

(H.444)

An act relating to health care reform.

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

* * * Implementing Health Care Provisions of the American Recovery and
Reinvestment Act * * *

Sec. 1. 18 V.S.A. chapter 219 is added to read:

CHAPTER 219. HEALTH INFORMATION TECHNOLOGY

§ 9351. HEALTH INFORMATION TECHNOLOGY PLAN

(a) The secretary of administration or designee shall be responsible for the overall coordination of Vermont's statewide health information technology plan. The secretary or designee shall administer and update the plan as needed, which shall include the implementation of an integrated electronic health information infrastructure for the sharing of electronic health information among health care facilities, health care professionals, public and private payers, and patients. The plan shall include standards and protocols designed to promote patient education, patient privacy, physician best practices, electronic connectivity to health care data, and, overall, a more efficient and less costly means of delivering quality health care in Vermont.

(b) The health information technology plan shall:

(1) support the effective, efficient, statewide use of electronic health information in patient care, health care policymaking, clinical research, health care financing, and continuous quality improvements;

(2) educate the general public and health care professionals about the value of an electronic health infrastructure for improving patient care;

(3) ensure the use of national standards for the development of an interoperable system, which shall include provisions relating to security, privacy, data content, structures and format, vocabulary, and transmission protocols;

(4) propose strategic investments in equipment and other infrastructure elements that will facilitate the ongoing development of a statewide infrastructure;

(5) recommend funding mechanisms for the ongoing development and maintenance costs of a statewide health information system, including funding options and an implementation strategy for a loan and grant program;

(6) incorporate the existing health care information technology initiatives to the extent feasible in order to avoid incompatible systems and duplicative efforts;

(7) integrate the information technology components of the Blueprint for Health established in chapter 13 of this title, the agency of human services' enterprise master patient index, and all other Medicaid management

information systems being developed by the office of Vermont health access, information technology components of the quality assurance system, the program to capitalize with loans and grants electronic medical record systems in primary care practices, and any other information technology initiatives coordinated by the secretary of administration pursuant to section 2222a of Title 3; and

(8) address issues related to data ownership, governance, and confidentiality and security of patient information.

(c) The secretary of administration or designee shall update the plan annually to reflect emerging technologies, the state's changing needs, and such other areas as the secretary or designee deems appropriate. The secretary or designee shall solicit recommendations from Vermont Information Technology Leaders, Inc. (VITL) and other entities in order to update the health information technology plan pursuant to this section, including applicable standards, protocols, and pilot programs, and may enter into a contract or grant agreement with VITL or other entities to update some or all of the plan. Upon approval by the secretary, the updated plan shall be distributed to the commission on health care reform; the commissioner of information and innovation; the commissioner of banking, insurance, securities, and health care administration; the director of the office of Vermont health access; the secretary of human services; the commissioner of health; the commissioner of

mental health; the commissioner of disabilities, aging, and independent living; the senate committee on health and welfare; the house committee on health care; affected parties; and interested stakeholders.

(d) The health information technology plan shall serve as the framework within which the commissioner of banking, insurance, securities, and health care administration reviews certificate of need applications for information technology under section 9440b of this title. In addition, the commissioner of information and innovation shall use the health information technology plan as the basis for independent review of state information technology procurements.

(e) The privacy standards and protocols developed in the statewide health information technology plan shall be no less stringent than applicable federal and state guidelines, including the “Standards for Privacy of Individually Identifiable Health Information” established under the Health Insurance Portability and Accountability Act of 1996 and contained in 45 C.F.R., Parts 160 and 164, and any subsequent amendments, and the privacy provisions established under Subtitle D of Title XIII of Division A of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, sections 13400 et seq. The standards and protocols shall require that access to individually identifiable health information is secure and traceable by an electronic audit trail.

(f) Qualified applicants may seek grants to invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information from federal agencies, including the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the U.S. Department of Agriculture, and the Federal Communications Commission. The secretary of administration or designee shall require applicants for grants authorized pursuant to Section 13301 of Title XXX of Division A of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, to submit the application for state review pursuant to the process established in federal Executive Order 12372, Intergovernmental Review of Federal Programs. Grant applications shall be consistent with the goals outlined in the strategic plan developed by the Office of the National Coordinator for Health Information Technology and the statewide health information technology plan.

§ 9352. VERMONT INFORMATION TECHNOLOGY LEADERS

(a) Governance. The general assembly and the governor shall each appoint one representative to the Vermont Information Technology Leaders, Inc. (VITL) board of directors.

(b) Conflict of interest. In carrying out their responsibilities under this section, directors of VITL shall be subject to conflict of interest policies established by the secretary of administration to ensure that deliberations and decisions are fair and equitable.

(c) Health information exchange operation. VITL shall be designated in the health information technology plan pursuant to section 9351 of this title to operate the exclusive statewide health information exchange network for this state. Nothing in this chapter shall impede local community providers from the exchange of electronic medical data.

(d) Privacy. The standards and protocols implemented by VITL shall be consistent with those adopted by the statewide health information technology plan pursuant to subsection 9351(e) of this title.

(e) Report. No later than January 15 of each year, VITL shall file a report with the commission on health care reform; the secretary of administration; the commissioner of information and innovation; the commissioner of banking, insurance, securities, and health care administration; the director of the office of Vermont health access; the secretary of human services; the commissioner of health; the commissioner of mental health; the commissioner of disabilities, aging, and independent living; the senate committee on health and welfare; and the house committee on health care. The report shall include an assessment of progress in implementing health information technology in Vermont and

recommendations for additional funding and legislation required. In addition, VITL shall publish minutes of VITL meetings and any other relevant information on a public website.

(f) Funding authorization. VITL is authorized to seek matching funds to assist with carrying out the purposes of this section. In addition, it may accept any and all donations, gifts, and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof, and from any person, firm, foundation, or corporation for any of its purposes and functions under this section and may receive and use the same, subject to the terms, conditions, and regulations governing such donations, gifts, and grants.

(g) Waivers. The secretary of administration or designee, in consultation with VITL, may seek any waivers of federal law, of rule, or of regulation that might assist with implementation of this section.

(h) Loan and grant programs. VITL shall solicit recommendations from the secretary of administration or designee, health insurers, the Vermont Association of Hospitals & Health Systems, Inc., the Vermont Medical Society, Bi-State Primary Care Association, the Council of Developmental and Mental Health Services, the Behavioral Health Network, the Vermont Health Care Association, the Vermont Assembly of Home Health Agencies, other health professional associations, and appropriate departments and agencies of

state government, in establishing a financing program, including loans and grants, to provide electronic health records systems to providers, with priority given to Blueprint communities and primary care practices serving low income Vermonters. Health information technology systems acquired under a grant or loan authorized by this section shall comply with data standards for interoperability adopted by VITL and the state health information technology plan. An implementation plan for this loan and grant program shall be incorporated into the state health information technology plan.

(i) Certification of meaningful use. To the extent necessary or required by federal law, VITL shall be authorized to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont.

(j) Scope of activities. VITL and any person who serves as a member, director, officer, or employee of VITL with or without compensation shall not be considered a health care provider as defined in subdivision 9432(8) of this title for purposes of any action taken in good faith pursuant to or in reliance upon provisions of this section relating to VITL's:

(1) Governance;

(2) Electronic exchange of health information and operation of the statewide health information exchange network as long as nothing in such

exchange or operation constitutes the practice of medicine pursuant to chapter 23 or 33 of Title 26;

(3) Implementation of privacy provisions;

(4) Funding authority;

(5) Application for waivers of federal law;

(6) Establishment and operation of a financing program providing electronic health records systems to providers; or

(7) Certification of health care providers' meaningful use of health information technology.

Sec. 2. 3 V.S.A. § 2222a(c) is amended to read:

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

* * *

(2) The Vermont health information technology project pursuant to ~~section 903 of Title 22~~ chapter 219 of Title 18.

Sec. 3. 18 V.S.A. § 9410(h)(3)(C) is amended to read:

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the commissioner may prescribe by regulation, ~~the Vermont information technology leaders (VITL) shall have access to the database for use in the development of a statewide health information technology plan pursuant to section 903 of Title 22, and the Vermont program for quality in health care shall have access to the~~ unified health care database for use in

improving the quality of health care services in Vermont. In using the database, the Vermont program for quality in health care shall agree to abide by the rules and procedures established by the commissioner for access to the data. The commissioner's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

Sec. 4. 18 V.S.A. § 9416 is amended to read:

§ 9416. VERMONT PROGRAM FOR QUALITY IN HEALTH CARE

(a) The commissioner shall contract with the Vermont Program for Quality in Health Care, Inc. to implement and maintain a statewide quality assurance system to evaluate and improve the quality of health care services rendered by health care providers of health care facilities, including managed care organizations, to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care, and that the cost of health care rendered was considered reasonable by the providers of professional health services in that area. The commissioner shall ensure that the information technology components of the quality assurance system are incorporated into and comply with the statewide health information technology plan developed under section ~~903 of Title 22~~ 9351 of this title and any other information technology initiatives coordinated by the secretary of administration pursuant to section 2222a of Title 3.

* * *

Sec. 5. 18 V.S.A. § 9437 is amended to read:

§ 9437. CRITERIA

A certificate of need shall be granted if the applicant demonstrates and the commissioner finds that:

* * *

(7) if the application is for the purchase or lease of new health care information technology, it conforms with the health information technology plan established under ~~section 903 of Title 22, upon approval of the plan by the general assembly~~ section 9351 of this title.

Sec. 6. 18 V.S.A. § 9440b is amended to read:

§ 9440b. INFORMATION TECHNOLOGY; REVIEW PROCEDURES

Notwithstanding the procedures in section 9440 of this title, upon approval by the general assembly of the health information technology plan developed under ~~section 903 of Title 22~~ section 9351 of this title, the commissioner shall establish by rule standards and expedited procedures for reviewing applications for the purchase or lease of health care information technology that otherwise would be subject to review under this subchapter. Such applications may not be granted or approved unless they are consistent with the health information technology plan and the health resource allocation plan. The commissioner's rules may include a provision requiring that applications be reviewed by the health information advisory group authorized under ~~section 903 of Title 22~~

9352 of this title. The advisory group shall make written findings and a recommendation to the commissioner in favor of or against each application.

Sec. 7. REPEAL

22 V.S.A. § 903 (health information technology) is repealed.

Sec. 8. HEALTH INFORMATION TECHNOLOGY PLANNING AND
IMPLEMENTATION GRANTS

(a) The secretary of administration or designee shall apply to the Secretary of Health and Human Services for an implementation grant to facilitate and expand the electronic movement and use of health information among organizations according to nationally recognized standards and implementation specifications. As part of the grant application, the secretary or designee shall submit a plan, which may include some or all of the elements of the plan administered by the secretary or designee pursuant to section 9351 of Title 18, and which shall:

(1) Be pursued in the public interest;

(2) Be consistent with the strategic plan developed by the National Coordinator of Health Information Technology;

(3) Include a description of the ways in which the state will carry out the activities described in the application for the planning grant under subsection

(c) of this section; and

(4) Contain such elements as the Secretary of Health and Human Services may require.

(b) Funds received pursuant to an implementation grant under subsection (a) of this section shall be used to conduct activities, including:

(1) Enhancing broad and varied participation in the authorized and secure nationwide electronic use and exchange of health information;

(2) Identifying state or local resources available toward a nationwide effort to promote health information technology;

(3) Complementing other federal grants, programs, and efforts toward the promotion of health information technology;

(4) Providing technical assistance for the development and dissemination of solutions to barriers to the exchange of electronic health information;

(5) Promoting effective strategies to adopt and utilize health information technology in medically underserved areas;

(6) Assisting patients in utilizing health information technology;

(7) Providing education and technical assistance in the use of health information technology to clinicians and key practice support staff and encouraging clinicians to work with federally designated Health Information Technology Regional Extension Centers, to the extent that they are available and valuable;

(8) Supporting public health and human service agencies' authorized use of and access to electronic health information;

(9) Promoting the use of electronic health records for quality improvement, including through quality measures reporting; and

(10) Such other activities as the Secretary of Health and Human Services or the National Coordinator of Health Information Technology may specify.

(c) The secretary of administration or designee shall apply to the Secretary of Health and Human Services, through the Office of the National Coordinator for Health Information Technology, for a grant to plan the activities described in subsection (b) of this section.

(d) In carrying out the activities funded by the planning and implementation grants, the state shall consult with and consider the recommendations of:

(1) Health care and human service providers, including those who provide services to low income and underserved populations;

(2) Health insurers;

(3) Patient or consumer organizations that represent the population to be served;

(4) Health information technology vendors;

(5) Health care purchasers and employers;

(6) All relevant state agencies, including the department of banking, insurance, securities, and health care administration; the department of information and innovation; and the agency of human services;

(7) Health profession schools, universities, and colleges;

(8) Clinical researchers;

(9) Other users of health information technology, such as health care providers' support and clerical staff and others involved in patient care and care coordination; and

(10) Such other entities as the Secretary of Health and Human Services determines appropriate.

(e) The secretary of administration or designee shall agree, as part of the grant application, to make available from the health IT-fund established under section 10301 of Title 32 nonfederal contributions, including in-kind contributions if appropriate, toward the costs of the implementation grant in an amount equal to:

(1) For fiscal year 2011, not less than \$1.00 for each \$10.00 of federal funds provided under the grant;

(2) For fiscal year 2012, not less than \$1.00 for each \$7.00 of federal funds provided under the grant;

(3) For fiscal year 2013 and each subsequent fiscal year, not less than \$1.00 for each \$3.00 of federal funds provided under the grant; and

(4) Before fiscal year 2011, such amounts, if any, as the Secretary of Human Services may determine to be required for receipt of federal funds under the grant.

Sec. 9. 32 V.S.A. § 10301 is amended to read:

§ 10301. HEALTH IT-FUND

(a) The Vermont health IT-fund is established in the state treasury as a special fund to be a source of funding for medical health care information technology programs and initiatives such as those outlined in the Vermont health information technology plan administered by the ~~Vermont Information Technology Leaders (VITL)~~ secretary of administration or designee. One hundred percent of the fund shall be disbursed for the advancement of health information technology adoption and utilization in Vermont as appropriated by the general assembly, less any disbursements relating to the administration of the fund. The fund shall be used for loans and grants to health care providers pursuant to section 10302 of this chapter and for the development of programs and initiatives sponsored by VITL and state entities designed to promote and improve health care information technology, including:

(1) a program to provide electronic health information systems and practice management systems for ~~primary~~ health care and human service practitioners in Vermont;

(2) financial support for VITL to build and operate the health information exchange network;

(3) implementation of the Blueprint for Health information technology initiatives, related public and mental health initiatives, and the advanced medical home and community care team project; and

(4) consulting services for installation, integration, and clinical process re-engineering relating to the utilization of healthcare information technology such as electronic ~~medical~~ health records.

* * *

Sec. 10. 32 V.S.A. § 10302 is added to read:

§ 10302. CERTIFIED ELECTRONIC HEALTH RECORD TECHNOLOGY
LOAN FUND

(a) Subject to the requirements set forth in subsection (d) of this section, the secretary of administration or designee shall establish a certified electronic health record technology loan fund (“loan fund”) within the health IT-fund for the purpose of receiving and disbursing funds from the Office of the National Coordinator of Health Information Technology for the loan program described in subsection (b) of this subsection.

(b) The secretary of administration or designee may apply to the Office of the National Coordinator of Health Information Technology for a grant to establish a loan program for health care providers to:

(1) facilitate the purchase of electronic health record technology;

(2) enhance the utilization of certified electronic health record technology, including costs associated with upgrading health information technology so that it meets criteria necessary to be a certified electronic health record technology;

(3) train personnel in the use of electronic health record technology; or

(4) improve the secure electronic exchange of health information.

(c) In addition to the application required by the National Coordinator, the secretary or designee shall also submit to the National Coordinator a strategic plan identifying the intended uses of the amounts available in the loan fund for a period of one year, including:

(1) a list of the projects to be assisted through the loan fund during such year;

(2) a description of the criteria and methods established for the distribution of funds from the loan fund during the year;

(3) a description of the financial status of the loan fund as of the date of the submission of the plan; and

(4) the short-term and long-term goals of the loan fund.

(d) Amounts deposited in the loan fund, including loan repayments and interest earned on such amounts, shall be used only as follows:

(1) to award loans that comply with the following:

(A) the interest rate for each loan shall not exceed the market interest rate;

(B) the principal and interest payments on each loan shall commence no later than one year after the date the loan was awarded, and each loan shall be fully amortized no later than 10 years after the date of the loan; and

(C) the loan fund shall be credited with all payments of principal and interest on each loan awarded from the loan fund;

(2) to guarantee, or purchase insurance for, a local obligation, all of the proceeds of which finance a project eligible for assistance under this subsection, if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved;

(3) as a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the state if the proceeds of the sale of the bonds will be deposited into the loan fund;

(4) to earn interest on the amounts deposited into the loan fund; and

(5) to make reimbursements described in subdivision (f)(1) of this section.

(e) The secretary of administration or designee may use annually no more than four percent of the grant funds to pay the reasonable costs of administering the loan programs pursuant to this section, including recovery of reasonable costs expended to establish the loan fund.

(f)(1) The loan fund may accept contributions from private sector entities, except that such entities may not specify the recipient or recipients of any loan issued under this subsection. The secretary or designee may agree to reimburse a private sector entity for any contribution to loan fund, provided that the amount of the reimbursement may not exceed the principal amount of the contribution made.

(2) The secretary or designee shall make publicly available the identity of, and amount contributed by, any private sector entity and may issue to the entity letters of commendation or make other awards, provided such awards are of no financial value.

(g) The secretary of administration or designee shall agree, as part of the grant application, to make available from the health IT-fund established under section 10301 of Title 32 nonfederal cash contributions, including donations from public or private entities, toward the costs of the loan program in an amount equal to at least \$1.00 for every \$5.00 of federal funds provided under the grant.

Sec. 11. LOANS TO DEVELOP CERTIFIED ELECTRONIC HEALTH
RECORD PROGRAMS

The secretary of administration or designee may contract with the Vermont Information Technology Leaders, Inc. or another entity to develop and administer a program making available to health care providers in this state

low- or no-interest loans to pay the provider's up-front costs for implementing certified electronic health record programs, which loans shall be repaid upon the provider's receipt of federal Medicare or Medicaid incentive payments for adoption and meaningful use of certified electronic health record technology.

Sec. 12. INFORMATION TECHNOLOGY PROFESSIONALS IN HEALTH
CARE GRANTS

The secretary of administration or designee shall convene a group of stakeholders representing the institutions of higher education in this state to evaluate federal grant opportunities available to establish or expand medical health informatics education programs for health care and information technology students to ensure the rapid and effective utilization of health information technologies. No later than November 15, 2009, the secretary or designee shall report to the commission on health care reform regarding the group's recommendations for maximizing the flow of federal funds into the state related to establishing or expanding medical health informatics education programs and its timeline for the anticipated activities of each institution of higher education relative to securing the federal funds.

Sec. 13. AUTHORIZATION TO SEEK FEDERAL FUNDS

The secretary of human services or designee may apply to the Secretary of Health and Human Services or other applicable agency for federal funds to enable Vermont to pursue its goals with respect to modernization and upgrades

of information technology and health information technology systems,
coordination of health information exchange, public health and other human
service prevention and wellness programs, and the Blueprint for Health.

* * * Continuation of Group Insurance (VIPER) * * *

Sec. 14. 8 V.S.A. § 4090a is amended to read:

§ 4090a. CONTINUATION OF GROUP

(a) All group health insurance policies, including dental policies, issued by an insurance company; or a nonprofit hospital or medical service corporation; a self-insured group ~~plan~~ plans; and prepaid health insurance plans, delivered or issued for delivery in this state, which insure employees or members for dental insurance or hospital and medical insurance on an expense incurred, service basis, or prepaid basis, other than for policies covering specific diseases or for accidental injuries only, shall provide that any person whose insurance under the group policy would terminate because of the ~~termination of employment, divorce or legal separation of the covered employee from the employee's spouse, a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy, or the death of the covered employee or member~~ occurrence of a qualifying event as defined in subsection (b) of this section shall be entitled to continue ~~their hospital and medical~~ his or her health insurance under that group policy.

(b) For purposes of this subchapter, “qualifying event” means:

(1) loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage;

(2) divorce, dissolution, or legal separation of the covered employee from the employee’s spouse or civil union partner;

(3) a dependent child ceasing to qualify as a dependent child under the generally applicable requirements of the policy; or

(4) death of the covered employee or member.

(c) The provisions of this section shall not apply if:

(1) The deceased person or ~~terminated~~ employee was not insured under the group policy ~~during the entire three months’ period preceding termination~~ on the date of the qualifying event.

(2) The person is ~~or could be~~ covered by Medicare.

(3) The person is ~~or could be~~ covered by any other group insured or uninsured arrangement which provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to such ~~termination~~ qualifying event, and no preexisting condition exclusion applies; provided, however, that the person shall remain eligible for continuation coverages which are not available under the insured or uninsured arrangement.

(4) The person has a loss of employment due to misconduct as defined in ~~21 V.S.A. § 1344~~ section 1344 of Title 21.

~~(e)~~(d) The continuation required by this section only applies to dental, hospital, and medical benefits.

~~(d)~~(e) Notice of the continuation privilege shall be included in each certificate of coverage and shall be provided by the employer to the employee within 30 days following the occurrence of any qualifying event.

Sec. 15. 8 V.S.A. § 4090b is amended to read:

§ 4090b. CONTINUATION; NOTICE; TERMS

(a) A person electing continuation shall notify the insurer, or the policyholder, or the contractor, or agent for the group if the policyholder did not contract for the policy directly with the insurer, of such election in writing within 60 days ~~if the employee or member is deceased, or 30 days if the employee has been terminated, the covered employee becomes divorced or legally separated, or a dependent child ceases to be a dependent child under the generally applicable requirements of the policy, of the date that coverage under the group policy would otherwise terminate, or the date the person is given notice of the right of continuation, whichever is sooner~~ after receiving notice following the occurrence of a qualifying event pursuant to subsection 4090a(e) of this title. Notice of election to continue under the group policy shall be accompanied by the initial contribution, which shall include payment for the

period from the qualifying event through the end of the month in which the election is made.

(b) Contributions shall be due on a monthly basis in advance to the insurer or the insurer's agent, and shall not be more than 102 percent of the group rate for the insurance being continued under the group policy on the due date of each payment.

Sec. 16. 8 V.S.A. § 4090c is amended to read:

§ 4090c. TERMINATION OF COVERAGE

Continuation of insurance under the group policy shall terminate upon the occurrence of any of the following:

(1) the date ~~six~~ 18 months after the date that insurance under the policy would have terminated due to ~~the death or loss of employment of the employee or member, the divorce or legal separation of the covered employee from the employee's spouse, or a dependent child ceasing to be a dependent child under the generally applicable requirements of the policy of the employee or member~~ a qualifying event, as defined in subsection 4090a(b) of this title;

(2) the person fails to make timely payment of the required contribution;

(3) the person is ~~or could be~~ covered by Medicare;

(4) the person is covered by any other group insured or uninsured arrangement that provides dental coverage or hospital and medical coverage for individuals in a group, under which the person was not covered

immediately prior to the occurrence of a qualifying event, as defined in subsection 4090a(b) of this title, and no preexisting condition exclusion applies; provided, however, that the person shall remain eligible for continuation coverages which are not available under the insured or uninsured arrangement; or

(5) the date on which the group policy is terminated or, in the case of an employee, the date the decedent's or terminated employee's employer terminates participation under the group policy. If such coverage is replaced by similar coverage under another group policy:

(A) the person shall have the right to become covered under that replacement policy, for the balance of the period that he or she would have remained covered under the prior group policy;

(B) the minimum level of benefits to be provided by the replacement policy shall be the applicable level of benefits of the prior group policy reduced by any benefits payable under that prior group policy; and

(C) the prior group policy shall continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement has not occurred.

Sec. 17. SPECIAL ENROLLMENT PERIOD

(a) An individual who does not have an election of continuation of coverage as described in 18 V.S.A. § 4090a(a) in effect on the effective date of

this act but who is an assistance eligible individual under Section 3001 of Title III of the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (ARRA), may elect continuation coverage pursuant to this subsection by making such election within 60 days following the date the issuer of the policy provides notice of the right to elect coverage as required by Section 3001(a)(7) of the ARRA. The issuer of the policy shall provide such notice of the right to elect coverage no later than 30 days following the effective date of this act.

(b) Continuation coverage for an individual who elects coverage pursuant to subsection (a) of this section shall commence on the first day of the first month beginning on or after the effective date of this act and shall not extend beyond the period of continuation coverage that would have applied if the coverage had instead been elected pursuant to 18 V.S.A. § 4090a(a).

(c) Notwithstanding any provision of law to the contrary, for an individual who elects continuation coverage pursuant to this section, the period beginning on the date of the qualifying event pursuant to 18 V.S.A. § 4090a(b) and ending on the first day of the first month beginning on or after the effective date of this act shall be disregarded for purposes of determining the 63-day periods referred to in connection with preexisting condition exclusions in Section 701(c)(2) of the Employee Retirement Income Security Act of 1974, Section 9801(c)(2) of the Internal Revenue Code of 1986, and Section

2701(c)(2) of the Public Health Service Act, and the 90-day period referred to in connection with preexisting condition exclusions in 18 V.S.A. § 4080a(g).

* * * Health Information Technology Reinvestment Fee * * *

Sec. 18. 8 V.S.A. § 4089k is amended to read:

§ 4089k. HEALTH CARE INFORMATION TECHNOLOGY
REINVESTMENT FEE

(a)(1) ~~Quarterly, beginning~~ Beginning October 1, ~~2008~~ 2009 and annually thereafter, each health insurer shall pay a fee into the health IT-fund established in section 10301 of Title 32. ~~The health insurer may choose either of the following fee options:~~

(1) ~~in the amount of~~ 0.199 of one percent of all health ~~care~~ insurance claims paid by the health insurer for its Vermont members in the previous fiscal ~~quarter, or~~ year ending June 30. The annual fee shall be paid in quarterly installments on October 1, January 1, March 1, and July 1.

(2) On or before September 1, 2009 and annually thereafter, the secretary of administration, in consultation with the commissioner of banking, insurance, securities, and health care administration, shall publish a list of health insurers subject to the fee imposed by this section, together with the paid claims amounts attributable to each health insurer for the previous fiscal year. The costs of the department of banking, insurance, securities, and health

care administration in calculating the annual claims data shall be paid from the Vermont health IT fund.

~~(2) an annual fee payable quarterly, to be calculated on or before August 1, 2008 and on or before August 1 of each succeeding year by the department of banking, insurance, securities, and health care administration, or by an agent retained by the department, in consultation with the secretary of administration, based on the proportion which the health insurer's total annual health care claims for the most recent four quarters of data available to the department bears to the total health care claims for all health insurers for the most recent four quarters of data available to the department, multiplied by the total fee revenue which would be raised if all health insurers chose the fee option established in subdivision (1) of this subsection. Such fee shall be subject to an annual recalculation by the department of banking, insurance, securities, and health care administration, or an agent retained by the department, with any surplus or shortfall in the amount collected adjudicated in the following fiscal quarter and bearing no interest or penalty to any party. The department's cost of such calculations and recalculations shall be paid from the Vermont Health IT Fund established under section 10301 of Title 32.~~

(b) It is the intent of the general assembly that all health insurers shall contribute equitably to the health IT-fund established in section 10301 of Title 32. In the event that the fee established in subsection (a) of this section is

found not to be enforceable as applied to third party administrators or other entities, the fee amounts owed by all other health insurers shall remain at existing levels and the general assembly shall consider alternative funding mechanisms that would be enforceable as to all health insurers.

(c) As used in this section:

(1) "Health insurance" means any group or individual health care benefit policy, contract, or other health benefit plan offered, issued, renewed, or administered by any health insurer, including any health care benefit plan offered, issued, ~~or renewed,~~ or administered by any health insurance company, any nonprofit hospital and medical service corporation, or any managed care organization as defined in section 9402 of Title 18. The term includes comprehensive major medical policies, contracts, or plans and Medicare supplemental policies, contracts, or plans, but does not include Medicaid, VHAP, or any other state health care assistance program financed in whole or in part through a federal program, unless authorized by federal law and approved by the general assembly. The term does not include policies issued for specified disease, accident, injury, hospital indemnity, dental care, ~~long term~~ long-term care, disability income, or other limited benefit health insurance policies.

(2) "Health insurer" means any person who offers, issues, renews or administers a health insurance policy, contract, or other health benefit plan in

this state, and includes third party administrators or pharmacy benefit managers who provide administrative services only for a health benefit plan offering coverage in this state. The term does not include a third party administrator or pharmacy benefit manager to the extent that a health insurer has paid the fee which would otherwise be imposed in connection with health care claims administered by the third party administrator or pharmacy benefit manager. The term also does not include a health insurer with a monthly average of fewer than 200 Vermont insured lives.

* * *

* * * Catamount Health Deductibles, Eligibility, and Income Calculation * * *

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

§ 4080f. CATAMOUNT HEALTH

(a) As used in this section:

(1) "Carrier" means a registered small group carrier as defined in section 4080a of this title.

(2) "Catamount Health" means the plan for coverage of primary care, preventive care, chronic care, acute episodic care, and hospital services as established in this section to be provided through a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization subscriber contract which is offered or issued to an individual and which meets the requirements of this section.

(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, 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) “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 the physician and patient relationship, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment and functional capacity development strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(5) “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) “Health service” means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual’s physical or mental

condition, including services ordered by a health care professional and medically necessary services to assist in activities of daily living.

(7) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have developed 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 the treatment of mental illness.

(9) "Uninsured" means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur, and: who had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application; who has had a nongroup health insurance plan with an annual deductible of no less than ~~\$10,000.00~~ \$7,500.00 for an individual or an annual deductible of no less than ~~\$20,000.00~~ \$15,000.00 for two-person or family coverage for at least six

months; or who lost private insurance or employer-sponsored coverage during the prior 12 months for any of the following reasons:

(A) The individual's private insurance or employer-sponsored coverage ended because of:

(i) loss of employment, including:

(I) a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their hours for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health; or

(II)(aa) A self-employed individual who was insured through the nongroup market whose insurance coverage ended as the direct result of either the termination of a business entity owned by the individual or the individual's inability to continue in his or her line of work, if the individual produces satisfactory evidence to the office of Vermont health access of the business termination or certifies by affidavit to the office of Vermont health access that he or she is not employed and is no longer seeking employment in the same line of work;

(bb) Subdivision (aa) of this subdivision (II) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115

Waiver allowing for a self-employment exception to the Catamount Health
waiting period;

- (ii) death of the principal insurance policyholder;
- (iii) divorce or dissolution of a civil union;
- (iv) no longer receiving coverage as a dependent under the plan of a parent or caretaker relative; or
- (v) no longer receiving COBRA, VIPER, or other state continuation coverage.

(B) College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies.

(C)(i) The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent

to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

(ii) Subdivision (i) of this subdivision (C) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health waiting period.

* * *

(d)(1) A carrier shall guarantee acceptance of any uninsured individual for any Catamount Health plan offered by the carrier. A carrier shall also guarantee acceptance of each dependent of an uninsured individual in Catamount Health. An individual who is eligible for Medicare may not purchase Catamount Health. An individual who is eligible for an employer-sponsored insurance plan may not purchase Catamount Health, except as provided for in subdivision (2) of this subsection. Any dispute regarding eligibility shall be resolved by the department in a manner to be determined by rule.

(2)(A) An individual with income less than or equal to 300 percent of the federal poverty level who is eligible for an employer-sponsored insurance plan may purchase Catamount Health if:

(i) the individual's employer-sponsored insurance plan is not an approved employer-sponsored plan under section 1974 of Title 33;

(ii) enrolling the individual in an approved employer-sponsored plan combined with premium assistance under section 1974 of Title 33 offered by the agency of human services is not cost-effective to the state as compared to enrolling the individual in Catamount Health combined with the assistance under subchapter 3a of chapter 19 of Title 33; or

(iii) the individual is eligible for employer-sponsored insurance premium assistance under section 1974 of Title 33, but is unable to enroll in the employer's insurance plan until the next open enrollment period.

(B) Decisions by the agency of human services regarding whether an individual's employer-sponsored plan is an approved employer-sponsored plan under section 1974 of Title 33 and decisions by the agency of human services regarding whether enrolling the individual in an approved employer-sponsored plan is cost-effective under section 1974 of Title 33 are matters fully within the discretion of the agency of human services. On appeal pursuant to section 3091 of Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.

(3)(A) An individual who loses eligibility for the employer-sponsored premium programs in section 1974 of Title 33 may purchase Catamount Health without being uninsured for 12 months.

(B) An individual ~~who has been enrolled in~~ whose most recent health care coverage was Medicaid, VHAP, Dr. Dynasaur, ~~or~~ any other health benefit plan authorized under Title XIX or Title XX of the Social Security Act, or Catamount Health shall not be subject to a 12-month waiting period before becoming eligible for Catamount Health.

(4) An individual of the age of majority who is claimed on a tax return as a dependent of a resident of another state shall not be eligible to purchase Catamount Health.

* * *

(e)(1) For a 12-month period from the earliest date of application, a carrier offering Catamount Health may limit coverage of preexisting conditions which existed during the 12-month period before the earliest date of application, except that such exclusion or limitation shall not apply to chronic care if the individual is participating in a chronic care management program, nor apply to pregnancy. A carrier shall waive any preexisting condition provisions for all individuals and their dependents who produce evidence of continuous creditable coverage during the previous nine months. If an individual has a preexisting condition excluded under a subsequent policy, such exclusion shall

not continue longer than the period required under the original contract or 12 months, whichever is less. The carrier shall credit prior coverage that occurred without a break in coverage of 63 days or more. A break in coverage shall be tolled after the earliest date of application, subject to reasonable time limits, as defined by the commissioner, for the individual to complete the application process. For an eligible individual, as such term is defined in Section 2741 of the Health Insurance Portability and Accountability Act of 1996, a carrier offering Catamount Health shall not limit coverage of preexisting conditions.

(2) Notwithstanding subdivision (1) of this subsection, a carrier offering Catamount Health shall not limit coverage of preexisting conditions for subscribers who apply before November 1, 2008. This subdivision (2) shall not apply to claims incurred prior to the effective date of this section.

(3) Notwithstanding subdivision (1) of this subsection, an individual who was insured in the nongroup market, lost his or her employment, terminated insurance coverage, and had no other private insurance or employer-sponsored coverage that included both hospital and physician services for the 12 months preceding his or her application for Catamount Health shall not be subject to a preexisting condition period upon enrolling in Catamount Health, if the individual:

(A) terminated his or her nongroup coverage within 90 days following the individual's loss of employment; and

(B) applied for Catamount Health within 63 days following the one-year anniversary of terminating his or her nongroup coverage.

* * *

Sec. 20. 33 V.S.A. § 1974 is amended to read:

§ 1974. EMPLOYER-SPONSORED INSURANCE; PREMIUM ASSISTANCE

* * *

(j) The premium contributions for individuals shall be as follows:

(1) Monthly premiums for each individual who is eligible for ~~the Vermont health access plan~~ premium assistance under subsection (b) of this section shall be the same as charged in the Vermont health access plan.

(2) Monthly premiums for each individual who is not eligible for the Vermont health access plan shall be:

(A) ~~Income less than or equal to 175 percent of FPL: \$60.00 per month.~~

(B) ~~Income greater than 175 percent and less than or equal to 200 percent of FPL: \$65.00 per month.~~

(C) ~~Income greater than 200 percent and less than or equal to 225 percent of FPL: \$110.00 per month.~~

(D) ~~Income greater than 225 percent and less than or equal to 250 percent of FPL: \$135.00 per month.~~

~~(E) Income greater than 250 percent and less than or equal to 275 percent of FPL: \$160.00 per month.~~

~~(F) Income greater than 275 percent and less than or equal to 300 percent of FPL: \$185.00 per month~~ the same as the premiums established in subsections (b) and (c) of section 1984 of this title.

Sec. 21. 33 V.S.A. § 1984 is amended to read:

§ 1984. INDIVIDUAL CONTRIBUTIONS

(a) The agency shall provide assistance to individuals eligible under this subchapter to purchase Catamount Health. For the lowest cost plan, the amount of the assistance shall be the difference between the premium for the lowest cost Catamount Health plan and the individual's contribution as defined in ~~subdivision (e)(1)~~ subsections (b) and (c) of this section. For plans other than the lowest cost plan, the assistance shall be the difference between the premium for the lowest cost Catamount Health plan and the individual's contribution as set out in ~~subdivision (e)(1)~~ subsections (b) and (c) of this section.

(b) ~~Subject to amendment in the fiscal year 2008 budget, the~~ The agency of administration or designee shall establish individual and family contribution amounts for Catamount Health under this subchapter ~~for the first year as based on the individual contributions established in subsection (c) of this section and shall index the contributions in future years~~ annually to the overall growth in

spending per enrollee in Catamount Health as established in section 4080f of Title 8. The agency shall establish family contributions by income bracket based on the individual contribution amounts and the average family size. ~~In fiscal year 2008, the individual's contribution shall be as established in subsection (c) of this section.~~

(c)(1) For the lowest cost plan, an individual's base contribution shall be:

(A) Income less than or equal to 175 percent of FPL: \$60.00 per month.

(B) Income greater than 175 percent and less than or equal to 200 percent of FPL: \$65.00 per month.

(C) Income greater than 200 percent and less than or equal to 225 percent of FPL: \$110.00 per month.

(D) Income greater than 225 percent and less than or equal to 250 percent of FPL: \$135.00 per month.

(E) Income greater than 250 percent and less than or equal to 275 percent of FPL: \$160.00 per month.

(F) Income greater than 275 percent and less than or equal to 300 percent of FPL: \$185.00 per month.

(G) Income greater than 300 percent of FPL: the actual cost of Catamount Health.

(2) For plans other than the lowest cost Catamount Health plan, an individual's base contribution shall be the sum of:

(A) the applicable contribution as set out in subdivision (1) of this subsection; and

(B) the difference between the premium for the lowest cost plan and the premium for the plan in which the individual is enrolled.

Sec. 22. GLOBAL COMMITMENT WAIVER AMENDMENTS;

RULEMAKING

(a) Upon determination by the secretary of human services, in consultation with the commission on health care reform, that the amendments to be requested pursuant to this subsection will not jeopardize the receipt of the enhanced federal medical assistance percentage funds pursuant to Sec. 5001(f)(1)(A) of Title V of Division B of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, no later than September 1, 2009, the secretary of human services shall request approval from the Centers for Medicare and Medicaid Services for amendments to the Global Commitment for Health Medicaid Section 1115 waiver to:

(1) implement the self-employment exception to the Catamount Health waiting period set forth in Sec. 19 of this act; and

(2) permit the agency of human services to amend the rules for the Vermont health access plan, the Catamount Health premium assistance

program, and the employer-sponsored insurance premium-assistance programs to designate depreciation as an allowable business expense when determining countable income for eligibility purposes.

(b) During the pendency of the waiver amendment request pursuant to subdivision (a)(2) of this section, the agency of human services shall amend the rules for the Vermont health access plan, the Catamount Health premium assistance program, and the employer-sponsored insurance premium-assistance programs to designate depreciation as an allowable business expense when determining countable income for eligibility purposes. The amended rules shall take effect upon approval of the waiver amendment, but in no event earlier than February 1, 2010.

Sec. 23. REPORT; IMPACT OF INCOME ELIGIBILITY CHANGE

No later than January 15, 2010, the office of Vermont health access shall report to the house committees on appropriations and on health care and the senate committees on appropriations and on health and welfare on the financial impact of modifying the income eligibility rules to allow depreciation as a business expense effective upon approval of the waiver amendment pursuant to Sec. 22(a)(2) of this act. The report shall include an analysis of estimated increases in enrollment, impacts on the premium amounts paid by the enrollees, and increases in federal funds due to the rule change.

* * * Administration of Catamount Health * * *

Sec. 24. 2 V.S.A. § 903 is amended to read:

§ 903. CATAMOUNT HEALTH; EMPLOYER-SPONSORED INSURANCE
ASSISTANCE; REQUEST FOR PROPOSALS

* * *

(b)(1) ~~Administration without assumption of risk~~ Program evaluation. No earlier than October 1, 2009, the commission on health care reform, in consultation with the secretary of administration or designee, shall:

(A) evaluate the Catamount Health market to determine whether it is a cost-effective method Compare the cost-effectiveness of the Catamount Health program with other available alternative methods of providing health care coverage to uninsured Vermonters, taking into consideration the rates and forms approved by the department of banking, insurance, securities, and health care administration; the costs of administration and reserves, including the extent to which the program's administrative complexity affects progress toward the goal of insuring 96 percent of Vermonters by 2010; the amount of Catamount Health assistance to be provided to individuals; whether the Catamount Health assistance is sufficient to make Catamount Health affordable to those individuals, and; the number of individuals for whom assistance is available given the appropriated amount; and the potential impacts on Vermont's programs of health care reform at the federal level. The

commission shall review, in consultation with the joint fiscal office, the sustainability of the Catamount Fund and impacts on the general fund, both under the current mode of operation and under any alternatives considered.

Prior to making its determination, the commission shall consider the recommendations of a health care and health insurance consultant selected jointly by the commission and the secretary of administration.

(B) Evaluate the cost-effectiveness of the employer-sponsored insurance assistance program established in section 1974 of Title 33. The commission shall:

(i) conduct a thorough review of the administrative costs of Vermont's state-sponsored health assistance programs, including program-specific figures for Catamount Health premium assistance, the employer-sponsored insurance assistance program for those eligible for Catamount Health, the Vermont health access plan (VHAP), and the employer-sponsored insurance assistance program for those eligible for VHAP;

(ii) recommend a method and format for reporting employer costs in the monthly financial reports submitted to the general assembly by the office of Vermont health access;

(iii) perform a historical analysis comparing the monthly costs for VHAP enrollees with access to employer-sponsored insurance to those without;

(iv) analyze why many potential applicants for state-sponsored health assistance programs do not complete the enrollment process, with a focus on what role, if any, the employer-sponsored insurance assistance program plays in the failure to enroll;

(v) assess the extent to which the agency of human services' engagement in a cost-benefit analysis of an applicant's employer-sponsored insurance results in a delay in the applicant's enrollment in a health plan; and

(vi) evaluate the health insurance costs of employers in this state and survey whether the employer-sponsored insurance assistance program has or may have any impact on the likelihood that they will continue to offer health insurance.

(C) The office of Vermont health access shall provide the commission with access to any information requested in order to conduct the activities specified in subdivision (B) of this subdivision (1), except the following:

(i) Names, addresses, and Social Security numbers of recipients of and applicants for services administered by the office.

(ii) Medical services provided to recipients.

(iii) Social and economic conditions or circumstances, except such de-identified information as the office may compile in the aggregate.

(iv) Agency evaluation of personal information.

(v) Medical data, including diagnosis and past history of disease or disability.

(vi) Information received for verifying income eligibility and amount of medical assistance payments, except such de-identified information as the office may compile in the aggregate.

(vii) Any additional types of information the office has identified for safeguarding pursuant to the requirements of 42 C.F.R. § 431.305.

(D) No later than January 15, 2010, the commission on health care reform shall report its findings and recommendations for the future of the employer-sponsored insurance assistance programs pursuant to subdivision (B) of this subdivision (1) to the house committee on health care and the senate committee on health and welfare.

* * *

* * * Vermont Health Access Plan * * *

Sec. 25. 33 V.S.A. § 1973 is amended to read:

§ 1973. VERMONT HEALTH ACCESS PLAN

* * *

(e) An individual who is or becomes eligible for Medicare shall not be eligible for the Vermont health access plan.

(f) For purposes of this section, “uninsured” means:

* * *

* * * Workers’ Compensation Medical Claim Payment Standards * * *

Sec. 26. 21 V.S.A. § 601 is amended to read:

§ 601. DEFINITIONS

Unless the context otherwise requires, words and phrases used in this chapter shall be construed as follows:

* * *

(22) “Health care provider” ~~shall mean~~ means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to provide professional health care service ~~in this state~~ to an individual during the individual’s medical care, treatment, or confinement.

* * *

(25) “Medical bill” means any claim, bill, or request for payment from a health care provider or employee for all or any portion of health care services provided to the employee for an injury for which the employee has filed a claim under this chapter.

(26) “Denied medical payment” or “medical bill denial” means a refusal to pay a medical bill based on the employer or insurance carrier asserting, supported by reasonable evidence, any one or more of the following:

(A) The employer or insurance carrier was not provided with sufficient information to determine the payer liability.

(B) The employer or insurance carrier was not provided with reasonable access to information needed to determine the liability or basis for payment of the claim.

(C) The employer or insurance carrier has no liability to pay a medical bill under the provisions of this chapter.

(D) The service was not reasonable or medically necessary.

(E) Another payer is liable.

(F) Another legal or factual ground for nonpayment.

(27) “Medically necessary care” means health care services for which an employer is otherwise liable under the provisions of this chapter, including diagnostic testing, preventive services, and aftercare, that are appropriate, in terms of type, amount, frequency, level, setting, and duration, to the injured employee’s diagnosis or condition. Medically necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professionals in the same specialties as typically provide the procedure or

treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and must:

(A) help restore or maintain the injured employee's health; or

(B) prevent deterioration of or palliate the injured employee's condition; or

(C) prevent the reasonably likely onset of a health problem or detect an incipient problem.

Sec. 27. 21 V.S.A. § 640a is added to read:

§ 640a. MEDICAL BILLS; PAYMENT; DISPUTE

(a) No later than 30 days following receipt of a bill from a health care provider for medical, surgical, hospital, nursing services, supplies, prescription drugs, or durable medical equipment provided to an injured employee, an employer or insurance carrier shall do one of the following:

(1) Pay or reimburse the bill.

(2) Provide written notification to the injured employee, the health care provider, and the commissioner that the medical bill is contested or denied.

The notice shall include specific reasons supporting the contest or denial, a description of any additional information needed by the employer or insurance carrier to determine liability for the medical bill, and a request that such

information be submitted to the employer or insurance carrier within 30 days following receipt of the notice.

(b) Disputes regarding payment of a medical bill may be filed with the commissioner by the injured employee or the health care provider. Disputes regarding payment of a medical bill or interest on that bill shall be determined by the commissioner or, at the option of either party, be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association. The decision of an arbitrator shall be provided to the commissioner, and the award may be entered as a judgment in a court of jurisdiction.

(c) If a medical bill was denied on the basis that the employer or insurance carrier was not provided with sufficient information to determine liability for payment pursuant to subdivision (a)(2) of this section, the employer or insurance carrier has 30 days following receipt of the additional information requested to pay or deny payment of the bill.

(d) Medical bills shall be paid within the time required in this section or according to the time requirements specified in a contract between the health care provider and the employer or insurance carrier.

(e) Interest shall accrue on an unpaid medical bill at the rate of 12 percent per annum calculated as follows:

(1) From the first calendar day following 30 days after the date the medical bill is received by the employer or insurance carrier for any of the following:

(A) A medical bill that was not denied.

(B) A medical bill that was denied and written notice was not provided or not provided within 30 days after receipt of the medical bill.

(2) For a medical bill that was denied based on insufficient information and notice was provided in compliance with subdivision (a)(2) of this section, from the first calendar day following 30 days after receipt of additional information sufficient to determine liability for payment.

(3) For a medical bill that was denied and notice was provided in compliance with subsection (a) of this section, from the first calendar day following 30 days after the date of a final arbitration award, judgment, or administrative order awarding payment of the disputed medical bill.

(4) For a medical bill that is paid in accordance with a contract between the health care provider and the employer or insurance carrier, from the day following the contract payment period or as otherwise specified in the contract.

(f) A health care provider shall submit a medical bill accompanied by medical documentation to the employer or insurance carrier within six months after the date the health care provider had actual knowledge that the services provided were related to a claim under this chapter. For the purposes of this

section, “medical documentation” means documentation that describes an injury and the treatment provided and includes all relevant treatment notes, medical records, and diagnostic codes with sufficient detail to review the medical necessity of the service and the appropriateness of the fee charged. Failure to submit the bill within six months does not bar payment unless the employer or insurance carrier is prejudiced by the delay. The commissioner may extend the six-month limit if the commissioner determines that the delay resulted from circumstances outside the control of the health care provider.

(g) A medical bill shall be submitted in a legible form with every field or data element relevant to the treatment completed and treatment coding that conforms to the criteria of the National Correct Coding Initiative. The medical bill shall be submitted in any one of the following electronic or paper formats:

(1) CMS 1500 or its electronic equivalent for medical.

(2) UB04 or its electronic equivalent for hospital inpatient and outpatient services.

(3) ADA J515 or its electronic equivalent for dental services.

(h) The commissioner may assess penalties as provided in section 688 of this title against an employer or insurance carrier that fails to comply with the provisions of this section and may also refer to the commissioner of banking, insurance, securities, and health care administration any employer or insurance carrier that neglects or refuses to pay medical bills as required by this section.

(i) Any interest or penalty paid by an employer or insurance carrier under this chapter shall be excluded from the claims data reported pursuant to 8 V.S.A. § 4687.

(j) An employer or insurance carrier shall not impose on any health care provider any retrospective denial of a previously paid medical bill or any part of that previously paid medical bill, unless:

(1) The employer or insurance carrier has provided at least 30 days' notice of any retrospective denial or overpayment recovery or both in writing to the health care provider. The notice must include:

(A) the injured employee's name;

(B) the service date;

(C) the payment amount;

(D) the proposed adjustment; and

(E) a reasonably specific explanation of the proposed adjustment.

(2) The time that has elapsed does not exceed 12 months from the later of the date of payment of the previously paid medical bill or the date of a final determination of compensability.

(k) The retrospective denial of a previously paid medical bill shall be permitted beyond 12 months from the later of the date of payment or the date of a final determination of compensability for any of the following reasons:

(1) The employer or insurance carrier has a reasonable belief that fraud or other intentional misconduct has occurred;

(2) The medical bill payment was incorrect because the health care provider was already paid for the health services identified in the medical bill;

(3) The health care services identified in the medical bill were not delivered by the health care provider;

(4) The medical bill payment is the subject of adjustment with another workers' compensation or health insurer; or

(5) The medical bill is the subject of legal action.

(1)(1) For purposes of subsections (j) and (k) of this section, for routine recoveries as described in subdivisions (A) through (J) of this subdivision (1), retrospective denial or overpayment recovery of any or all of a previously paid medical bill shall not require 30 days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies:

(A) Duplicate payment to a health care provider for the same professional service;

(B) Payment with respect to an individual for whom the employer or insurance carrier is not liable as of the date the service was provided;

(C) Payment for a noncovered service, not to include services denied as not medically necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism;

(D) Erroneous payment for services due to employer or insurance carrier administrative error;

(E) Erroneous payment for services where the medical bill was processed in a manner inconsistent with the data submitted by the health care provider;

(F) Payment where the health care provider provides the employer or insurance carrier with new or additional information demonstrating an overpayment;

(G) Payment to a health care provider at an incorrect rate or using an incorrect fee schedule;

(H) Payment of medical bills for the same injured employee that are received by the employer or insurance carrier out of the chronological order in which the services were performed;

(I) Payment where the health care provider has received payment for the same services from another payer whose obligation is primary; or

(J) Payments made in coordination with a payment by a government payer that require adjustment based on an adjustment in the government-paid portion of the medical bill.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, recoveries which, in the reasonable business judgment of the employer or insurance carrier, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more of the situations in subdivisions (1)(A) through (J) of this subsection apply.

(3) Nothing in this subsection shall be construed to affect the time frames established in subdivision (j)(2) or subsection (k) of this section.

* * * Fair Contract Standards * * *

Sec. 28. 18 V.S.A. § 9412 is amended to read:

§ 9412. ENFORCEMENT

(a) In order to carry out the duties under this chapter, the commissioner, in addition to the powers provided in ~~8 V.S.A. § 72~~ this chapter and in Title 8, may examine the books, accounts, and papers of health insurers, health care providers ~~and,~~ health care facilities, health plans, contracting entities, covered entities, and payers, as defined in section 9418 of this title and may administer oaths and may issue subpoenas to a person to appear and testify or to produce documents or things.

* * *

Sec. 29. 18 V.S.A. § 9418 is amended to read:

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

(a) ~~As Except as otherwise specified, as used in this section, subchapter:~~

(1) ~~“Health plan” means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation or a workers’ compensation policy of a casualty insurer licensed to do business in Vermont. “Health plan” also includes a health plan that requires its medical groups, independent practice associations or other independent contractors to pay claims for the provision of health care services.~~

(2) ~~“Claim” means any claim, bill, or request for payment for all or any portion of provided health care services that is submitted by:~~

(A) A health care provider or a health care facility pursuant to a contract or agreement with the health plan; or

(B) A health care provider, a health care facility, or a patient covered by the health plan.

(3)(2) ~~“Contest”~~ “Contested claim” means the circumstance in which the health plan was not provided with a claim submitted to a payer, health plan, or contracting entity that does not include:

(A) Sufficient information needed to determine payer liability; or

(B) Reasonable access to information needed to determine the liability or basis for payment of the claim.

(3) “Contracting entity” means any entity that contracts directly or indirectly with a health care provider for either the delivery of health care services or the selling, leasing, renting, assigning, or granting of access to a contract or terms of a contract. For purposes of this subchapter, the office of Vermont health access, health care providers, physician hospital organizations, health care facilities, and stand-alone dental plans are not contracting entities.

(4) “Covered entity” means an organization that enters into a contract with a contracting entity to gain access to a provider network contract. For purposes of this subchapter, the office of Vermont health access is not a covered entity.

(4)(5) “Denied” or “denial” means the circumstance in which the plan asserts that it has no liability to pay a claim, based on eligibility status of the patient, coverage of a service under the health plan, medical necessity of a service, liability of another payer, or other grounds.

(6) “Edit” or “editing” means a practice or procedure pursuant to which one or more adjustments are made to Current Procedural Terminology (CPT) codes, American Society of Anesthesiologists’ (ASA) current procedural terminology, the American Dental Association’s (ADA) current dental terminology, or Healthcare Common Procedure Coding System (HCPCS) Level II codes included in a claim that result in:

(A) Payment being made based on some, but not all, of the codes originally billed by a participating health care provider;

(B) Payment being made based on different codes from those originally billed by a participating health care provider;

(C) Payment for one or more of the codes included in the claim originally billed by a participating health care provider being reduced by application of payer's editing software, such as multiple procedure logic software;

(D) Payment for one or more of the codes being denied;

(E) A reduced payment as a result of services provided to an insured that are claimed under more than one procedure code on the same service date;
or

(F) Any combination of the subdivisions in this subdivision (6).

(7) "Health care contract" or "contract" means a contract entered into, amended, or renewed between a contracting entity or health plan and a health care provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of health care services to insureds, including primary care health services, preventive health services, chronic care services, and specialty health care services.

(8) "Health plan" means a health insurer, disability insurer, health maintenance organization, medical or hospital service corporation, and, to the

extent permitted under federal law, any administrator of an insured or self-insured plan. "Health plan" also includes a health plan that requires its medical groups, independent practice associations, or other independent contractors to pay claims for the provision of health care services.

(9) "Health care provider" or "provider" means a person, partnership, or corporation licensed, certified, or otherwise authorized by law to provide professional health care services in this state and shall include a health care provider group, network, independent practice association, or physician hospital organization that is acting exclusively as an administrator on behalf of a health care provider to facilitate the provider's participation in health care contracts. The term includes a hospital but does not include a pharmacist, pharmacy, nursing home, or a health care provider organization or physician hospital organization that leases its network to a covered entity or contracts directly with employers or self-insured plans.

(10) "Insured" means any person eligible for health care benefits under a health benefit plan, and includes all of the following terms: enrollee, subscriber, member, insured, dependent, covered individual, and beneficiary.

(11) "Most favored nation clause" means a provision in a health care contract that:

(A) Prohibits, or grants a contracting entity an option to prohibit, a participating provider who contracts with another contracting entity from

accepting lower payment for the provision of health care services than the payment specified in the first contracting entity's contract.

(B) Requires, or grants a contracting entity an option to require, the participating provider to accept a lower payment in the event the participating provider agrees to provide health care services for any other contracting entity at a lower price.

(C) Requires, or grants a contracting entity an option to require, termination or renegotiation of the existing health care contract in the event the participating provider agrees to provide health care services for any other contracting entity at a lower price.

(D) Requires the participating provider to disclose the participating provider's contractual reimbursement rates with other contracting entities.

(12) "National Correct Coding Initiative," or "NCCI" means the Centers for Medicare and Medicaid Services' (CMS) published list of edits and adjustments that are made to health care providers' claims submitted for services or supplies provided to patients insured under the federal Medicare program and other federal insurance programs.

(13) "Participating provider" means a health care provider that has a health care contract with a contracting entity and is entitled to reimbursement for health care services rendered to an insured under the health care contract. The term includes a hospital, but does not include a pharmacist, pharmacy, or

nursing home, or a health care practitioner organization or physician-hospital organization that leases the health care practitioner organization's or physician-hospital organization's network to a covered entity or contracts directly with employers or self-insured plans.

(14) "Payer" means any person or entity that assumes the financial risk for the payment of claims under a health care contract or the reimbursement for health care services rendered to an insured by a participating provider under the health care contract. The term "payer" does not include:

(A) the office of Vermont health access; or

(B) reinsurers that neither pay claims directly nor act as contracting entities.

(15) "Procedure codes" means a set of descriptive codes indicating the procedure performed by a health care provider and includes the American Medical Association's Current Procedural Terminology codes (CPT), the Healthcare Common Procedure Coding System Level II Codes (HCPCS), the American Society of Anesthesiologists' (ASA) current procedural terminology, and the American Dental Association's current dental terminology.

(16) "Product" means, to the extent permitted by state and federal law, one of the following types of categories of coverage for which a participating

provider may be obligated to provide health care services pursuant to a health care contract:

- (A) Health maintenance organization;
- (B) Preferred provider organization;
- (C) Fee-for-service or indemnity plan;
- (D) Medicare Advantage HMO plan;
- (E) Medicare Advantage private fee-for-service plan;
- (F) Medicare Advantage special needs plan;
- (G) Medicare Advantage PPO;
- (H) Medicare supplement plan;
- (I) Workers compensation plan;
- (J) Catamount Health; or
- (K) Any other commercial health coverage plan or product.

(b) No later than ~~45~~ 30 days following receipt of a claim, a health plan, contracting entity, or payer shall do one of the following:

- (1) Pay or reimburse the claim.
- (2) Notify the claimant in writing that the claim is contested or denied.

The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan, contracting entity, or payer to determine liability for the claim.

~~(c) If the claim submitted is to a health plan that is a workers' compensation insurance policy,~~

~~(1) The health plan shall within 45 days following receipt of the claim:~~

~~(A) pay or reimburse the claim; or~~

~~(B) notify in writing the claimant and the commissioner of labor that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan to determine liability for the claim.~~

~~(2) Disputes regarding any claims under this subsection shall be resolved pursuant to the provisions of chapters 9 and 11 of Title 21.~~

~~(3) The commissioner of labor may assess interest and penalties as provided in subsections (e) and (f) of this section against a health plan that fails to comply with the provisions of this section or any order of the commissioner. These remedies are in addition to any other penalties available under Title 8 and chapters 9 and 11 of Title 21.~~

~~(d) If a claim is contested because the health plan, contracting entity, or payer was not provided with sufficient information to determine payer liability and for which written notice has been provided as required by subdivision (b)(2) of this section, then the health plan, contracting entity, or payer shall have ~~45~~ 30 days after receipt of the additional information to complete consideration of the claim.~~

(d) A health plan, contracting entity or payer shall acknowledge receipt of an electronic claim to the submitting party within 24 hours after the beginning of the next business day following receipt of the claim. For purposes of this subsection, the term “submitting party” means:

(1) a health care provider submitting a claim to a contracting entity, health plan, or payer; or

(2) a clearinghouse submitting a claim on behalf of a health care provider to a contracting entity, health plan, or payer.

(e) Interest shall accrue on a claim at the rate of 12 percent per annum calculated as follows:

(1) For a claim that is uncontested, from the first calendar day following the ~~45-day~~ 30-day period following the date the claim is received by the health plan, contracting entity, or payer.

(2) For a nonelectronic contested claim, for which notice was provided as required by subdivision (b)(2) of this section, or for an electronic contested claim for which notice and acknowledgment were provided as required in subdivision (b)(2) and subsection (c) of this section, from the first calendar day after the ~~45-day~~ 30-day period following the date that sufficient additional information is received.

(3) For a nonelectronic contested claim for which notice was not provided as required by subdivision (b)(2) of this section or for which notice

was provided later than the ~~45~~ 30 days required by subdivision (b)(2) of this section, from the first calendar day after the ~~45-day~~ 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

(4) For a contested electronic claim, for which notice and acknowledgment were not provided as required by subdivision (b)(2) and subsection (c) of this section, or for which notice or acknowledgment were provided later than the time required by subdivision (b)(2) and subsection (c) of this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

(5) For a claim that was denied or for which notice of denial was provided as required by subdivision (b)(2) of this section, from the first calendar day after the ~~45-day~~ 30-day period following the date of a final arbitration award, judgment, or administrative order that found a plan, contracting entity, or payer to be liable for payment of the claim.

(6) For a claim that was denied, for which notice of denial was not provided as required by subdivision (b)(2) of this section, or for which notice was provided later than the 30 days required by subdivision (b)(2) of this section, from the first calendar day after the 30-day period following the date the original claim was received by the health plan, contracting entity, or payer.

(f) The commissioner may suspend the accrual of interest under subsection (e) of this section if the commissioner determines that the health plan's failure to pay a claim within the applicable time limit is the result of a major disaster, act-of-God or unanticipated major computer system failure or that the action is necessary to protect the solvency of the health plan.

(g) All payments shall be made within the time periods provided by this section unless otherwise specified in the contract between the health plan and the health care provider or the health care facility. The health plan shall provide notice as required by subsection (b) of this section and pay interest on uncontested and contested claims as required in subsection ~~(d)~~(e) of this section from the day following the contract payment period, unless otherwise specified in the contract.

~~(h) Any dispute concerning payment of a claim or interest on a claim, arising out of or relating to the provisions of this section shall, at the option of either party, be settled by arbitration in accordance with the Commercial Rules of the American Arbitration Association, and judgment upon the arbitrator's award may be entered in any court having jurisdiction.~~

~~(i) In addition to any other remedy provided by law, if the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than \$500.00 for each violation, and may order the~~

~~health plan to cease and desist from further violations and order the health plan to remediate the violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:~~

- ~~(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.~~
- ~~(2) The gravity of the violation or practice.~~
- ~~(3) The history of previous violations or practices of a similar nature.~~
- ~~(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.~~
- ~~(5) Any other relevant factors.~~

(j) A health plan in this state shall not impose on any provider any retrospective denial of a previously paid claim or any part of that previously paid claim, unless:

- (1) The health plan has provided at least 30 days' notice of any retrospective denial or overpayment recovery or both in writing to the provider. The notice must include:
 - (A) the patient's name;
 - (B) the service date;
 - (C) the payment amount;
 - (D) the proposed adjustment; and

(E) a reasonably specific explanation of the proposed adjustment.

(2) The time that has elapsed since the date of payment of the previously paid claim does not exceed 12 months.

~~(i)~~(i) The retrospective denial of a previously paid claim shall be permitted beyond 12 months from the date of payment for any of the following reasons:

(1) The plan has a reasonable belief that fraud or other intentional misconduct has occurred;

(2) The claim payment was incorrect because the health care provider of ~~the insured~~ was already paid for the health services identified in the claim;

(3) The health care services identified in the claim were not delivered by the provider;

(4) The claim payment is the subject of adjustment with another health ~~insurer~~ plan; or

(5) The claim ~~payment~~ is the subject of legal action.

~~(j)~~(j)(1) For purposes of subsections (h) and (i) of this section, for routine recoveries as described in subdivisions (A) through (J) of this subdivision (1), retrospective denial or overpayment recovery of any or all of a previously paid claim shall not require 30 days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies:

- (A) Duplicate payment to a health care provider for the same professional service;
- (B) Payment with respect to an individual who was not a plan member as of the date the service was provided;
- (C) Payment for a noncovered service, not to include services denied as not medically necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism;
- (D) Erroneous payment for services due to plan administrative error;
- (E) Erroneous payment for services where the claim was processed in a manner inconsistent with the data submitted by the provider;
- (F) Payment where the health care provider provides the plan with new or additional information demonstrating an overpayment;
- (G) Payment to a health care provider at an incorrect rate or using an incorrect fee schedule;
- (H) Payment of claims for the same plan member that are received by the health plan out of the chronological order in which the services were performed;
- (I) Payment where the health care provider has received payment for the same services from another payer whose obligation is primary; or

(J) Payments made in coordination with a payment by a government payer that require adjustment based on an adjustment in the government-paid portion of the claim.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, recoveries which, in the reasonable business judgment of the payer, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more of the situations in subdivisions (1)(A) through (1)(J) of this subsection apply.

(3) Nothing in this subsection shall be construed to affect the time frames established in subdivision (h)(2) or subsection (i) of this section.

(k) Notwithstanding this section, a health plan may not retroactively deny or recoup a pharmacy point-of-sale payment except in the circumstances of fraud, intentional misconduct, a member not receiving the prescription, or error in the processing of the claim.

~~(m)~~(l) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner pursuant to section 9408 of this title relating to claims administration and adjudication standards, and rules adopted by the commissioner pursuant to section 9414 of this title and section

4088f of Title 8 relating to pay for performance or other payment methodology standards.

~~(n)(m)~~ The provisions of this section shall not apply to stand-alone dental plans ~~or to a workers' compensation policy of a casualty insurer~~ licensed to do business in Vermont.

Sec. 30. 18 V.S.A. § 9418a is amended to read:

§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE
TO CODING RULES

(a) ~~As used in this section:~~

~~(1) "Claim" means any claim, bill, or request for payment for all or any portion of provided health care services that is submitted by:~~

~~(A) A health care provider or a health care facility pursuant to a contract or agreement with the health plan; or~~

~~(B) A health care provider, a health care facility, or a patient covered by the health plan.~~

~~(2) "Contest" means the circumstance in which the health plan was not provided with:~~

~~(A) Sufficient information needed to determine payer liability; or~~

~~(B) Reasonable access to information needed to determine the liability or basis for payment of the claim.~~

~~(3) "Health plan" means a health insurer, disability insurer, health maintenance organization, or medical or hospital service corporation, but does not include a stand-alone dental plan or a workers' compensation policy of a casualty insurer licensed to do business in Vermont. "Health plan" also includes a health plan that requires its medical groups, independent practice associations, or other independent contractors to pay claims for the provision of health care services.~~

~~(b)~~ Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's ~~current procedural terminology~~ Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services ~~health care common procedure coding system~~ Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards that are no more restrictive than the following, except as provided in subsection (c) of this section:

- (1) The CPT, HCPCS, and NCCI;
- (2) National specialty society edit standards; or
- (3) Other appropriate edit standards, guidelines, or conventions

approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) or (2) of this section is not required:

- (1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or
- (2) For services not addressed by NCCI standards or national specialty society edit standards.

~~(e)~~(d) Nothing in this section shall preclude a health plan, contracting entity, covered entity, or payer from determining that any such claim is not eligible for payment in full or in part, based on a determination that:

- (1) The claim is contested as defined in subdivision ~~9418(a)(3)~~ 9418(a)(2) of this title;
- (2) The service provided is not a covered benefit under the contract, including a determination that such service is not medically necessary or is experimental or investigational;
- (3) The insured did not obtain a referral, prior authorization, or precertification, or satisfy any other condition precedent to receiving covered benefits from the health care provider;

(4) The covered benefit exceeds the benefit limits of the contract;

(5) The person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her coverage agreement;

(6) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or

(7) The health plan, contracting entity, covered entity, or payer determines through coordination of benefits that another ~~health insurer~~ entity is liable for the claim.

~~(d)~~(e) Nothing in this section shall be deemed to require a health plan, contracting entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to dictate the amount of a claim to be paid by a health plan, contracting entity, covered entity, or payer to a health care provider.

~~(e)~~(f) No health plan, contracting entity, covered entity, or payer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services (downcoding), except that a health plan, contracting entity, covered entity, or payer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines, and CPT conventions.

~~(f)~~(g) Notwithstanding the provisions of subsection ~~(e)~~(d) of this section, and other than the edits contained in the conventions in ~~subsection (b)~~ subsections (a) and (b) of this section, health plans, contracting entities,

covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for ~~covered~~ services on other bases and shall have the right to reassign or reduce the code level for selected claims for ~~covered~~ services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

~~(g)~~(h) Every health plan, contracting entity, covered entity, and payer shall publish on its provider website and in its provider newsletter if applicable the:

(1) The name of any commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) The standard or standards, pursuant to subsection (b) of this section, that the entity uses for claim edits;

(3) The payment percentages for modifiers; and

(4) any Any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product after the effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer.

~~(i) The Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide ~~such the~~ information ~~upon written request of~~ in subsection (h) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.~~

~~(h) In addition to any other remedy provided by law, if the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the health plan of no more than \$500.00 for each violation, and may order the health plan to cease and desist from further violations and order the health plan to remediate the violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:~~

~~(1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.~~

~~(2) The gravity of the violation or practice.~~

~~(3) The history of previous violations or practices of a similar nature.~~

~~(4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.~~

~~(5) Any other relevant factors.~~

~~(i) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner pursuant to section 9408 of this title relating to claims administration and adjudication standards, and rules adopted by the commissioner pursuant to section 9414 of this title and section 4088f of Title 8 relating to pay for performance or other payment methodology standards.~~

(j) For purposes of this section, "health plan" includes a workers' compensation policy of a casualty insurer licensed to do business in Vermont.

(k) Prior to the effective date of subsections (b) and (c) of this section, MVP Healthcare is requested to convene a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. No later than January 1, 2011, the work group is requested to report its findings and recommendations, including any recommendations for legislative changes to subsections (b) and

(c) of this section, to the house committee on health care and the senate
committee on health and welfare.

Sec. 31. 18 V.S.A. § 9418b is amended to read:

§ 9418b. PRIOR AUTHORIZATION

(a) ~~As used in this section:~~

~~(1) "Claim" means any claim, bill, or request for payment for all or any
portion of provided health care services that is submitted by:~~

~~(A) A health care provider or a health care facility pursuant to a
contract or agreement with the health plan; or~~

~~(B) A health care provider, a health care facility, or a patient covered
by the health plan.~~

~~(2) "Health plan" means a health insurer, disability insurer, health
maintenance organization, or medical or hospital service corporation but does
not include a stand-alone dental plan or a workers' compensation policy of a
casualty insurer licensed to do business in Vermont. "Health plan" also
includes a health plan that requires its medical groups, independent practice
associations, or other independent contractors to pay claims for the provision
of health care services.~~

~~(b) Health plans shall pay claims for health care services for which prior
authorization was required by and received from the health plan, unless:~~

- (1) The insured was not a covered individual at the time the service was rendered;
- (2) The insured's benefit limitations were exhausted;
- (3) The prior authorization was based on materially inaccurate information from the health care provider;
- (4) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or
- (5) The health plan determines through coordination of benefits that another health insurer is liable for the claim.

~~(e)~~(b) Notwithstanding the provisions of subsection ~~(b)~~(a) of this section, nothing in this section shall be construed to prohibit a health plan from denying continued or extended coverage as part of concurrent review, denying a claim if the health plan is not primarily obligated to pay the claim, or applying payment policies that are consistent with an applicable law, rule, or regulation.

~~(d)~~(c) A health plan shall furnish, upon request from a health care provider, a current list of services and supplies requiring prior authorization.

~~(e)~~(d) A health plan shall post a current list of services and supplies requiring prior authorization to the insurer's website.

~~(f)~~(e) In addition to any other remedy provided by law, if the commissioner finds that a health plan has engaged in a pattern and practice of violating this section, the commissioner may impose an administrative penalty against the

health plan of no more than \$500.00 for each violation, and may order the health plan to cease and desist from further violations and order the health plan to remediate the violation. In determining the amount of penalty to be assessed, the commissioner shall consider the following factors:

- (1) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan.
- (2) The gravity of the violation or practice.
- (3) The history of previous violations or practices of a similar nature.
- (4) The economic benefit derived by the health plan and the economic impact on the health care facility or health care provider resulting from the violation.
- (5) Any other relevant factors.

~~(g)~~(f) Nothing in this section shall be construed to prohibit a health plan from applying payment policies that are consistent with applicable federal or state laws and regulations, or to relieve a health plan from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner pursuant to section 9408 of this title, relating to claims administration and adjudication standards, and rules adopted by the commissioner pursuant to section 9414 of this title and section 4088f of Title 8, relating to pay for performance or other payment methodology standards.

Sec. 32. 18 V.S.A. § 9418c is added to read:

§ 9418c. FAIR CONTRACT STANDARDS

(a) Required information.

(1) Each contracting entity shall provide and each health care contract shall obligate the contracting entity to provide participating health care providers information sufficient for the participating provider to determine the compensation or payment terms for health care services, including all of the following:

(A) The manner of payment, such as fee-for-service, capitation, case rate or risk;

(B) On request, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that a provider in the same specialty typically uses or that the requesting provider actually bills. Fee schedule information may be provided by CD-ROM or electronically, at the election of the contracting entity, but a provider may elect to receive a hard copy of the fee schedule information instead of the CD-ROM or electronic version.

(C) A clearly understandable, readily available mechanism, such as a specific website address, that includes the following information:

(i) the name of the commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer uses;

(ii) the standard or standards from subsection 9418a(c) of this title that the entity uses for claim edits;

(iii) payment percentages for modifiers; and

(iv) any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product, which are made at the request of the health plan, contracting entity, covered entity, or payer, and which have been approved by the commissioner pursuant to subsection 9418a(b) or (c) of this title.

(2) Contracting entities shall provide the information described in subdivisions (a)(1)(A) and (B) of this section to health care providers who are actively engaged in the process of determining whether to become a participating provider in the contracting entity's network.

(3) Contracting entities may require health care providers to execute written confidentiality agreements with respect to fee schedule and claim edit information received from contracting entities.

(4) Each health care contract shall include the following information:

(A) Any product, company, or network for which the participating provider has agreed to provide services;

(B) For each product or network, reimbursement terms and methodologies, unless the terms are identical for multiple products or networks;

(C) The term of the health care contract;

(D) Termination notice period and reasons for termination;

(E) Language that identifies the entity responsible for the processing of the participating provider's compensation or payment, including contact information, including telephone, fax, and e-mail. This requirement may be satisfied by providing a specific web address that contains the necessary information.

(F) Any internal mechanism provided by the contracting entity to resolve disputes concerning the interpretation or application of the terms and conditions of the contract. A contracting entity may satisfy this requirement by providing a clearly understandable, readily available mechanism, such as a specific website address or an appendix, that allows a participating provider to determine the procedures for the internal mechanism to resolve those disputes.

(G) A list of addenda, if any, to the contract.

(b) Summary disclosure form.

(1) Each contracting entity shall include a summary disclosure form with a health care contract that includes all of the information specified in subsection (a) of this section. The information in the summary disclosure form shall refer to the location in the health care contract, whether a page number, section of the contract, appendix, or other identifier, that specifies the provisions in the contract to which the information in the form refers.

(2) The summary disclosure form shall include all of the following information:

(A) That the form is merely a guide to the health care contract and that the terms and conditions of the health care contract constitute the actual contract rights of the parties.

(B) That reading the form is not a substitute for reading the entire health care contract.

(C) That by signing the health care contract, the participating provider will be bound by the contract's terms and conditions.

(D) That the terms and conditions of the health care contract may be amended pursuant to section 9418d of this title, and the participating provider is encouraged to carefully read any proposed amendments sent after execution of the contract.

(E) That nothing in the summary disclosure form creates any additional rights or causes of action in favor of either party.

(3) No contracting entity that includes any information in the summary disclosure form with the reasonable belief that the information is truthful and accurate shall be subject to a civil action for damages or to binding arbitration based on information included in the summary disclosure form. Inclusion of intentional misstatements or intentional misrepresentations in the summary disclosure form shall be considered a violation of this chapter subject to

enforcement under section 9418g of this title. This section does not impair or affect any power of the department of banking, insurance, securities, and health care administration to enforce any applicable law.

(4) The summary disclosure form described in subdivisions (1) and (2) of this subsection shall be in substantially the following form:

“SUMMARY DISCLOSURE FORM

Compensation terms

Manner of payment:

Fee for service

Capitation

Risk

Other See

Reimbursement schedule available at

Claim edit information available at

List of products, product types, or networks covered by this contract (fill in names as applicable):

.....

.....

.....

.....

.....

Term of this contract

Termination notice period

Contracting entity, covered entity, or payer responsible for processing
payment available at

Internal mechanism for resolving disputes regarding contract terms
available at

Addenda to contract (list addenda, if any)

Telephone number to access a readily available mechanism, such as a
specific website address, to allow a participating provider to receive the
information listed above from the payer:

Rental network information

.....
.....

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to
the attached Health Care Contract. The terms and conditions of the attached
Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the
entire Health Care Contract. When you sign the Health Care Contract, you
will be bound by its terms and conditions. These terms and conditions may be
amended over time pursuant to 18 V.S.A. § 9418d. You are encouraged to

read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.”

(5) Upon request, contracting entities shall provide the summary disclosure form to a participating provider or a provider who is actively engaged in the process of determining whether to become a participating provider within 60 days of the request.

(c) When a contracting entity presents a proposed health care contract for consideration by a provider, the contracting entity shall provide in writing or make reasonably available the information required in subdivisions (a)(1)(A) and (B) of this section.

(d) Upon request, the contracting entity shall identify any utilization management, quality improvement, price or quality transparency program, or a similar program that the contracting entity uses to review, monitor, evaluate, or assess the services provided pursuant to a health care contract. The contracting entity shall disclose the policies, procedures, or guidelines of such a program upon request by the participating provider who is subject to or is participating in the program within 14 days after the date of the request.

(e) The requirements of subdivision (b)(5) of this section do not prohibit a contracting entity from requiring a reasonable confidentiality agreement

between the provider and the contracting entity regarding the terms of the proposed health care contract.

Sec. 33. 18 V.S.A. § 9418d is added to read:

§ 9418d. CONTRACT AMENDMENTS

(a) A health care contract may be amended by mutual agreement of the parties.

(b) Absent mutual agreement of the parties, a health care contract may be amended only as follows:

(1) The contracting entity shall provide to the participating provider notice of the amendment and the amendment in writing not later than 60 days prior to the effective date of the amendment. The notice shall be conspicuously entitled "Notice of Amendment to Contract" and shall include a summary of the amendment as described in subdivision (4) of this subsection. The notice period may be extended by mutual agreement of the parties.

(2) The participating provider shall have 60 days after receiving the amendment, notice, and summary pursuant to subdivision (1) of this subsection to object, in writing, to the proposed amendment. If the participating provider objects to the amendment and there is no resolution of the objection within 60 days following the contracting entity's receipt of the written objection, either party may terminate the contract upon written notice of termination provided to the other party. Termination shall become effective in the time period

specified in the health care contract. If no termination period is specified in the health care contract, the termination shall become effective 90 days after the notice of termination is provided. The terms of the underlying contract shall remain in effect through the termination period and shall be unaffected by the proposed amendment.

(3) If the participating provider does not object to the amendment in the manner specified in subdivision (2) of this subsection, the amendment shall be effective as specified in the notice described in subdivision (1) of this subsection.

(4) The notice of amendment shall include a summary cover sheet that shall include the following information:

(A) a brief explanation of the amendment;

(B) the date the amendment will become effective;

(C) a notice of right to object in writing to the amendment;

(D) the time frame for objection;

(E) the address to send an objection;

(F) Contact information for the person to call to discuss the amendment for further information, or to resolve an objection;

(G) the effect of an objection;

(H) the right to terminate the contract if the objection is not resolved;

(I) the time period for the effective date of any such termination; and

(J) the address to send a notice of termination.

(c) Subsection (b) of this section shall not apply in the following circumstances:

(1) The delay caused by compliance with the 60-day notice period in subdivision (b)(1) of this section could result in imminent harm to an insured.

(2) The amendment of a health care contract is required by a state or federal law, rule, or regulation that includes an effective date for the amendment.

(3) The provider affirmatively accepts the amendment in writing and agrees to an earlier effective date than that specified in the notice required by subdivision (b)(1) of this section.

(4) The participating provider's payment or compensation is based on the current Medicaid or Medicare physician reimbursement schedule, and the amendment reflects a change in payment or compensation resulting solely from a change in that physician reimbursement schedule.

(5) The amendment is a routine change or update of the health care contract made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by a third party source. For purposes of this subdivision:

(A) "Service code, procedure code, or reporting code" means the American Medical Association's Current Procedural Terminology, the

American Dental Association's Current Dental Terminology, the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System, the World Health Organization's International Classification of Diseases, or the Drug Topics Red Book average wholesale price; and

(B) "Third party source" means the American Medical Association; the American Society of Anesthesiologists; the American Dental Association; the Centers for Medicare and Medicaid Services; the National Center for Health Statistics; the U.S. Department of Health and Human Services Office of the Inspector General; the Vermont department of banking, insurance, securities, and health care administration; or the Vermont agency of human services.

(d) Notwithstanding subsections (a), (b), and (c) of this section, a health care contract may be amended by operation of law as required by any applicable state or federal law, rule, or regulation.

(e) Subsection (b) of this section shall not apply to amendments of health care contracts with hospitals.

Sec. 34. 18 V.S.A. § 9418e is added to read:

§ 9418e. MOST FAVORED NATION CLAUSES PROHIBITED

(a) No later than 180 days after the effective date of this section, no contracting entity shall do any of the following:

(1) Offer to a provider, hospital, pharmacist, or pharmacy a health care contract that includes a most favored nation clause;

(2) Enter into a health care contract with a provider, hospital, pharmacist, or pharmacy that includes a most favored nation clause; or

(3) Amend an existing health care contract previously entered into with a provider, hospital, pharmacist, or pharmacy to include a most favored nation clause.

Sec. 35. 18 V.S.A. § 9418f is added to read:

§ 9418f. RENTAL NETWORK CONTRACTS

(a) Definitions. As used in this section:

(1) “Health care services” means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

(2)(A) “Provider” means a physician, a physician organization, or a physician hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider’s participation in health care contracts.

(B) “Provider” does not include a physician organization or physician hospital organization that leases or rents the physician organization’s or physician hospital organization’s network to a covered entity.

(3) “Provider network contract” means a contract between a contracting entity and a provider specifying the rights and responsibilities of the

contracting entity and provider for the delivery of and payment for health care services to covered individuals.

(b) Scope. This section shall not apply to:

(1) Provider network contracts for services provided to Medicaid, Medicare, or the state children's health insurance program (SCHIP) beneficiaries.

(2) Circumstances in which access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity.

(c)(1) Registration. Any person not otherwise licensed or registered by the commissioner that intends to conduct business as a contracting entity shall register with the commissioner prior to commencing business. Each person not licensed or registered by the commissioner as a contracting entity upon the effective date of this section shall have 30 days within which to register with the commissioner.

(2) Registration shall consist of the submission of the following information:

(A) the official name of the contracting entity;

(B) the mailing address and main telephone number for the contracting entity's main headquarters; and

(C) the name and telephone number of the contracting entity's representative who shall serve as the primary contact with the commissioner.

(3) The information required by this subsection shall be submitted in written or electronic format, as prescribed by the commissioner.

(4) Annually on July 1, each person registered as a contracting entity under this section shall pay to the commissioner a fee of \$200.00. Fees collected under this subdivision shall be deposited into the health care special fund, number 21070, and shall be available to the commissioner to offset the cost of administering the registration process.

(d)(1) Contracting entity rights and responsibilities. A contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:

(A) the provider network contract specifically states that the contracting entity may enter into an agreement with a third party, allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and

(B) the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

(2) A contracting entity that grants access to a provider's health care services and contractual discounts pursuant to a provider network contract shall:

(A) identify and provide to the provider, upon request at the time a provider network contract is entered into with a provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider's health care services and contractual discounts pursuant to a provider network contract;

(B) maintain a website or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties to which the contracting entity has executed contracts to grant access to such provider's health care services and contractual discounts pursuant to a provider network contract;

(C) provide the covered entity with sufficient information regarding the provider network contract to enable the covered entity to comply with all relevant terms, limitations, and conditions of the provider network contract;

(D) require that the covered entity who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the covered entity on each remittance advice or explanation of payment form furnished to a health care provider when such discount is pursuant to the contracting entity's provider network contract;

(E) notify the covered entity who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than 30 days prior to the effective date of the final termination of the provider network contract; and

(F) require those that are by contract eligible to claim the right to access a provider's discounted rate to cease claiming entitlement to those rates or other contracted rights or obligations for services rendered after termination of the provider network contract.

(3) The notice required under subdivision (2)(E) of this subsection can be provided through any reasonable means, including written notice, electronic communication, or an update to an electronic database or other provider listing.

(4) Subject to any applicable continuity of care requirements, agreements, or contractual provisions:

(A) a covered entity's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated;

(B) claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and

(C) claims for health care services performed before the termination date of the provider network contract, but processed after the termination date,

are eligible for processing and payment in accordance with the provider network contract.

(5)(A) All information made available to providers in accordance with the requirements of this section shall be confidential and shall not be disclosed to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.

(B) Nothing in this section shall be construed to prohibit a contracting entity from requiring the provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities.

(e) Rental by third parties prohibited. A covered entity, having itself been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, may not further lease, rent, or otherwise grant access to the contract to any other person.

(f)(1) Unauthorized access to provider network contracts. It is a violation of this subchapter subject to enforcement under section 9418g of this title to access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or covered entity, as specified in this section.

(2) Contracting entities and third parties are obligated to comply with subdivision (d)(2)(B) of this section concerning the services referenced on a remittance advice or explanation of payment. A provider may refuse the discount taken on the remittance advice or explanation of payment if the discount is taken without a contractual basis or in violation of these sections. However, an error in the remittance advice or explanation of payment may be corrected within 30 days following notice by the provider.

(3) A contracting entity may not lease, rent, or otherwise grant a covered entity access to a provider network contract unless the covered entity accessing the health care contract is:

(A) a payer, a third party administrator, or another entity that administers or processes claims on behalf of the payer;

(B) a preferred provider organization or preferred provider network, including a physician organization or physician hospital organization; or

(C) an entity engaged in the electronic claims transport between the contracting entity and the payer that does not provide access to the provider's services and a discount to any other covered entity.

Sec. 36. 18 V.S.A. § 9418g is added to read:

§ 9418g. ENFORCEMENT

In addition to any other remedy provided by law, the commissioner may, in his or her sole discretion, enforce the provisions of this subchapter as specified

in this section. In determining whether to undertake an enforcement action, the commissioner may consider the relative resources of the complaining party and the alleged noncompliant party, the commissioner's other enforcement responsibilities, and such other factors as the commissioner deems appropriate.

(1) The commissioner shall have the power to examine and investigate any health plan, contracting entity, covered entity, or payer to determine if the health plan, contracting entity, covered entity, or payer has violated the provisions of this subchapter, or any rules or order of the commissioner adopted or issued thereunder.

(2) If the commissioner finds that a health plan, contracting entity, covered entity, or payer has violated this subchapter, or any rules or order of the commissioner adopted or issued thereunder, the commissioner may order the health plan, contracting entity, covered entity, or payer to cease and desist from further violations and may order the health plan, contracting entity, covered entity, or payer to remediate the violation.

(3) If the commissioner finds that a health plan, contracting entity, covered entity, or payer has violated this subchapter, or any rules or order of the commissioner adopted or issued thereunder, the commissioner may impose an administrative penalty against the health plan, contracting entity, covered entity, or payer of no more than \$1,000.00 for each violation and no more than

\$10,000.00 for each willful violation. In determining the amount of the penalty to be assessed, the commissioner shall consider the following factors:

(A) The appropriateness of the penalty with respect to the financial resources and good faith of the health plan, contracting entity, covered entity, or payer.

(B) The gravity of the violation or practice.

(C) The history of previous violations or practices of a similar nature.

(D) The economic benefit derived by the health plan, contracting entity, covered entity, or payer and the economic impact on the health care facility or health care provider resulting from the violation.

(E) Any other relevant factors.

(4) Any dispute arising out of or relating to the provisions of this subchapter shall, at the option of either party, be settled by arbitration in accordance with the commercial rules of the American Arbitration Association or the rules or procedures of another mutually agreed upon alternative dispute resolution forum, such as the American Health Lawyers Association.

Judgment upon the arbitrator's award may be entered in any court having jurisdiction, and the arbitrator's award shall be binding on both parties.

(5) Nothing in this subchapter shall be construed to prohibit a health plan, contracting entity, covered entity, or payer from applying payment policies that are consistent with applicable federal or state laws and

regulations, or to relieve a health plan, contracting entity, covered entity, or payer from complying with payment standards established by federal or state laws and regulations, including rules adopted by the commissioner.

Sec. 37. STATUTORY REVISION

Sections 9418 through 9418g of Title 18 shall be recodified as subchapter 2 (Claims Processing and Contract Standards) of chapter 221 of Title 18.

Sec. 38. WORKERS' COMPENSATION CONTRACT STANDARDS
STUDY

The Vermont Medical Society is requested to convene a work group consisting of representatives of workers' compensation carriers, health care providers, state agencies, and other interested stakeholders to study the provisions of sections 9418b through 9418f of Title 18 to determine whether some or all of these provisions should apply to workers' compensation carriers. No later than January 15, 2010, the work group is request to report its findings and recommendations to the house committee on health care and the senate committee on health and welfare.

* * * Treatment of a Partner of a Patient Diagnosed with Chlamydia * * *

Sec. 39. 26 V.S.A. § 1369 is added to read:

§ 1369. TREATMENT OF PARTNER OF PATIENT DIAGNOSED WITH
CHLAMYDIA INFECTION

(a) Notwithstanding any other provision of law or rule to the contrary, an individual licensed to practice medicine under this chapter or chapter 33 of this title, an individual certified as a physician's assistant under chapter 31 of this title, or an individual licensed to practice nursing under chapter 28 of this title who is authorized to prescribe and dispense prescription drugs and who diagnoses a sexually transmitted chlamydia infection in an individual patient may prescribe and dispense those prescription drugs to the patient's sexual partner or partners for the treatment of chlamydia without an examination of the sexual partner or partners.

(b) A health care professional who prescribes prescription drugs to a patient's sexual partner or partners without an examination pursuant to subsection (a) of this section shall include with each such prescription a letter that:

(1) cautions the partner not to take the medication if he or she is allergic to the drug prescribed; and

(2) recommends that the partner visit a health care professional for an evaluation.

Sec. 40. STUDY ON EMERGENCY RESPONSE FOR PATIENTS
SUFFERING A STROKE

The Vermont association of hospitals and health systems (VAHHS) is requested to convene a group consisting of emergency room physicians from around the state, including one representative from the Vermont chapter of the American College of Emergency Physicians and at least one representative from the Vermont emergency department medical directors committee; neurologists from Fletcher Allen Health Care and Dartmouth Hitchcock Medical Center who specialize in the treatment of strokes; and one representative from the American Heart Association/American Stroke Association. No later than November 15, 2009, VAHHS is requested to provide a report to the house committee on health care and the senate committee on health and welfare, recommending ways to integrate timely, effective stroke treatment in Vermont considering evidence-based treatments accepted by the American Academy of Neurology or the American College of Emergency Physicians, or both. The report shall include:

(1) information about the capacity of each hospital to provide emergency treatment of strokes following the guidelines accepted by The Joint Commission (TJC), including the services that each hospital offers, the types of relevant providers available at each hospital and the hours of availability, and the challenges posed by emergency transportation systems in Vermont;

(2) recommendations about additional services or infrastructure necessary to ensure that all Vermonters are able to receive the recommended treatment for strokes; and

(3) draft recommendations for the triage, stabilization, and appropriate routing by emergency medical service providers of patients who suffered a stroke, and coordination and communication between hospitals and between treating physicians.

* * * Vaccine Purchasing Pool * * *

Sec. 41. INTENT

It is the intent of the general assembly to establish an immunization pilot program for Vermonters in order to ensure universal access to immunizations for children and adults and to ensure that vaccines are purchased on a statewide basis at the lowest practicable cost to individuals, insurers, and the state. It is also the intent of the general assembly to ensure that vaccines for adults may be purchased in bulk and distributed throughout the state in the same manner as the pediatric vaccine distribution program established under 42 U.S.C. § 1396s (Social Security Act). And it is the intent of the general assembly to ensure sufficient state involvement and action to comply with federal anti-trust provisions by replacing competition with state regulation and supervision.

Sec. 42. 18 V.S.A. § 1130 is amended to read:

§ 1130. ~~IMMUNIZATIONS; PROVISION~~ IMMUNIZATION PILOT
PROGRAM

(a) As used in this section:

(1) “Health care facility” shall have the same meaning as in section 9402 of this title.

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

(3) “Health insurer” shall have the same meaning as in section 9402 of this title, but does not apply to insurers providing coverage only for a specified disease or other limited benefit coverage.

(4) “~~immunizations~~ Immunizations” means vaccines and the application of the vaccines as recommended by the practice guidelines for children and adults established by the Advisory Committee on Immunization Practices (ACIP) to the Centers for Disease Control and Prevention (CDC).

(5) “State health care programs” shall include Medicaid, the Vermont health access plan, Dr. Dynasaur, and any other health care program providing immunizations with funds through the Global Commitment for Health waiver approved by the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act.

~~(b) To the extent allowed by the appropriation, the department shall provide payment for any Vermont resident to receive immunizations without cost to the individual, except that individuals enrolled in Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, or any federal health insurance or federal program covering immunizations shall receive coverage under those programs.~~

(1) The department of health shall establish an immunization pilot program with the ultimate goal of ensuring universal access to vaccines for all Vermonters at no charge to the individual and to reduce the cost at which the state may purchase vaccines. The pilot program shall be in effect from January 1, 2010 through December 31, 2012. During the term of the pilot program, the department shall purchase, provide for the distribution of, and monitor the use of vaccines as provided for in this subsection and subsection (c) of this section. The cost of the vaccines and an administrative surcharge shall be reimbursed by health insurers as provided for in subsections (e) and (f) of this section.

(2) The department shall solicit, facilitate, and supervise the participation of health care professionals, health care facilities, and insurers in the immunization pilot program in order to accomplish the state's goal of universal access to immunizations at the lowest practicable cost to individuals, insurers, and state health care programs.

(3) The department shall gather and analyze data regarding the immunization pilot program for the purpose of ensuring its quality and maximizing protection of Vermonters against diseases preventable by vaccination.

(c) The immunization pilot program shall include a bulk purchasing pool to maximize the discounts, rebates, or negotiated price of all vaccines for children and certain recommended vaccines for adults. The department shall determine which vaccines for adults shall be purchased under the program. The department may join a multi-state purchasing pool or contract with a wholesale distributor to negotiate prices for the vaccines provided through the program.

(d) The immunization pilot program shall provide for distribution of the vaccines to health care professionals and health care facilities for administration to patients.

(e) Health insurers shall reimburse the department for the actual cost of vaccines provided to their subscribers and for the administration surcharge established in subsection (f) of this section.

(f) The department shall charge each health insurer a surcharge for the costs and administration of the immunization pilot program. The surcharge shall be deposited into an existing special fund and used solely for the purpose of administering the pilot program.

(g)(1) No later than July 1, 2009, the commissioner shall convene an advisory committee to provide recommendations regarding the immunization pilot program, including:

(A) the vaccines to be included in the pilot program;

(B) the pilot program's target patient utilization goal for each vaccine selected for inclusion in the pilot;

(C) the purchase price of vaccines;

(D) the administrative surcharge established pursuant to subsection (f) of this section; and

(E) the design of the evaluation for the immunization pilot program.

(2) The advisory committee shall include representatives from the three largest health insurers licensed to do business in Vermont and the office of Vermont health access and shall be chaired by the chief of the immunization program for the department of health.

(3) The advisory committee shall meet throughout the term of the pilot program.

(h) The department of health shall develop, with input from the advisory committee established pursuant to subsection (g) of this section, an evaluation methodology to determine the costs and effectiveness of the pilot program, including whether the total cost to health insurers of participation in the pilot

program is less than or equal to their estimated costs had they not participated in the program.

(i) The department may adopt rules under chapter 25 of Title 3 if necessary to implement this section.

Sec. 43. ADJUSTMENT TO FY10 SPENDING AUTHORITY FOR
GLOBAL COMMITMENT

(a) In order to provide for increased costs to the Catamount Health assistance program due to the expansion of the definition of “uninsured” and the modification of the preexisting condition exclusion in Sec. 18 of this act and the modification of the income calculation rules in Sec. 21 of this act, the appropriations for public health and Medicaid for fiscal year 2010 shall be those set forth in H.441 as passed by the House, except as provided for in this subsection. Of the Catamount funds appropriated in Sec. B. 312, Health - public health, \$77,000 shall be transferred to Sec. B.301, Secretary’s office - Global Commitment. The reduction in Sec. B.312 shall reduce the Catamount funds for the immunization program under 18 V.S.A. § 1130 as amended by Sec. 43 of this act. In Sec. B.301, these funds shall be combined with matching federal funds estimated to be \$121,000 to provide a total increase of \$198,000 in funding in Sec. B.307, Office of Vermont health access - Medicaid program - Global Commitment, to fund the costs of Secs. 18 and 21 of this act.

(b) The provisions of this section shall take precedence over any other funding provision related to these appropriations enacted for fiscal year 2010.

* * * Healthy Workers Program * * *

Sec. 44. INTENT

It is the intent of the general assembly to establish a healthy workers program to provide preventive health services, prenatal care, outreach, and education to workers employed in the Vermont agricultural sector.

Sec. 45. HEALTHY WORKERS PROGRAM; REPORT

(a) As used in this section:

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

(2) "Immunizations" means vaccines and the application of the vaccines as recommended by the practice guidelines for children and adults established by the Advisory Committee on Immunization Practices to the Centers for Disease Control and Prevention.

(3) "Vermont farm health connection" means a consortium comprising Vermont's clinics for the uninsured, federally qualified health centers, and the Bi-State Primary Care Association working together to implement pilot

programs in Addison and Franklin Counties to test design principles for a replicable system of high-quality health care for farm workers.

(b) The department of health shall collaborate with the Vermont farm health connection to:

(1) participate in the development of a sustainable, statewide infrastructure to provide outreach and health services to farm workers.

(2) provide access to:

(A) screening for communicable diseases;

(B) immunizations; and

(C) prenatal services.

(3) in consultation with the office of Vermont health access, research the required federal authority and fiscal implications of extending public health program benefits to pregnant women identified through the consortium's work.

(c) No later than January 15, 2010, the department of health and the Vermont farm health connection shall report to the senate committee on health and welfare and the house committee on health care regarding the status of the program's implementations and recommendations for any legislative action necessary to advance the goal of statewide outreach and access to health services for farm workers.

(d) No later than March 1, 2010, the Vermont farm health connection shall report to the senate committee on health and welfare and the house committee

on health care regarding the results of its assessment of the needs of three to five additional Vermont counties for health care services for farm workers.

Sec. 46. 9 V.S.A. chapter 80 is added to read:

CHAPTER 80. FLAME RETARDANTS

§ 2971. BROMINATED FLAME RETARDANTS

(a) As used in this section:

(1) “Brominated flame retardant” means any chemical containing the element bromine that is added to plastic, foam, or textile to inhibit flame formation.

(2) “Congener” means a specific PBDE molecule.

(3) “DecaBDE” means decabromodiphenyl ether or any technical mixture in which decabromodiphenyl ether is a congener.

(4) “Flame retardant” means any chemical that is added to a plastic, foam, or textile to inhibit flame formation.

(5) “Manufacturer” means any person who manufactures a final product containing a regulated brominated flame retardant or any person whose brand-name is affixed to a product containing a regulated brominated flame retardant.

(6) “Motor vehicle” means every vehicle intended primarily for use and operation on the public highways, and shall include farm tractors and other machinery used in the production, harvesting, and care of farm products.

(7) "OctaBDE" means octabromodiphenyl ether or any technical mixture in which octabromodiphenyl ether is a congener.

(8) "PentaBDE" means pentabromodiphenyl ether or any technical mixture in which a pentabromodiphenyl ether is a congener.

(9) "PBDE" means polybrominated diphenyl ether.

(10) "Technical mixture" means a PBDE mixture that is sold to a manufacturer. A technical mixture is named for the predominant congener in the mixture, but is not exclusively made up of that congener.

(b) As of July 1, 2010, no person may offer for sale, distribute for sale, distribute for promotional purposes, or knowingly sell at retail a product containing octaBDE or pentaBDE in a concentration greater than 0.1 percent by weight.

(c) Except for inventory purchased prior to July 1, 2009, a person may not, as of July 1, 2010, manufacture, offer for sale, distribute for sale, or knowingly sell at retail the following products containing decaBDE in a concentration greater than 0.1 percent by weight:

(1) A mattress or mattress pad; or

(2) Upholstered furniture.

(d) Except for inventory purchased prior to July 1, 2009, a person may not, as of July 1, 2012, manufacture, offer for sale, distribute for sale, or knowingly

sell at retail a television or computer with a plastic housing containing decaBDE in a concentration greater than 0.1 percent by weight.

(e) This section shall not apply to:

- (1) the sale or resale of used products; or
- (2) motor vehicles or parts for use on motor vehicles.

(f) As of July 1, 2010, a manufacturer of a product that contains decaBDE and that is prohibited under subsection (c) or (d) of this section shall notify persons that sell the manufacturer's product of the requirements of this section.

(g) A manufacturer shall not replace decaBDE, pursuant to this section, with a chemical that is:

(1) Classified as "known to be a human carcinogen" or "reasonably anticipated to be a human carcinogen" in the most recent report on carcinogens by the National Toxicology Program in the U.S. Department of Health and Human Services;

(2) Classified as "carcinogenic to humans" or "likely to be carcinogenic to humans in the U.S. Environmental Protection Agency's most recent list of chemicals evaluated for carcinogenic potential; or

(3) Identified by the U.S. Environmental Protection Agency as causing birth defects, hormone disruption, or harm to reproduction or development.

(h) A violation of this section shall be deemed a violation of the Consumer Fraud Act, chapter 63 of Title 9. The attorney general has the same authority

to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring civil actions, and private parties have the same rights and remedies as provided under subchapter 1 of chapter 63 of Title 9.

(i) In addition to any other remedies and procedures authorized by this section, the attorney general may request a manufacturer of upholstered furniture, mattresses, mattress pads, computers, or televisions offered for sale or distributed for sale in this state to provide the attorney general with a certificate of compliance with this section with respect to such products. Within 30 days of receipt of the request for a certificate of compliance, the manufacturer shall:

(1) Provide the attorney general with a certificate declaring that its product complies with the requirements of this section; or

(2) Notify persons who sell in this state a product of the manufacturer's which does not comply with this section that sale of the product is prohibited, and submit to the attorney general a list of the names and addresses of those notified.

(j) The attorney general shall consult with retailers and retailer associations in order to assist retailers in complying with the requirements of this section.

Sec. 47. 8 V.S.A. chapter 107, subchapter 11 is added to read:

Subchapter 11. Orally Administered Anticancer Medication

§ 4100g. ORALLY ADMINISTERED ANTICANCER MEDICATION;

COVERAGE REQUIRED

(a) A health insurer that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is no less favorable on a financial basis than intravenously administered or injected anticancer medications covered under the insured's plan.

(b) As used in this section, "health insurer" means any insurance company that provides health insurance as defined in subdivision 3301(a)(2) of this title, nonprofit hospital and medical service corporations, and health maintenance organizations. The term does not apply to coverage for specified disease or other limited benefit coverage.

Sec. 48. ORALLY ADMINISTERED ANTICANCER MEDICATION

STUDY

(a) The department of banking, insurance, securities, and health care administration shall study the impact of implementing a requirement for health insurance coverage of orally administered anticancer medication. In conducting the study, the department shall consider:

(1) projected impacts on health insurance premiums;

(2) options for mitigating the impact on premiums of the coverage requirement;

(3) the administrative complexities associated with the coverage requirement;

(4) the public policy implications of expanding required coverage for treatment-specific medications and procedures;

(5) appropriate safeguards for accomplishing the purpose of the coverage requirement; and

(6) such other factors as the department deems appropriate.

(b) No later than January 15, 2010, the department shall report its findings and recommendations to the senate committee on health and welfare and the house committee on health care.

Sec. 49. APPROPRIATION

In fiscal year 2010, the sum of \$3,000.00 is appropriated to the department of banking, insurance, securities, and health care administration from the health care special fund, number 21070, for the purpose of administering the registration fee pursuant to 18 V.S.A. § 9418f.

Sec. 50. HOSPITAL BUDGETS

(a) A number of health care reform initiatives in Vermont, including the Blueprint for Health, health information technology, and an exploration of the variations in hospital utilization, are expected to yield results in containing

health care costs in this state. As Vermont is able to rein in health care spending, it is anticipated that hospitals will also play an important role by continuing to slow the increase in hospital budget growth.

(b) In approving hospital budgets for fiscal years 2010, 2011, and 2012, the goal of the commissioner of banking, insurance, securities, and health care administration shall be to lower the average systemwide rate increase for all Vermont hospital budgets below the average systemwide rate increase for all Vermont hospitals during the previous three years. As part of his or her efforts, the commissioner may:

(1) Establish an annual systemwide target rate increase;

(2) Limit expenditure growth, including restricting the introduction of new programs and program enhancements;

(3) Limit capital spending; or

(4) Implement other reasonable means to achieve the purposes of this section.

(c) In approving hospital budgets pursuant to section 9456 of Title 18, nothing in this section shall be deemed to limit the authority of the commissioner to consider individual hospital circumstances or the impact of individual budget increases on the overall cost of Vermont's health care system.

(d) No later than January 15 in the years 2010, 2011, and 2012, the commissioner of banking, insurance, securities, and health care administration shall report the results of the annual hospital budget approvals to the senate committee on health and welfare and the house committee on health care.

Sec. 51. EFFECTIVE DATES

(a) Secs. 14 through 17, inclusive, of this act shall take effect upon passage.”

(b) Sec. 18, 8 V.S.A. § 4089k, of this act shall take effect on July 1, 2009, and the amendments to that section shall apply to the calculation, assessment, and payment of the health information technology reinvestment fee beginning on October 1, 2009.

(c) Secs. 19 and 20 (Catamount Health) shall take effect April 1, 2010.

(d) Sec. 22(b) (rulemaking on depreciation) shall take effect for the purposes of the rulemaking process on July 1, 2009, but the rule shall not take effect earlier than February 1, 2010.

(e) Health plans and contracting entities and payers shall comply with the amendments to Sec. 29, 18 V.S.A. § 9418(b), (c), (d), and (e) (payment for health care services), no later than July 1, 2010.

(f) Sec. 30, 18 V.S.A. § 9418a(b) and (c) (edit standards), shall take effect July 1, 2011.

(g) Sec. 32, 18 V.S.A. § 9418c(a)(1) through (4) (disclosure of payment information), with the exception of subdivision (a)(1)(C) (disclosure of claim edit information), shall take effect as follows:

(1) Contracting entities shall provide the information required in subdivisions (a)(1) through (3) beginning on July 1, 2009.

(2) Contracts shall obligate contracting entities to provide the information required in subdivision (a)(1) of this section, with the exception of subdivision (a)(1)(C), upon request beginning no later than September 1, 2009, and for all participating health care providers no later than January 1, 2010.

(3) Contracting entities and contracts shall comply with the provisions of subdivision (a)(1)(C) of this section no later than July 1, 2010.

(h) The summary disclosure form required by Sec. 32, 18 V.S.A. § 9418c(d), shall be included in all contracts entered into or renewed on or after July 1, 2009 and shall be provided for all other existing contracts no later than July 1, 2014.

(i) Contracting entities and covered entities shall comply with the provisions of Sec. 35, 18 V.S.A. § 9418f (rental networks), no later than January 1, 2010.

(j) This section, Sec. 37 (statutory revision), and Sec. 40 (stroke treatment study) shall take effect on passage.

(k) Sec. 47 shall take effect on April 1, 2010 and shall apply to all health benefit plans on and after April 1, 2010 on such date as a health insurer offers, issues, or renews the health benefit, but in no event later than April 1, 2011.

(l) All remaining sections shall take effect on July 1, 2009.

Approved: June 2, 2009