitized; and the impact of any cost-sharing requirements on an individual's ability to access care. The board shall consider waiving any cost-sharing requirement for evidence-based primary and preventive care; for palliative care; and for chronic care for individuals participating in chronic care management and, where circumstances warrant, for individuals with chronic conditions who are not participating in a chronic care management program.

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

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

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

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

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

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

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

(3) For individuals eligible for Medicare, the benefit package shall include the benefits provided to these individuals under federal law, as well as

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

§ 1826. BLUEPRINT FOR HEALTH

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

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

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

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

§ 1827. ADMINISTRATION; ENROLLMENT

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

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

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

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

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

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

(e) The agency shall seek permission from the Centers for Medicare and Medicaid Services to be the administrator for the Medicare program in Vermont. If the agency is unsuccessful in obtaining such permission, Green Mountain Care 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).

(f) Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by any other health benefit plan, including private health insurance, retiree health benefits, or federal health benefit plans offered by the Veterans' Administration, by the military, or to federal employees.

(g) The agency may seek a waiver under Section 1115 of the Social Security Act to include Medicaid and under Section 2107(e)(2)(A) of the Social Security Act to include CHIP in Green Mountain Care. If the agency is unsuccessful in obtaining one or both of these waivers, Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XIX of the Social Security Act (Medicaid) or Title XXI of the Social Security Act (CHIP), as applicable.

(h) Any prescription drug coverage offered by Green Mountain Care shall be consistent with the standards and procedures applicable to the pharmacy best practices and cost control program established in sections 1996 and 1998 of this title.

(i) Green Mountain Care shall maintain a robust and adequate network of health care professionals located in Vermont or regularly serving Vermont residents, including mental health and substance abuse professionals. The agency shall contract with outside entities as needed to allow for the appropriate portability of coverage under Green Mountain Care for Vermont residents who are temporarily out of the state.

(j) The agency shall make available the necessary information, forms, access to eligibility or enrollment systems, and billing procedures to health care professionals to ensure immediate enrollment for individuals in Green Mountain Care at the point of service or treatment.

(k) An individual aggrieved by an adverse decision of the agency or plan administrator may appeal to the human services board as provided in 3 V.S.A. § 3090.

(l) The agency, in collaboration with the department of banking, insurance, securities, and health care administration, shall monitor the extent to which residents of other states move to Vermont for the purpose of receiving health services and the impact, positive or negative, of any such migration on Vermont's health care system and on the state's economy, and make appropriate recommendations to the general assembly based on its findings.

§ 1828. BUDGET PROPOSAL

The Green Mountain Care board, in collaboration with the agencies of administration and of human services, shall be responsible for developing each year a three-year Green Mountain Care budget for proposal to the general assembly and to the governor, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

§ 1829. GREEN MOUNTAIN CARE FUND

(a) The Green Mountain Care fund is established in the state treasury as a special fund to be the single source to finance health care coverage for Green Mountain Care.

(b) Into the fund shall be deposited:

(1) transfers or appropriations from the general fund, authorized by the general assembly;

(2) if authorized by a waiver from federal law, federal funds for Medicaid, Medicare, and the Vermont health benefit exchange established in chapter 18, subchapter 1 of this title; and

(3) the proceeds from grants, donations, contributions, taxes, and any other sources of revenue as may be provided by statute or by rule.

(c) The fund shall be administered pursuant to 32 V.S.A. chapter 7, subchapter 5, except that interest earned on the fund and any remaining balance shall be retained in the fund. The agency 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:

(1) the administration and delivery of health services covered by Green Mountain Care as provided in this subchapter; and

(2) expenses related to the duties and operation of the Green Mountain Care board pursuant to 18 V.S.A. chapter 220.

§ 1830. COLLECTIVE BARGAINING RIGHTS

Nothing in this subchapter shall be construed to limit the ability of collective bargaining units to negotiate for coverage of health services pursuant to 3 V.S.A. § 904 or any other provision of law.

§ 1831. PUBLIC PROCESS

The agency of human services shall provide a process for soliciting public input on the Green Mountain Care benefit package on an ongoing basis, including a mechanism by which members of the public may request inclusion of particular benefits or services. The process may include receiving written comments on proposed new or amended rules or holding public hearings or both.

§ 1832. RULEMAKING

The secretary of human services may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this subchapter. When establishing rules relating to the Green Mountain Care benefit package, the secretary shall ensure that the rules are consistent with the benefit package defined by the Green Mountain Care board pursuant to section 1825 of this title and to 18 V.S.A. chapter 220.

Sec. 4a. HOUSEHOLD HEALTH INSURANCE SURVEY

The department of banking, insurance, securities, and health care administration shall include questions on its household health insurance survey that enable the department to determine the extent to which residents of other states move to Vermont for the purpose of receiving health services. The department shall provide its findings to the agency of human services to enable the agency to monitor migration into the state as required in 33 V.S.A. § 1827.

Sec. 4b. EXCHANGE IMPLEMENTATION

(a) The commissioner of Vermont health access shall make a reasonable effort to maintain contracts with at least two health insurers to provide qualified health benefit plans, in addition to the multistate plans required by the Affordable Care Act, in the Vermont health benefit exchange in 2014 if at least two health insurers are interested in participating and meet the requirements of 33 V.S.A. § 1806; provided that the commissioner shall not be required to solicit participation by insurers outside the state in order to contract with two insurers.

(b) Nothing in this section shall be construed to require the commissioner to contract with a health insurer to provide a plan that does not meet the requirements specified in 33 V.S.A. chapter 18, subchapter 1.

Sec. 4c. HEALTH COVERAGE FINDINGS AND STUDY

(a) The general assembly finds that:

(1) Federal law requires certain health care providers to provide emergency treatment to all individuals, regardless of immigration status.

(2) Federal law prohibits coverage of undocumented immigrants through Medicaid and through the Vermont health benefit exchange. Federal funds would not be available to cover undocumented immigrants through Green Mountain Care.

(3) Federal law requires that employers provide health insurance coverage for certain immigrants working seasonally in Vermont. Dairy workers, however, are not included in this category because they are year-round workers.

(4) Some employers of undocumented immigrants pay employment taxes for these workers, and these workers do not derive health care benefits from the government.

(b) No later than January 15, 2013, the Green Mountain Care board shall examine and report to the general assembly on:

(1) The potential costs of services provided to undocumented immigrants by health care professionals if these immigrants are not covered through Green Mountain Care, including any increased costs of care delayed due to the lack of coverage for primary care; and

(2) The potential costs of providing coverage for health services to undocumented immigrants through Green Mountain Care, including any state funds necessary to fund the services.

(c) The secretary of administration or designee shall work with Vermont's congressional delegation to:

(1) provide a mechanism for legal status under federal immigration law for nonseasonal farm workers; and

(2) clarify any impacts of covering or not covering undocumented immigrants through Green Mountain Care on the receipt of a waiver under section 1332 of the Affordable Care Act.

Sec. 5. 33 V.S.A. § 401 is amended to read:

§ 401. COMPOSITION OF DEPARTMENT

The department of Vermont health access, created under 3 V.S.A. § 3088, shall consist of the commissioner of Vermont health access, the medical director, a health care eligibility unit; and all divisions within the department, including the divisions of managed care; health care reform; the Vermont health benefit exchange; and Medicaid policy, fiscal, and support services.

Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY UNIT

After March 15, 2012 but not later than July 1, 2013, the secretary of administration shall transfer to and place under the supervision of the commissioner of Vermont health access all employees, professional and support staff, consultants, positions, and all balances of all appropriation amounts for personal services and operating expenses for the administration of health care eligibility currently contained in the department for children and families. No later than January 15, 2012, the secretary shall provide to the house committees on health care and on human services and the senate committee on health and welfare a plan for transferring the positions and funds.

** * * Consumer and Health Care Professional Advisory Committee * * **

Sec. 7. 33 V.S.A. § 402 is added to read:

§ 402. MEDICAID AND EXCHANGE ADVISORY COMMITTEE

(a) A Medicaid and exchange advisory committee is created for the purpose of advising the commissioner of Vermont health access with respect to policy development and program administration for the Vermont health benefit exchange, Medicaid, and Medicaid-funded programs, consistent with the requirements of federal law.

(b)(1) The commissioner of Vermont health access shall appoint members of the advisory committee established by this section, who shall serve staggered three-year terms. The total membership of the advisory committee shall be 22 members. The commissioner may remove members of the committee who fail to attend three consecutive meetings and may appoint replacements. The commissioner may reappoint members to serve more than one term.

(2)(A) The commissioner of Vermont health access shall appoint one representative of health insurers licensed to do business in Vermont to serve on the advisory committee. The commissioner of health shall also serve on the advisory committee.

(B) Of the remaining members of the advisory committee, one-quarter of the members shall be from each of the following constituencies:

(i) beneficiaries of Medicaid or Medicaid-funded programs.

(ii) individuals, self-employed individuals, and representatives of small businesses eligible for or enrolled in the Vermont health benefit exchange.

(iii) advocates for consumer organizations.

(iv) health care professionals and representatives from a broad range of health care professionals.

(3) Members whose participation is not supported through their employment or association shall receive per diem compensation pursuant to 32 V.S.A. § 1010 and reimbursement of travel expenses. In addition, members who are eligible for Medicaid or who are enrolled in a qualified health benefit plan in the Vermont health benefit exchange and whose income does not exceed 300 percent of the federal poverty level shall also receive reimbursement of expenses, including costs of child care, personal assistance services, and any other service necessary for participation in the advisory committee and approved by the commissioner.

(c)(1) The advisory committee shall have an opportunity to review and comment on agency policy initiatives pertaining to quality improvement initiatives and to health care benefits and eligibility for individuals receiving services through Medicaid, programs funded with Medicaid funds under a Section 1115 waiver, or the Vermont health benefit exchange. It also shall have the opportunity to comment on proposed rules prior to commencement of the rulemaking process pursuant to 3 V.S.A. chapter 25 and on waiver or waiver amendment applications prior to submission to the Centers for Medicare and Medicaid Services.

(2) Prior to the annual budget development process, the department of Vermont health access shall engage the advisory committee in setting priorities, including consideration of scope of benefits, beneficiary eligibility, health care professional reimbursement rates, funding outlook, financing options, and possible budget recommendations.

(d)(1) The advisory committee shall make policy recommendations on proposals of the department of Vermont health access to the department, the Green Mountain Care board, the health access oversight committee, the senate committee on health and welfare, and the house committees on health care and on human services. When the general assembly is not in session, the commissioner shall respond in writing to these recommendations, a copy of

which shall be provided to the members of each of the legislative committees of jurisdiction and to the Green Mountain Care board.

(2) During the legislative session, the commissioner shall provide the advisory committee at regularly scheduled meetings with updates on the status of policy and budget proposals.

(e) The commissioner shall convene the advisory committee at least 10 times during each calendar year. If at least one-third of the members of the advisory committee so choose, the members may convene up to four additional meetings per calendar year on their own initiative by sending a request to the commissioner. The department shall provide the committee with staffing and independent technical assistance as needed to enable it to make effective recommendations.

(f) A majority of the members of the committee shall constitute a quorum, and all action shall be taken upon a majority vote of the members present and voting.

Sec. 8. INTEGRATION PLAN

(a) No later than January 15, 2012, the secretary of administration or designee shall present a factual report and make recommendations to the house committee on health care and the senate committees on health and welfare and on finance on the following issues:

(1) How to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with the Vermont health benefit exchange and Green Mountain Care established in 33 V.S.A. chapter 18, including:

(A) Whether it is advisable to establish a basic health program for individuals with incomes above 133 percent of the federal poverty level (FPL) and at or below 200 percent of FPL pursuant to Section 1331 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended ("Affordable Care Act"), to ensure that the health coverage is comprehensive and affordable for this population.

(B)(i) The statutory changes necessary to integrate the private insurance markets with the Vermont health benefit exchange, including whether to impose a moratorium on the issuance of new association policies prior to 2014, as well as whether to continue exemptions for associations pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health benefit exchange and if so, what criteria to use.

(ii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, and for employees, of defining a small employer for purposes of the Vermont health benefit exchange for the period from January 1, 2014 through December 31, 2015 as an employer with up to 50 employees or as an employer with up to 100 employees, including an analysis of the impacts of the definition on teachers, municipal employees, and associations. For purposes of the analysis pursuant to this subdivision, "employer" means all for-profit entities, nonprofit entities, public entities, and individuals who are self-employed.

(iii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing qualified health benefit plans to be sold to individuals and small groups both inside and outside the Vermont health benefit exchange.

(iv) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing nonqualified health benefit plans that comply with the provisions of the Affordable Care Act to be sold to individuals and small groups outside the exchange.

(C) In consultation with the Green Mountain Care board, the design of a common benefit package for the Vermont health benefit exchange. When creating the common benefit package, the secretary shall compare the essential benefits package defined under federal regulations implementing the Affordable Care Act with Vermont's insurance mandates, consider the affordability of cost-sharing both with and without the cost-sharing subsidy provided under federal regulations implementing the Affordable Care Act, and determine the feasibility and appropriate design of cost-sharing amounts for evidence-based health services with proven effectiveness.

(D) The impact of the availability of supplemental insurance plans on offerings in the small and individual group markets.

(E) The potential for purchasing prescription drugs in Green Mountain Care through Medicaid, the 340B drug pricing program, or another bulk purchasing mechanism.

(2) Once Green Mountain Care is implemented, whether to allow employers and individuals to purchase coverage for supplemental health services from Green Mountain Care or to allow private insurers to provide supplemental insurance plans.

(3) How to enable parents to make coverage under Green Mountain Care available to an adult child up to age 26 who would not otherwise be

eligible for coverage under the program, including a recommendation on the amount of and mechanism for collecting a financial contribution for such coverage and information on the difference in costs to the system between allowing all adult children up to age 26 to be eligible and limiting eligibility to adult children attending a college or university.

(4) whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state's exposure to financial risk in the operation of Green Mountain Care; if so, how to accomplish such implementation; and the impact, if any, on the state's bond rating.

(5) How to fully align the administration of Medicaid, Medicare, Dr. Dynasaur, the Catamount Health premium assistance program, the Vermont health access program, and other public or private health benefit programs in order to simplify the administrative aspects of health care delivery. In his or her recommendations, the secretary or designee shall estimate the cost-savings associated with such administrative simplification and identify any federal waivers or other agreements needed to accomplish the purposes of this subdivision (5).

(b) The commissioner of labor, in consultation with the commissioner of Vermont health access, the commissioner of banking, insurance, securities, and health care administration, and interested stakeholders, shall evaluate the feasibility of integrating or aligning Vermont's workers' compensation system with Green Mountain Care, including providing any covered services in addition to those in the Green Mountain Care benefit package that may be appropriate for injuries arising out of and in the course of employment. No later than January 15, 2012, the commissioner of labor shall report the results of the evaluation and, if integration or alignment has been found to be feasible, make recommendations on how to achieve it.

(c) The commissioner of Vermont health access, in consultation with the commissioner of banking, insurance, securities, and health care administration; the commissioner of taxes; and the commissioner of motor vehicles shall review the requirements for maintaining minimum essential coverage under Section 1501 of the Affordable Care Act, including the enforcement mechanisms provided in that act. No later than January 15, 2012, the commissioner of Vermont health access shall recommend to the house committee on health care and the senate committees on finance and on health and welfare any additional enforcement mechanisms necessary to ensure that most, if not all, Vermonters will obtain sufficient health benefit coverage.

Sec. 9. FINANCING PLANS

(a) The secretary of administration or designee shall recommend two plans for sustainable financing to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance no later than January 15, 2013.

(1) One plan shall recommend the amounts and necessary mechanisms to finance any initiatives which must be implemented by January 1, 2014 in order to provide coverage to all Vermonters in the absence of a waiver from certain federal health care reform provisions established in Section 1332 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended (“Affordable Care Act”).

(2) The second plan shall recommend the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private universal health care system. The secretary shall recommend whether nonresidents employed by Vermont businesses should be eligible for Green Mountain Care and solutions to other cross-border issues.

(b) In developing both financing plans, the secretary shall consider the following:

(1) all financing sources, including adjustments to the income tax, a payroll tax, consumption taxes, provider assessments required under 33 V.S.A. chapter 19, the employer assessment required by 21 V.S.A. chapter 25, other new or existing taxes, and additional options as determined by the secretary;

(2) the impacts of the various financing sources, including levels of deductibility of any tax or assessment system contemplated and consistency with the principles of equity expressed in 18 V.S.A. § 9371;

(3) issues involving federal law and taxation;

(4) impacts of tax system changes:

(A) on individuals, households, businesses, public sector entities, and the nonprofit community, including the circumstances under which a particular tax change may result in the potential for double payments, such as premiums and tax obligations;

(B) over time, on changing revenue needs; and

(C) for a transitional period, while the tax system and health care cost structure are changing;

(5) growth in health care spending relative to needs and capacity to pay;

(6) anticipated federal funds that may be used for health services and how to maximize the amount of federal funding available for this purpose;

(7) the amounts required to maintain existing state insurance benefit requirements and other appropriate considerations in order to determine the state contribution toward federal premium tax credits available in the Vermont health benefit exchange pursuant to the Affordable Care Act;

(8) additional funds needed to support recruitment and retention programs for high-quality health care professionals in order to address the shortage of primary care professionals and other specialty care professionals in this state;

(9) additional funds needed to provide coverage for the uninsured who are eligible for Medicaid, Dr. Dynasaur, and the Vermont health benefit exchange in 2014;

(10) funding mechanisms to ensure that operations of both the Vermont health benefit exchange and Green Mountain Care are self-sustaining;

(11) how to maximize the flow of federal funds to the state for individuals eligible for Medicare, such as enrolling eligible individuals in Medicare and paying or supplementing the cost-sharing requirements on their behalf;

(12) the use of financial or other incentives to encourage healthy lifestyles and patient self-management for individuals enrolled in Green Mountain Care;

(13) preserving retirement health benefits while enabling retirees to participate in Green Mountain Care;

(14) the implications of Green Mountain Care on funds set aside to pay for future retiree health benefits; and

(15) changes in federal health funding through reduced payments to health care professionals or through limitations or restrictions on the availability of grant funding or federal matching funds available to states through the Medicaid program.

(c) In developing the financing plan for Green Mountain Care, the secretary of administration or designee shall consult with interested stakeholders, including health care professionals, employers, and members of the public, to determine the potential impact of various financing sources on Vermont businesses and on the state's economy and economic climate. No

later than February 1, 2012, the secretary or designee shall report his or her findings on the impact on businesses and the economy and any related recommendations to the house committees on health care and on commerce and to the senate committees on health and welfare, on finance and on economic development, housing and general affairs.

(d) In addition to the consultation required by subsection (c) of this section, in developing the financing plan for Green Mountain Care, the secretary of administration or designee shall solicit input from interested stakeholders, including health care professionals, employers, and members of the public and shall provide opportunities for public engagement in the design of the financing plan.

(e) The secretary of administration or designee shall consider strategies to address individuals who receive health coverage through the Veterans Administration, TRICARE, the Federal Employees Health Benefits Program, the government of a foreign nation, or from another federal governmental or foreign source.

Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

(a) The secretary of administration or designee, in consultation with the Green Mountain Care board and the commissioner of Vermont health access, shall review the health information technology plan required by 18 V.S.A. § 9351 to ensure that the plan reflects the creation of the Vermont health benefit exchange; the transition to a public-private universal health care system pursuant to 33 V.S.A. chapter 18, subchapter 2; and any necessary development or modifications to public health information technology and data and to public health surveillance systems, to ensure that there is progress toward full implementation.

(b) In conducting this review, the secretary of administration may issue a request for proposals for an independent design and implementation plan which would describe how to integrate existing health information systems to carry out the purposes of this act, detail how to develop the necessary capacity in health information systems, determine the funding needed for such development, and quantify the funding sources available for such development. The health information technology plan or design and implementation plan shall also include a review of the multi-payer database established in 18 V.S.A. § 9410 to determine whether there are systems modifications needed to use the database to reduce fraud, waste, and abuse; and shall include other systems analysis as specified by the secretary.

(c) The secretary shall make recommendations to the house committee on health care and the senate committee on health and welfare based on the design and implementation plan no later than January 15, 2012.

Sec. 11. HEALTH SYSTEM PLANNING, REGULATION, AND PUBLIC HEALTH

(a) No later than January 15, 2012, the secretary of administration or designee shall make recommendations to the house committee on health care and the senate committee on health and welfare on how to unify Vermont's current efforts around health system planning, regulation, and public health, including:

(1) How best to align the agency of human services' public health promotion activities with Medicaid, the Vermont health benefit exchange functions, Green Mountain Care, and activities of the Green Mountain Care board established in 18 V.S.A. chapter 220.

(2) After reviewing current resources, including the community health assessments, how to create an integrated system of community health assessments, health promotion, and planning, including by:

(A) improving the use and usefulness of the health resource allocation plan established in 18 V.S.A. § 9405 in order to ensure that health resource planning is effective and efficient; and

(B) recommending a plan to institute a public health impact assessment process to ensure appropriate consideration of the impacts on public health resulting from major policy or planning decisions made by municipalities, local entities, and state agencies.

(3) In collaboration with the director of the Blueprint for Health established in 18 V.S.A. chapter 13 and health care professionals, how to coordinate quality assurance efforts across state government and private payers; optimize quality assurance programs; and ensure that health care professionals in Vermont utilize, are informed of, and engage in evidence-based practice, using standards and algorithms such as those developed by the National Committee for Quality Assurance.

(4) How to reorganize and consolidate health care-related functions in agencies and departments across state government in order to ensure integrated and efficient administration of all of Vermont's health care programs and initiatives.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall review the hospital budget review process provided in 18 V.S.A. chapter 221, subchapter 7, and

the certificate of need process provided in 18 V.S.A. chapter 221, subchapter 5 and recommend to the house committee on health care and the senate committee on health and welfare statutory modifications needed to enable the participation of the Green Mountain Care board as set forth in 18 V.S.A. § 9375.

Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

No later than March 15, 2012, the Green Mountain Care board established in 18 V.S.A. chapter 220, in consultation with the commissioner of banking, insurance, securities, and health care administration and the commissioner of Vermont health access, shall recommend to the house committee on health care and the senate committee on health and welfare any necessary modifications to the regulatory processes for health care professionals and managed care organizations in order to align these processes with the payment reform strategic plan.

Sec. 12a. 18 V.S.A. chapter 222 is added to read:

CHAPTER 222. ACCESS TO HEALTH CARE PROFESSIONALS

§ 9491. HEALTH CARE WORKFORCE; STRATEGIC PLAN

(a) The director of health care reform in the agency of administration shall oversee the development of a current health care workforce development strategic plan that continues efforts to ensure that Vermont has the health care workforce necessary to provide care to all Vermont residents. The director of health care reform may designate an entity responsible for convening meetings and for preparing the draft strategic plan. The Green Mountain Care board established in chapter 220 of this title shall review the draft strategic plan and shall approve the final plan and any subsequent modifications.

(b) The director or designee shall collaborate with the area health education centers, the workforce development council established in 10 V.S.A. § 541, the prekindergarten-16 council established in 16 V.S.A. § 2905, the department of labor, the department of health, the department of Vermont health access and other interested parties, to develop and maintain the plan. The director of health care reform shall ensure that the strategic plan includes recommendations on how to develop Vermont's health care workforce, including:

(1) the current capacity and capacity issues of the health care workforce and delivery system in Vermont, including the shortages of health care professionals, specialty practice areas that regularly face shortages of qualified health care professionals, issues with geographic access to services, and unmet health care needs of Vermonters.

(2) the resources needed to ensure that the health care workforce and the delivery system are able to provide sufficient access to services given demographic factors in the population and in the workforce as well as other factors, and able to participate fully in health care reform initiatives, including how to ensure that all Vermont residents have a medical home through the Blueprint for Health pursuant to chapter 13 of this title and how to transition to electronic medical records.

(3) how state government, universities and colleges, the state's educational system, entities providing education and training programs related to the health care workforce, and others may develop the resources in the health care workforce and delivery system to educate, recruit, and retain health care professionals to achieve Vermont's health care reform principles and purposes.

(4) review data on the extent to which individual health care professionals begin and cease to practice in their applicable fields in Vermont.

(5) identify factors which either hinder or assist in recruitment or retention of health care professionals, including an examination of the processes for prior authorizations, and make recommendations for further improving recruitment and retention efforts.

(6) assess the availability of state and federal funds for health care workforce development.

(c) Beginning January 15, 2013, the director or designee shall provide the strategic plan approved by the Green Mountain Care board to the general assembly and shall provide periodic updates on modifications as necessary.

Sec. 13. WORKFORCE ISSUES

(a)(1) Currently, Vermont has a shortage of primary care professionals, and many practices are closed to new patients. It also experiences periodic and geographic shortages of specialty care professionals necessary to ensure that Vermonters have reasonable access to a broad range of health services within the state. In order to ensure sufficient patient access now and in the future, it is necessary to plan for the implementation of Green Mountain Care and utilize Vermont's health care professionals to the fullest extent of their professional competence.

(2) The board of nursing, the board of medical practice, and the office of professional regulation shall collaborate to determine how to optimize the primary care workforce by reviewing the licensure process, scope of practice requirements, reciprocity of licensure, and efficiency of the licensing process, and by identifying any other barriers to augmenting Vermont's primary care

workforce. No later than January 15, 2012, the boards and office shall provide to the house committee on health care and the senate committee on health and welfare joint recommendations for improving the primary care workforce through the boards' and office's rules and procedures, including specific recommendations to modify scopes of practice to enable health care professionals to perform to the fullest extent of their professional competence.

(b) The director of health care reform or designee, in collaboration with the department of labor, and the agency of human services, the prekindergarten-16 council established in 16 V.S.A. § 2905, the workforce development council, and other interested parties, shall create a plan to address the retraining needs of employees who may become dislocated due to a reduction in health care administrative functions when the Vermont health benefit exchange and Green Mountain Care are implemented. The plan shall include consideration of new training programs and scholarships or other financial assistance necessary to ensure adequate resources for training programs and to ensure that employees have access to these programs. The department and agency shall provide information to employers whose workforce may be reduced in order to ensure that the employees are informed of available training opportunities. The department shall provide the plan to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.

Sec. 13a. PRIOR AUTHORIZATIONS

The Green Mountain Care board shall consider:

(1) compensating health care providers for the completion of requests for prior authorization; and

(2) exempting from prior authorization requirements for specific services in Green Mountain Care those health care professionals whose prior authorization requests are routinely granted for those services.

* * * Cost Estimates * * *

Sec. 14. COST ESTIMATES; MEETINGS

(a) No later than April 21, 2011, the legislative joint fiscal office and the department of banking, insurance, securities, and health care administration shall provide to the house committee on health care and the senate committee on health and welfare an initial, draft estimate of the costs of Vermont's current health care system compared to the costs of a reformed health care system upon implementation of Green Mountain Care and the additional provisions of this act. To the extent possible, the estimates shall be based on the department of banking, insurance, securities, and health care

administration's expenditure report and additional data available in the multi-payer database established in 18 V.S.A. § 9410.

(b) The legislative joint fiscal office and the department of banking, insurance, securities, and health care administration shall report their final estimates of the costs described in subsection (a) of this section to the committees of jurisdiction no later than November 1, 2011.

(c) The house committee on health care and the senate committee on health and welfare may meet while the legislature is not in session to receive updates on reports and work in progress related to the provisions of this act. To the extent practicable, such meetings shall coincide with scheduled meetings of the joint fiscal committee.

* * * Rate Review * * *

Sec. 15. 8 V.S.A. § 4062 is amended to read:

§ 4062. *FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS*

(a)(1) No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates, and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, or in the case of a request for a rate increase, until a decision by the Green Mountain Care board as provided herein, unless the commissioner shall sooner give his or her written approval thereto. Prior to approving a rate increase, the commissioner shall seek approval for such rate increase from the Green Mountain Care board established in 18 V.S.A. chapter 220, which shall approve or disapprove the rate increase within 10 business days. The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board.

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this state. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20

days upon written request of the insurer. ~~In all other cases, the commissioner shall give his or her approval.~~

~~(3) After the expiration of such 30 days from the filing of any such form, premium rate or rule, the review period provided herein or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 ~~days~~ days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.~~

~~(b) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file a summary applicable to the cumulative rate increase. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, and any other information required by the commissioner. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.~~

~~(c)(1) The commissioner shall provide information to the public on the department's website about the public availability of the filings and summaries required under this section.~~

~~(2) Beginning no later than January 1, 2012, the commissioner shall post the filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the department's website within five days of filing. The department shall provide an electronic mechanism for the public to comment on proposed rate increases over five percent. The public shall have 21 days from the posting of the summaries and filings to provide public comment. The department shall review and consider the public comments prior to the expiration of the review period pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for their consideration in approving any rate increases.~~

(d)(1) The following provisions of this section shall not apply to policies for specific disease, accident, injury, hospital indemnity, dental care, disability income, or other limited benefit coverage, but shall apply to long-term care policies:

(A) the requirement in subdivision (a)(1) for the Green Mountain Care board's approval for any rate increase;

(B) the review standards in subdivision (a)(2) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and

(C) subsections (b) and (c) of this section.

(2) The exemptions from the provisions described in subdivisions (1)(A) through (C) of this subsection shall also apply to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred.

Sec. 15a. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate, or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 15b. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the commissioner for his or her approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the commissioner of a nonrefundable fee of \$50.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15c. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the commissioner of banking, insurance, securities, and health care administration under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by such commissioner. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the commissioner of a nonrefundable fee of \$50.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15d. 8 V.S.A. § 5104(a) is amended to read:

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The commissioner may request and shall receive any information that is needed to determine whether to approve the policy form or rate. In addition to any other information requested, the commissioner shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including but not limited to Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section 4062 of this title.

(2) The commissioner shall refuse to approve the form of evidence of coverage, filing or rate if it contains any provision which is unjust, unfair, inequitable, misleading or contrary to the law of the state or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

** * * Health Benefit Information * * **

Sec. 16. 21 V.S.A. § 2004 is added to read:

§ 2004. HEALTH BENEFIT COSTS

(a) Employers shall provide their employees with an annual statement indicating:

(1) the total monthly premium cost paid for any employer-sponsored health benefit plan;

(2) the employer's share and the employee's share of the total monthly premium; and

(3) any amount the employer contributes toward the employee's cost-sharing requirement or other out-of-pocket expenses.

(b) Notwithstanding the provisions of subsection (a) of this section, an employer who reports the cost of coverage under an employer-sponsored health benefit plan as required by 26 U.S.C. § 6051(a)(14) shall be deemed to be in full compliance with the requirements of this section.

Sec. 16a. 33 V.S.A. § 1901(g) is added to read:

(g) The department of Vermont health access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the state's share and the beneficiary's share of such cost.

** * * Consumer Protection * * **

Sec. 17. REVIEW OF BAN ON DISCRETIONARY CLAUSES

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting a National Association of Insurance Commissioners (NAIC) model act prohibiting insurers from using discretionary clauses in their health benefit contracts. The purpose of the NAIC model act is to prohibit insurance clauses that purport to reserve discretion to the insurer to interpret the terms of the policy, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare on the advantages and disadvantages of Vermont adopting the NAIC model act.

** * * Single Formulary * * **

Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

No later than January 15, 2012, the department of Vermont health access, after consultation with health insurers, third-party administrators, and the drug utilization and review board, shall provide recommendations to the house committee on health care and the senate committee on health and welfare regarding:

(1) A single prescription drug formulary to be used by all payers of health services which allows for some variations for Medicaid due to the availability of rebates and discounts and which allows health care professionals prescribing drugs purchased pursuant to Section 340B of the Public Health Service Act to use the 340B formulary. The recommendations shall address the feasibility of requesting a waiver from Medicare Part D in order to ensure Medicare participation in the formulary, as well as the feasibility of enabling all prescription drugs purchased by or on behalf of Vermont residents to be purchased through the Medicaid program or pursuant to the 340B drug pricing program.

(2) A single mechanism for negotiating rebates and discounts across payers using a single formulary, and the advantages and disadvantages of using a single formulary to achieve uniformity of coverage.

(3) A uniform set of drug management rules aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management. The standards for pharmacy benefit management shall address timely decisions, access to clinical peers, access to evidence-based rationales, exemption processes, and tracking and reporting data on prescriber satisfaction.

** * * Repeal of Public Oversight Commission * * **

Sec. 19. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

** * **

~~(15) “Public oversight commission” means the commission established in section 9407 of this title.~~

~~(16) “Unified health care budget” means the budget established in accordance with section 9406 of this title.~~

~~(17)~~(16) “State health plan” means the plan developed under section 9405 of this title.

Sec. 20. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION PLAN

* * *

(b) On or before July 1, 2005, the commissioner, in consultation with the secretary of human services, shall submit to the governor a four-year health resource allocation plan. The plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

* * *

(2) In the preparation of the plan, the commissioner shall assemble an advisory committee of no fewer than nine nor more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, payers, third-party payers, and consumer representatives, ~~and up to three members of the public oversight commission.~~ The advisory committee shall review drafts and provide recommendations to the commissioner during the development of the plan. Upon adoption of the plan, the advisory committee shall be dissolved.

(3) The commissioner, with the advisory committee, shall conduct at least five public hearings, in different regions of the state, on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the commissioner shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the commissioner shall publish in the manner prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place and period during which to direct written comments to the commissioner. In addition, the commissioner may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(4) The commissioner shall develop a mechanism for receiving ongoing public comment regarding the plan and for revising it every four years or as needed. ~~The public oversight commission shall recommend revisions to the plan at least every four years and at any other time it determines revisions are warranted.~~

* * *

Sec. 21. 18 V.S.A. § 9405a is amended to read:

§ 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

Each hospital shall have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Needs identified through the process shall be integrated with the hospital's long-term planning and shall be described as a component of its four-year capital expenditure projections provided to the public oversight commission under subdivision 9407(b)(2) of this title. The process shall be updated as necessary to continue to be consistent with such planning and capital expenditure projections, and identified needs shall be summarized in the hospital's community report.

Sec. 22. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The commissioner, in consultation with representatives from ~~the public oversight commission~~, hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules establishing a standard format for community reports, as well as the contents, which shall include:

** * **

(c) The community reports shall be provided to the ~~public oversight commission and the commissioner~~. The commissioner shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators.

Sec. 23. 18 V.S.A. § 9433(c) is amended to read:

(c) The commissioner shall consult with hospitals, nursing homes and professional associations and societies, ~~the public oversight commission~~, the secretary of human services, and other interested parties in matters of policy affecting the administration of this subchapter.

Sec. 24. 18 V.S.A. § 9440 is amended to read:

§ 9440. PROCEDURES

** * **

(c) The application process shall be as follows:

** * **

(4) Within 90 days of receipt of an application, the commissioner shall notify the applicant that the application contains all necessary information

required and is complete, or that the application review period is complete notwithstanding the absence of necessary information. The commissioner may extend the 90-day application review period for an additional 60 days, or for a period of time in excess of 150 days with the consent of the applicant. The time during which the applicant is responding to the commissioner's notice that additional information is required shall not be included within the maximum review period permitted under this subsection. The ~~public oversight commission may recommend, or the~~ commissioner may determine that the certificate of need application shall be denied if the applicant has failed to provide all necessary information required to review the application.

** * **

(d) The review process shall be as follows:

(1) The ~~public oversight commission~~ commissioner shall review:

(A) The application materials provided by the applicant.

(B) ~~The assessment of the applicant's materials provided by the department.~~

(C) Any information, evidence, or arguments raised by interested parties or amicus curiae, and any other public input.

(2) The ~~public oversight commission~~ department shall hold a public hearing during the course of a review.

(3) ~~The public oversight commission shall make a written findings and a recommendation to the commissioner in favor of or against each application. A record shall be maintained of all information reviewed in connection with each application.~~

(4) ~~A review shall be completed and the~~ The commissioner shall make a final decision within 120 days after the date of notification under subdivision (c)(4) of this section. Whenever it is not practicable to complete a review within 120 days, the commissioner may extend the review period up to an additional 30 days. Any review period may be extended with the written consent of the applicant and all other applicants in the case of a review cycle process.

(5)(4) After reviewing each application ~~and after considering the recommendations of the public oversight commission,~~ the commissioner shall make a decision either to issue or to deny the application for a certificate of need. The decision shall be in the form of an approval in whole or in part, or an approval subject to such conditions as the commissioner may impose in furtherance of the purposes of this subchapter, or a denial. In granting a

partial approval or a conditional approval the commissioner shall not mandate a new health care project not proposed by the applicant or mandate the deletion of any existing service. Any partial approval or conditional approval must be directly within the scope of the project proposed by the applicant and the criteria used in reviewing the application.

~~(6)(A)(5)~~ *If the commissioner proposes to render a final decision denying an application in whole or in part, or approving a contested application, the commissioner shall serve the parties with notice of a proposed decision containing proposed findings of fact and conclusions of law, and shall provide the parties an opportunity to file exceptions and present briefs and oral argument to the commissioner. The commissioner may also permit the parties to present additional evidence.*

~~(B) If the commissioner's proposed decision is contrary to the recommendation of the public oversight commission:~~

~~(i) the notice of proposed decision shall contain findings of fact and conclusions of law demonstrating that the commissioner fully considered all the findings and conclusions of the public oversight commission and explaining why his or her proposed decision is contrary to the recommendation of the public oversight commission and necessary to further the policies and purposes of this subchapter; and~~

~~(ii) the commissioner shall permit the parties to present additional evidence.~~

~~(7)(6)~~ *Notice of the final decision shall be sent to the applicant, competing applicants, and interested parties. The final decision shall include written findings and conclusions stating the basis of the decision.*

~~(8)(7)~~ *The commissioner shall establish rules governing the compilation of the record used by the public oversight commission and the commissioner in connection with decisions made on applications filed and certificates issued under this subchapter.*

(e) The commissioner shall adopt rules governing procedures for the expeditious processing of applications for replacement, repair, rebuilding, or reequipping of any part of a health care facility or health maintenance organization destroyed or damaged as the result of fire, storm, flood, act of God, or civil disturbance, or any other circumstances beyond the control of the applicant where the commissioner finds that the circumstances require action in less time than normally required for review. If the nature of the emergency requires it, an application under this subsection may be reviewed by the

commissioner only, without notice and opportunity for public hearing or intervention by any party.

(f) Any applicant, competing applicant, or interested party aggrieved by a final decision of the commissioner under this section may appeal the decision to the supreme court. ~~If the commissioner's decision is contrary to the recommendation of the public oversight commission, the standard of review on appeal shall require that the commissioner's decision be supported by a preponderance of the evidence in the record.~~

* * *

Sec. 25. 18 V.S.A. § 9440a is amended to read:

§ 9440a. APPLICATIONS, INFORMATION, AND TESTIMONY; OATH REQUIRED

(a) Each application filed under this subchapter, any written information required or permitted to be submitted in connection with an application or with the monitoring of an order, decision, or certificate issued by the commissioner, and any testimony taken before the ~~public oversight commission,~~ the commissioner, or a hearing officer appointed by the commissioner shall be submitted or taken under oath. The form and manner of the submission shall be prescribed by the commissioner. The authority granted to the commissioner under this section is in addition to any other authority granted to the commissioner under law.

(b) Each application shall be filed by the applicant's chief executive officer under oath, as provided by subsection (a) of this section. The commissioner may direct that information submitted with the application be submitted under oath by persons with personal knowledge of such information.

(c) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

Sec. 25a. 18 V.S.A. § 9456(h) is amended to read:

(h)(1) If a hospital violates a provision of this section, the commissioner may maintain an action in the superior court of the county in which the hospital is located to enjoin, restrain or prevent such violation.

* * *

(3)(A) *The commissioner shall require the officers and directors of a hospital to file under oath, on a form and in a manner prescribed by the commissioner, any information designated by the commissioner and required pursuant to this subchapter. The authority granted to the commissioner under this subsection is in addition to any other authority granted to the commissioner under law.*

(B) *A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner ~~or to the public oversight commission~~ or to a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.*

** * * Conforming Revisions * * **

Sec. 26. 18 V.S.A. § 5 is amended to read:

§ 5. DUTIES OF DEPARTMENT OF HEALTH

The department of health is hereby designated as the sole state agency for the purposes of shall:

(1) ~~Conducting~~ Conduct studies, ~~developing~~ develop state plans, and ~~administering~~ administer programs and state plans for hospital survey and construction, hospital operation and maintenance, medical care, and treatment of alcoholics and alcoholic rehabilitation substance abuse.

(2) ~~Providing~~ Provide methods of administration and such other action as may be necessary to comply with the requirements of federal acts and regulations as relate to studies, ~~developing~~ development of plans and ~~administering~~ administration of programs in the fields of health, public health, health education, hospital construction and maintenance, and medical care.

(3) ~~Appointing~~ Appoint advisory councils, with the approval of the governor.

(4) ~~Cooperating~~ Cooperate with necessary federal agencies in securing federal funds ~~now or which may hereafter~~ become available to the state for all prevention, public health, wellness, and medical programs.

(5) Seek accreditation through the Public Health Accreditation Board.

(6) Create a state health improvement plan and facilitate local health improvement plans in order to encourage the design of healthy communities and to promote policy initiatives that contribute to community, school, and workplace wellness, which may include providing assistance to employers for

wellness program grants, encouraging employers to promote employee engagement in healthy behaviors, and encouraging the appropriate use of the health care system.

Sec. 27. 18 V.S.A. § 9410(a)(1) is amended to read:

(a)(1) The commissioner shall establish and maintain a unified health care data base to enable the commissioner and the Green Mountain Care board to carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) Determining the capacity and distribution of existing resources.

(B) Identifying health care needs and informing health care policy.

(C) Evaluating the effectiveness of intervention programs on improving patient outcomes.

(D) Comparing costs between various treatment settings and approaches.

(E) Providing information to consumers and purchasers of health care.

(F) Improving the quality and affordability of patient health care and health care coverage.

Sec. 28. Sec. 10 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 10. IMPLEMENTATION OF CERTAIN FEDERAL HEALTH CARE REFORM PROVISIONS

(a) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of health shall undertake such planning steps and other actions as are necessary to secure grants and other beneficial opportunities for Vermont provided by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

(b) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of Vermont health access shall undertake such planning steps as are necessary to ensure Vermont's participation in beneficial opportunities created by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

Sec. 29. Sec. 31(d) of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

(d) Term of committee. The committee shall cease to exist on ~~January 31, 2011~~ June 30, 2011.

Sec. 30. Sec. 14 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 14. PAYMENT REFORM; PILOTS

** * **

(4)(A) No later than February 1, 2011, the director of payment reform shall provide a strategic plan for the pilot projects to the house committee on health care and the senate committee on health and welfare. The strategic plan shall provide:

(i)(A) A description of the proposed payment reform pilot projects, including a description of the possible organizational model or models for health care providers or professionals to coordinate patient care, a detailed design of the financial model or models, and an estimate of savings to the health care system from cost reductions due to reduced administration, from a reduction in health care inflation, or from other sources.

(ii)(B) An ongoing program evaluation and improvement protocol.

(iii)(C) An implementation time line for pilot projects, with the first project to become operational no later than January 1, 2012, and with two or more additional pilot projects to become operational no later than July 1, 2012.

~~(B) The director shall not implement the pilot projects until the strategic plan has been approved or modified by the general assembly.~~

*Sec. 31. GREEN MOUNTAIN CARE BOARD NOMINATIONS;
APPOINTMENTS*

(a) Notwithstanding the provisions of 18 V.S.A. § 9390(b)(2), no later than June 1, 2011, the governor, the speaker of the house of representatives, and the president pro tempore of the senate shall appoint the members of the Green Mountain Care board nominating committee. The members shall serve until their replacements are appointed pursuant to 18 V.S.A. § 9390 between January 1, 2013 and February 1, 2013.

(b) The governor shall appoint the members of the Green Mountain Care board pursuant to the process set forth in 18 V.S.A. chapter 220, subchapter 2, to begin employment no earlier than October 1, 2011. In making the initial appointments to the board, the governor shall ensure that the skills and qualifications of the board members complement those of the other members of the board.

Sec. 32. REPEAL

(a) 33 V.S.A. § 1901c (Medical care advisory committee) is repealed effective July 1, 2012.

(b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective July 1, 2011.

Sec. 33. APPROPRIATIONS

(a) In fiscal year 2012, the sum of \$703,693.00 in general funds and \$321,231.00 in federal funds is appropriated to the Green Mountain Care board to carry out its functions.

(b) In fiscal year 2012, the sum of \$25,000.00 is appropriated from the general fund to the secretary of administration for the medical malpractice proposal pursuant to Sec. 2(e) of this act.

(c) In fiscal year 2012, the sum of \$138,000.00 is appropriated from the general fund to the agency of administration for salary and benefits for the director of health care reform.

Sec. 33a. COMPENSATION

For fiscal year 2012, the salary for the chair of the Green Mountain Care board shall be \$116,688.00.

Sec. 34. EFFECTIVE DATES

(a) Secs. 1 (intent), 1a (principles), and 2 (strategic plan); 3 (18 V.S.A. chapter 220, subchapter 2 (Green Mountain Care board nominating committee); 8 (integration plan), and 9 (financing plans); 10 (HIT); 11 (health planning); 12 (regulatory process); 13 (workforce); 14 (cost estimates); 17 (discretionary clauses); 18 (single formulary); 26 (department of health); 28 (ACA grants); 29 (primary care workforce committee); 30 (approval of pilot projects); and 31 (initial Green Mountain Care board nominating committee appointments) of this act and this section shall take effect on passage.

(b) Sec. 1b (agency of administration), and Secs. 3, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Care board), 3a (health care ombudsman), 3b (positions), 3c (payment reform), 3d and 3e (manufacturers of prescribed products), 4c (health care coverage study), 5 (DVHA), 6 (health care eligibility), 12a (health care workforce strategic plan); 13a (prior authorizations), 19–25a and 32 (repeal of public oversight commission), 33 (appropriations), and 33a (compensation) shall take effect on July 1, 2011.

(c)(1) Secs. 4 (Vermont health benefit exchange; Green Mountain Care), 4a (household health insurance survey), and 4b (exchange implementation) shall take effect on July 1, 2011.

(2) The Vermont health benefit exchange shall begin enrolling individuals no later than November 1, 2013 and shall be fully operational no later than January 1, 2014.

(3) Green Mountain Care shall be implemented as set forth in 33 V.S.A. § 1822.

(d) Sec. 7, 3 V.S.A. § 402 (Medicaid and exchange advisory board), shall take effect on July 1, 2012.

(e) Secs. 15-15d (rate review) shall take effect on January 1, 2012 and shall apply to all filings on and after January 1, 2012.

(f) Sec. 27 (VHCURES) shall take effect on October 1, 2011.

(g) Secs. 16 (health benefit information) and 16a (Medicaid program costs) shall take effect on January 1, 2012, and the reporting requirement shall apply to each calendar year, beginning with 2012.