H.510

Introduced by Representatives Poirier of Barre City, Hooper of Montpelier, Ancel of Calais, Bohi of Hartford, Botzow of Pownal, Browning of Arlington, Cheney of Norwich, Clarkson of Woodstock, Donovan of Burlington, Emmons of Springfield, Fisher of Lincoln, Howard of Rutland City, Lorber of Burlington, Malcolm of Pawlet, Martin of Springfield, Miller of Shaftsbury, Mitchell of Barnard, Moran of Wardsboro, Nuovo of Middlebury, Pellett of Chester, Peltz of Woodbury, Sharpe of Bristol, South of St. Johnsbury, Stevens of Waterbury, Sweaney of Windsor, Till of Jericho, Webb of Shelburne, Weston of Burlington, Zenie of Colchester and Zuckerman of Burlington

Referred to Committee on

Date:

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

Statement of purpose: This bill proposes to provide comprehensive, affordable, quality health care coverage for all Vermont residents and to contain health care costs. It would establish a public health care coverage option called Green Mountain Care with sliding-scale premiums and cost-sharing that would be available to all Vermont residents and would be

funded, in part, with a payroll tax. The bill would also focus on hospital cost containment by implementing a statewide global hospital budget and negotiated hospital payments for individual hospitals while providing hospital services to all Vermont residents. The bill would require all Vermont residents to have health care coverage at least equivalent to the actuarial value of Green Mountain Care and would assess a financial penalty against those who fail to maintain such coverage. The bill would institute a candy and soft drink tax to help fund Green Mountain Care, as well as a 10-percent payroll tax on all employers with more than four employees. The bill would require health insurers to allow parents to continue to cover adult children up to age 27 on their health plan, would eliminate private insurance exclusions on coverage of preexisting conditions, and would allow individuals to purchase insurance in the nongroup market regardless of whether they are eligible for an employer-sponsored plan. Finally, the bill would repeal the commission on health care reform and would appropriate $500,000.00 to the state's health care provider and educator loan repayment program.

An act relating to a public health care coverage option

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

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

CHAPTER 18. GREEN MOUNTAIN CARE

§ 1801. DEFINITIONS

In this chapter:

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

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

(3) "Children's Health Insurance Program" or "CHIP" means the medical assistance program established under Title XXI of the Social Security Act.

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

(5) "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.

(6) "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.

(7) "Commissioner" means the commissioner of banking, insurance, securities, and health care administration.

(8) "Health benefit plan" means a health benefit plan offered or administered by a health insurer, as defined by section 9402 of Title 18, and the out-of-state counterparts to such plans.

(9) "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.

(10) "Hospital" shall have the same meaning as in section 1902 of Title 18 and may include hospitals located out of state.

(11) "Medicaid" means the medical assistance program established under Title XIX of the Social Security Act.

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

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

(14) "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.

(15) "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.

(16) "Secretary" means the secretary of the agency of human services or designee.

(17) "Vermont resident" means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont

indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.

Subchapter 1. Health Care Coverage

§ 1802. GREEN MOUNTAIN CARE

(a) The agency of human services shall establish Green Mountain Care, a public health care coverage option with sliding-scale premiums and cost-sharing for all Vermont residents. Green Mountain Care shall include coverage for eligible low income residents with Medicaid funds to the extent approved by the Centers for Medicare and Medicaid Services.

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

§ 1803. ELIGIBILITY

(a) Green Mountain Care shall be available to all Vermont residents, except as otherwise provided in subsection (c) of this section.

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

(c) An individual who is eligible for Medicare shall not be eligible for Green Mountain Care.

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

(e) The agency shall fund Green Mountain Care benefits with Medicaid or CHIP funds for eligible individuals as determined through a Medicaid waiver under Section 1115 of the Social Security Act. The agency may provide long-term care services through Choices for Care instead of through Green Mountain Care. Green Mountain Care shall comply with the provisions of subchapter 1 of chapter 19 of this title and all applicable federal laws.

§ 1804. COVERED HEALTH SERVICES

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

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

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

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

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

(B) not exclude from its network or list of authorized providers any licensed mental health or substance abuse provider located within the geographic coverage area of Green Mountain Care if the provider is willing to meet the terms and conditions for participation established by Green Mountain Care; and

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

(b)(1) For individuals eligible for Medicaid, the benefit package shall include the benefits provided to these individuals on September 30, 2011, except that, consistent with federal law, the general assembly may modify benefits to these individuals. Individuals whose benefits are paid for with Medicaid or CHIP funds shall receive, at a minimum, the Green Mountain Care benefit package.

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

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

§ 1805. CHRONIC CARE MANAGEMENT

(a)(1) The agency shall create a chronic care management program as provided for in this section, which may be administered or provided by a private entity for individuals with one or more chronic conditions who are enrolled in Green Mountain Care. The program shall not include individuals who are also eligible for Medicare, who are enrolled in the Choices for Care Medicaid Section 1115 waiver, or who are in an institute for mental disease as defined in 42 C.F.R. § 435.1009.

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

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

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

(1) a method involving the health care professional in identifying eligible patients, including the use of the chronic care information system established in section 702 of Title 18, an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk assessment for each individual;

(2) the process for coordinating care among health care professionals;

(3) the methods of increasing communications among health care professionals and patients, including patient education, self-management, and follow-up plans;

(4) the educational, wellness, and clinical management protocols and tools used by the care management organization, including management guideline materials for health care professionals to assist in patient-specific recommendations;

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

(6) payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve the quality of care, including case management fees, pay for performance, payment for technical support and data entry associated with patient registries,

the cost of staff coordination within a medical practice, and any reduction in a health care professional's productivity;

(7) payment to the care management organization which would put all or a portion of the care management organization's fee at risk if the management is not successful in reducing costs to the state;

(8) a requirement that the data on enrollees be shared, to the extent allowable under federal law, with the secretary of administration in order to inform the health care reform initiatives under section 2222a of Title 3;

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

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

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

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

(f) The terms used in this section shall have the meanings defined in section 701 of Title 18.

§ 1806. SLIDING-SCALE PREMIUMS

(a)(1) Except as provided for in section 1901 of this title, the agency shall establish individual, two-person, and family premium amounts on a sliding scale for Green Mountain Care. In the sliding scale, the agency shall use income increments based on the federal poverty level that include 50 percentage points per increment.

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

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

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

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

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

§ 1807. SLIDING-SCALE COST SHARING

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

(1) There shall be sliding scale deductibles based on income with a range from $0.00 to $250.00 for an individual, $0.00 to $350.00 for a two-person group, and $0.00 to $500.00 for a family for health services received in network, and a range from $0.00 to $500.00 for an individual, $0.00 to $750.00 for a two-person group, and $0.00 to $1,000.00 for a family for health services received out of network. The agency shall propose the applicable income increments and amounts for each deductible level annually as part of the legislative budget process. Individuals, two-person groups, and families with incomes at or below 100 percent of the federal poverty level shall not pay a deductible.

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

(3) Co-payments shall be as follows:

(A) $10.00 for an office visit;

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

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

(4) Prescription drug coverage shall be provided without a deductible. Co-payments for prescription drugs shall be on a sliding scale based on income, with a range from $1.00 to $10.00 for generic drugs, $2.00 to $30.00 for drugs on the preferred drug list, and $3.00 to $50.00 for nonpreferred drugs. The agency shall propose the applicable income increments and amounts for each co-payment level annually as part of the legislative budget process.

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

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

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

§ 1808. ADMINISTRATION

(a) The agency of human services shall implement Green Mountain Care to provide Vermont residents with coverage no later than October 1, 2011. The agency shall provide options for individuals to enroll in an individual, two-person, or a family plan with a sliding-scale premium established in section 1806 of this chapter.

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

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

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

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

(2) The agency shall collect additional information necessary to determine the individual's premium and cost-sharing amounts and requirements necessary to determine if Medicaid or CHIP funds are available for that individual or family after submission of the application, but shall provide payment for any services received by the individual at the time the application is submitted. Coverage for individuals ineligible for Medicaid shall be from the date of application. Coverage for individuals eligible for Medicaid shall be retroactive for three months.

(3) An individual who has been found presumptively eligible for Green Mountain Care pursuant to this section on three or more occasions but has failed to pay the required premiums and cost-sharing amounts subsequent to each such finding of eligibility may continue to receive services under Green Mountain Care but shall be subject to the assessment established in section 1852 of this title for the applicable calendar year as though such individual

failed to comply with the individual mandate, regardless of the individual's coverage status or whether such individual would otherwise be eligible for an exemption from the assessment.

(f) Nothing in this subchapter shall require an individual covered by health insurance to terminate that insurance. An individual enrolled in Green Mountain Care may elect to maintain supplemental health insurance if the individual so chooses, provided that after October 1, 2011, the supplemental insurance shall cover only services that are not already covered by Green Mountain Care.

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

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

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

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

§ 1809. BUDGET FOR PACKAGE OF HEALTH SERVICES

(a) The agency shall develop a budget for Green Mountain Care based on the payment methodologies established in section 1810 of this title, payment amounts established in section 1811 of this title, and the hospital budgeting and payment provisions provided for in subchapter 3 of this chapter.

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

§ 1810. PAYMENTS TO HEALTH CARE PROFESSIONALS

(a) No later than February 1, 2011, the agency shall determine by rule pursuant to chapter 25 of Title 3 the type of payment method to be used for health services under Green Mountain Care. The payment methods shall encourage cost-containment; provision of high quality, evidence-based health services in an integrated setting; patient self-management; and healthy lifestyles. In developing the payment methods, the agency shall consult with health care professionals prior to filing draft rules for comment.

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

(1) periodic payments based on approved annual global hospital budgets as provided for in subchapter 3 of this chapter;

(2) capitated payments;

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

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

(5) fee-for-service.

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

§ 1811. PAYMENT AMOUNTS

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

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

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

(B)(i) for primary or preventive care or chronic care management, the rate derived from the Medicare fee schedule at an amount 10 percent greater than fee schedule amounts paid under the Medicare program in 2009; and

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

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

(c) Payment amounts for hospital services shall be established as provided in subchapter 3 of this chapter.

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

§ 1812. GREEN MOUNTAIN CARE TRUST FUND

(a) The Green Mountain Care trust fund is established in the state treasury for the purpose of financing health care coverage for beneficiaries of Green Mountain Care as established under this subchapter. Monies from this fund may be transferred to the Global Commitment fund for the purposes of establishing the federal Medicaid match for eligible individuals and to the Vermont hospital security trust fund for the Green Mountain Care hospital payment established in subchapter 3 of this chapter.

(b) Into the fund shall be deposited:

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

(2) the candy and soft drink tax allocated in section 9820 of Title 32;

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

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

(5) assessments for failure to comply with the individual responsibility requirement established in subchapter 4 of this chapter;

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

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

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

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

Subchapter 2. Pharmacy Best Practices and Cost Containment

§ 1821. PHARMACY BEST PRACTICES

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

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

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

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

(A) a supplemental rebate program; and

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

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

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

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

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

§ 1822. PREFERRED DRUG LIST

(a)(1) The drug utilization review board shall make recommendations to the secretary for the adoption of the preferred drug list. The board's recommendations shall be based upon evidence-based considerations of clinical efficacy, adverse side-effects, safety, appropriate clinical trials, and cost-effectiveness. "Evidence-based" shall have the same meaning as in section 4622 of Title 18. The secretary shall provide the board with evidence-based information about clinical efficacy, adverse side-effects, safety, appropriate clinical trials, and shall provide information about cost-effectiveness of available drugs in the same therapeutic class.

(2) The board shall meet at least quarterly. The board shall comply with the requirements of subchapter 2 of chapter 5 of Title 1 (open meetings) and subchapter 3 of chapter 5 of Title 1 (open records), except that the board may go into executive session to discuss drug alternatives and receive information on the relative price, net of any rebates, of a drug under discussion and the drug price in comparison to the prices, net of any rebates, of alternative drugs available in the same class to determine cost-effectiveness, and in order to comply with subsection 1826(c) of this title to consider information relating to

a pharmaceutical rebate or to supplemental rebate agreements, which information is protected from disclosure by federal law or the terms and conditions required by the Centers for Medicare and Medicaid Services as a condition of rebate authorization under the Medicaid program.

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

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

(5) Members of the board shall receive per diem compensation and reimbursement of expenses in accordance with section 1010 of Title 32.

(6) The secretary shall encourage participation in a joint purchasing consortium by inviting representatives of the programs and entities to participate as observers or nonvoting members in the drug utilization review board, and by inviting the representatives to use the preferred drug list in connection with the plans' prescription drug coverage.

(b) The agency shall seek assistance from entities conducting independent research into the effectiveness of prescription drugs to provide technical and

clinical support in the development and the administration of the preferred drug list and the evidence-based education program established in subchapter 2 of Title 18.

§ 1823. PHARMACY MAIL ORDER

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

§ 1824. CONSUMER PROTECTION RULES; PRIOR AUTHORIZATION

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

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

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

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

(B) The prescriber's determination concerning whether the standards established in this subdivision (2) have been demonstrated shall be final if any

documentation required at the direction of the drug utilization board has been provided.

(b) The agency shall provide information on how prescribers, pharmacists, beneficiaries, and other interested parties can obtain a copy of the preferred drug list, whether any change has been made to the preferred drug list since it was last issued, and the process by which exceptions to the preferred list may be made.

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

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

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

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

(4) Any request for authorization or approval of a drug that the prescriber indicates, including the clinical reasons for the request, is for an

emergency or urgent condition that shall be responded to in no more than four hours from the time the agency receives the request.

(5) In emergency circumstances, or if the response to a request for prior authorization is not provided within the time period established in subdivision (4) of this subsection, a 72-hour supply of the drug prescribed shall be deemed to be authorized by the agency, provided it is a prescription drug approved by the Food and Drug Administration, and provided, for drugs dispensed to a Medicaid-funded enrollee in Green Mountain Care, it is subject to a rebate agreement with the Centers for Medicare and Medicaid Services.

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

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

§ 1825. PHARMACY BENEFIT MANAGEMENT

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

§ 1826. SUPPLEMENTAL REBATES

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

(b) The agency shall negotiate supplemental rebates, price discounts, and other mechanisms to reduce net prescription drug costs by means of any negotiation strategy which the secretary determines will result in the maximum economic benefit to the program and to consumers in this state, while

maintaining access to high quality prescription drug therapies. The agency may negotiate through a purchasing pool or directly with manufacturers. The provisions of this subsection do not authorize agreements with pharmaceutical manufacturers where financial support for medical services covered by the Medicaid program is accepted as consideration for placement of one or more prescription drugs on the preferred drug list.

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

Subchapter 3. Hospital Cost Containment

§ 1831. PURPOSE

The purpose of this subchapter is to provide the opportunity to reduce hospital and related administrative costs in order to ensure the sustainability of providing access to payment for health services under Green Mountain Care. The general assembly recognizes that the health care system is in crisis, and that all Vermonters do not have the financial ability to pay for increasing health insurance premiums or for the rising costs of health care. Vermonters

need access to care, regardless of ability to pay or insurance coverage. Additionally, the state must seek financial sustainability of the health care system, including reducing health care spending and transaction costs.

§ 1832. VERMONT HOSPITAL SECURITY PLAN

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

(b) The Vermont hospital security plan shall:

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

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

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

§ 1833. GLOBAL HOSPITAL BUDGETS

(a) Annually beginning with hospital fiscal year 2012, the commissioner of banking, insurance, securities, and health care administration, in collaboration with the secretary of human services, shall develop a global hospital budget for the state and individual negotiated inclusive hospital budgets for each hospital located in Vermont. The commissioner shall consider the portions of the health resource allocation plan under section 9405 of Title 18 applicable to hospitals; the portions of the unified health care budget under section 9406 of Title 18 applicable to hospitals; the hospital budgets reviewed under section 9456 of Title 18; the negotiated inclusive hospital payments under section 1835 of this title; and all other revenue received by hospitals in the development of the global hospital budget. The global hospital budget for the state shall be reported annually to the general assembly on or before January 15 for the following fiscal year.

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

under subchapter 5 of chapter 221 of Title 18 are consistent with the global hospital budget.

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

§ 1834. GREEN MOUNTAIN CARE HOSPITAL PAYMENTS

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

§ 1835. NEGOTIATED INCLUSIVE HOSPITAL PAYMENTS

The commissioner shall negotiate with each Vermont hospital for an inclusive hospital payment for specified health services provided to all individuals by that hospital. The payment amount shall be based upon the hospital's share of the global hospital budget developed under section 1833 of this title, the Green Mountain Care hospital payment, and other information necessary to the determination of the appropriate payment, including all other

revenue received from other sources. The payment amount shall not include any sums to be expended for hospital advertising purposes. The agency shall adopt by rule standards and procedures necessary to implement this section.

§ 1836. PAYMENTS TO OUT-OF-STATE HOSPITALS

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

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

§ 1837. VERMONT HOSPITAL SECURITY TRUST FUND

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

(b) Into the fund shall be deposited:

(1) transfers from other funds, including the Green Mountain Care trust fund and the global commitment fund, authorized by the general assembly;

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

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

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

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

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

Subchapter 4. Individual Responsibility Requirement

§ 1851. DEFINITIONS

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

(1) "Benchmark benefit plan" means a health benefit plan that provides coverage for preventive services and provides additional coverage that is at least equivalent to the actuarial value of Green Mountain Care. The term does not include a high deductible plan unless such plan is offered by an employer and the employer pays into the employee's health savings account an amount of funds sufficient to enable the employee to receive first dollar coverage under the plan.

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

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

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

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

(D) made a declaration of homestead pursuant to section 5410 of Title 32;

(E) submitted a claim pursuant to subsection 6066(b) of Title 32 (income sensitivity adjustment);

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

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

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

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

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

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

(L) is registered to vote in this state;

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

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

§ 1852. HEALTH COVERAGE MANDATE; REPORTING; ASSESSMENTS

(a) As of April 1, 2012, the following individuals age 18 and over shall obtain and maintain health coverage at least equivalent to the benchmark benefit plan:

(1) Vermont residents; and

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

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

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

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

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

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

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

(2) The assessment shall be imposed for each of the months for which the individual did not meet the coverage requirement in subsection (a) of this section; provided, however, that any lapse in coverage of 63 days or fewer shall not be counted in calculating the assessment; and provided further that

nothing in this subsection shall be deemed to authorize the commissioner of taxes to retain any amount for such purposes that otherwise would be paid to a claimant, agency, or agencies as debts pursuant to subchapter 12 of chapter 151 of Title 32.

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

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

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

§ 1853. EXEMPTION FOR REFUSAL OF COVERAGE BASED ON SINCERELY HELD RELIGIOUS BELIEFS

(a) An individual shall be exempt from the coverage requirement pursuant to subsection 1852(a) of this title if the individual files a sworn affidavit with his or her income tax return stating that such individual did not have creditable coverage, and that his or her sincerely held religious beliefs are the basis of his

or her refusal to obtain and maintain the required coverage during the 12 months of the taxable year for which the return was filed.

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

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

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

(1) the application is consistent with the health resource allocation plan and, as applicable, the financial parameters set by the global hospital budget established under section 1813 of Title 33;

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

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

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

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

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

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

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

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

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

(8) be consistent with the global hospital budget established under section 1813 of Title 33.

Sec. 4. FEDERAL WAIVERS

(a) The secretary of human services shall apply for a federal Medicare waiver no later than September 30, 2010, to allow the state to modify the payment standards or amounts in order to include Medicare funds in the global hospital budget established under section 1833 of Title 33.

(b) The secretary of human services shall apply for an amendment to the Global Commitment for Health and the Choices for Care federal Medicaid waivers no later than September 30, 2010, to allow the state to modify the payment standards or amounts in order to include Medicaid funds in the global hospital budget established under section 1833 of Title 33.

(c)(1) The secretary shall also apply for an amendment to the Global Commitment for Health waiver to provide benefits to individuals and families

through Green Mountain Care, instead of the current programs approved under the waiver.

(2) At minimum, this waiver amendment shall request federal participation for individuals up to 300 percent of the federal poverty level and request that there be no asset eligibility requirement, except as provided for under Vermont's current Global Commitment for Health waiver for mandatory and optional Medicaid populations.

(3) The waiver amendment request shall continue the managed care organization (MCO) structure allowing the office of Vermont health access to be a public MCO and maintaining the ability to provide MCO investments for reducing the rate of uninsured or underinsured in Vermont; increasing the access of quality health care to uninsured, underinsured, and Green Mountain Care beneficiaries; providing public health approaches to improve the health outcomes and the quality of life for Medicaid-eligible individuals and Green Mountain Care enrollees in Vermont; and encouraging the formation and maintenance of government and community partnerships in health care.

(d) If the waiver amendments are denied, the secretary may continue to provide medical assistance to eligible and enrolled individuals under provisions of the Global Commitment for Health waiver in effect upon passage of this act.

* * * Medicaid Provisions * * *

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

(b) The secretary may charge a ~~monthly~~ Green Mountain Care premium, ~~in amounts set by the general assembly~~ as provided for in section 1806 of this title, to ~~each~~ an individual 18 years or older who is eligible for ~~enrollment in the health access program, as authorized by section 1973 of this title and as implemented by rules. All premiums collected by the agency of human services or designee for enrollment in the health access program shall be deposited in the state health care resources fund established in section 1901d of this title~~ benefits paid for with Medicaid funds under the amended Global Commitment to Health waiver. Individuals eligible for Medicaid as defined in section 1801 of this title shall not be charged a premium unless specifically authorized by this section. Any Green Mountain Care co-payments, coinsurance, or other cost sharing to be charged to individuals whose benefits are paid for with Medicaid funds shall also be authorized and set by the general assembly.

(c) The secretary may charge a ~~monthly~~ Green Mountain Care premium, in amounts set by the general assembly, ~~per~~ for an individual, two-person group, or family for pregnant women and children eligible for medical assistance under sections 1902(a)(10)(A)(i)(III), (IV), (VI), and (VII) of Title XIX of the Social Security Act, whose family income exceeds 185 percent of the federal

poverty level, as permitted under section 1902(r)(2) of that act. ~~Fees collected under this subsection shall be credited to the state health care resources fund established in section 1901d of this title and shall be available to the agency to offset the costs of providing Medicaid services.~~ Any Green Mountain Care co-payments, coinsurance, or other cost sharing to be charged to individuals or families whose benefits are paid for with Medicaid or the Children's Health Insurance Program (CHIP) funds as defined in section 1801 of this title shall also be authorized and set by the general assembly.

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

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

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

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

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

~~(2) The department and the office shall submit reports at the end of each quarter required by subdivision (1) of this subsection to the house and senate committees on appropriations, the senate committee on health and welfare, the house committee on human services, the health access oversight committee, and the Medicaid advisory board.~~

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

Sec. 7. TRANSITIONAL PROVISIONS

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

(b) If the Centers for Medicare and Medicaid Services grant the waiver amendment requested in Sec. 4 of this act, beginning October 1, 2011, the agency of human services shall provide individuals currently eligible for

Medicaid, the Vermont health access plan, the employer-sponsored insurance program, Catamount Health Assistance, Dr. Dynasaur, or other coverage funded with Medicaid or the Children's Health Insurance Program (CHIP), as defined in section 1801 of this title, with a Green Mountain Care card at the time of the individual or family's recertification for current coverage.

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

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

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

Sec. 8. APPLICABILITY TO COLLECTIVE BARGAINING AGREEMENTS

Individuals insured through health benefit plans entered into as the result of a collective bargaining agreement shall not be subject to the benchmark benefit plan requirement of the individual coverage mandate in subsection 1852(a) of Title 33 until after the first renegotiation of the employment contract following April 1, 2012.

* * * Tax Financing * * *

Sec. 9. 32 V.S.A. § 9701(48) and (49) are added to read:

(48) Candy: means a preparation of sugar, honey, or other natural or artificial sweeteners in combination with chocolate, fruits, nuts, or other ingredients or flavorings in the form of bars, drops, or pieces. "Candy" shall not include any preparation containing flour and shall require no refrigeration.

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

Sec. 10. 32 V.S.A. § 9741(13) is amended to read:

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

Sec. 11. 32 V.S.A. § 9820 is added to read:

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

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

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

Sec. 12. 32 V.S.A. § 7823 is amended to read:

§ 7823. DEPOSIT OF REVENUE

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

Sec. 13. 21 V.S.A. chapter 27 is added to read:

CHAPTER 27. GREEN MOUNTAIN CARE CONTRIBUTIONS

§ 2101. ADMINISTRATION AND ENFORCEMENT OF CHAPTER

(a) The administration of this chapter is vested in the commissioner of the department of labor. All forms necessary and proper for the administration and enforcement of this chapter shall be prescribed and furnished by the commissioner. The commissioner shall appoint such agents, clerks, stenographers and other assistants as he or she may deem necessary for effecting the purposes of this chapter, but their salaries shall be fixed by the commissioner with the approval of the governor. The commissioner may require any such agent, clerk, stenographer, or other assistant to execute a bond in such sum as such commissioner shall determine for the faithful discharge of his or her duties. Any such agent, clerk, stenographer, or other assistant may be removed by the commissioner. The commissioner may prescribe regulations and rulings not inconsistent with law to carry into effect the provisions of this chapter, which regulations and rulings, when reasonably designed to carry out the intent and purpose of this chapter, shall be prima facie evidence of its proper interpretation. The commissioner, from time to time, shall publish for distribution such regulations prescribed by him or her and such rulings as he or she shall deem to be of general interest.

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

§ 2102. DEFINITIONS

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

§ 2103. EMPLOYER CONTRIBUTION

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

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

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

§ 2104. EMPLOYEE PREMIUM PAYMENT

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

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

(c) Every employer required to deduct the Green Mountain Care or other health benefit plan premium pursuant to subsection (a) or (b) of this section shall be liable for the payment of the premium and shall be indemnified against the claims and demands of any person for the amount of the payment made by the employer.

* * * Insurance Provisions * * *

Sec. 14. 8 V.S.A. § 4089d is amended to read:

§ 4089d. COVERAGE; DEPENDENT AND YOUNG ADULT CHILDREN

(a) As used in this section, "health insurance plan" ~~shall mean any group or individual policy, nonprofit hospital or medical service corporation, subscriber contract, health maintenance organization contract, self-insured group plan, and prepaid health insurance plans delivered, issued for delivery, renewed, replaced, or assumed by another insurer, or in any other way continued in force in this state~~ means any health insurance policy or health benefit plan offered by a health insurer, as defined in section 9402 of Title 18, and any health benefit plan offered or administered by the state or any subdivision or instrumentality of the state.

* * *

(e) Notwithstanding any other provision of this section, a family health insurance plan shall include an adult child up to the age of 27 as long as the child is unmarried, has no dependents of his or her own, is a Vermont resident, and does not have health insurance coverage through any branch of the military. For purposes of this section, "Vermont resident" means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.

(f) Nothing in this section shall be construed to require an employer to pay all or a portion of the premium for family coverage attributable to the coverage of a young adult child.

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

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

Sec. 16. 8 V.S.A. § 4080a(p) is added to read:

(p) The commissioner shall disapprove any rates filed by any registered small group carrier, whether initial or revised, for small group insurance policies unless the anticipated loss ratios for the entire period for which rates

are computed are at least 90 percent. For the purpose of this section, "anticipated loss ratio" shall mean a comparison of earned premiums to losses incurred plus a factor for industry trend in which the methodology for calculating trend shall be determined by the commissioner by rule.

Sec. 17. 8 V.S.A. § 4080b is amended to read:

§ 4080b. NONGROUP HEALTH BENEFIT PLANS

(a) As used in this section:

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

~~(2)~~ "Nongroup plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract or a health maintenance organization health benefit plan offered or issued to an individual, including but not limited to common health care plans approved by the commissioner under subsection (e) of this section. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, Medicare supplemental policies, and dental policies. The term also does not include hospital indemnity policies or specified disease indemnity or expense policies, provided such policies are sold only as supplemental coverage when a common health care plan or other comprehensive health care policy is in effect. By July 1, 1993, the commissioner shall review and approve or

disapprove, according to the provisions of section 4062 of this title, any supplemental health insurance policy form offered or issued to an individual within the state of Vermont.

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

* * *

(g) ~~For a 12-month period from the effective date of coverage, a registered nongroup carrier may limit coverage of preexisting conditions which exist during the 12-month period before the effective date of coverage; provided that a registered nongroup carrier shall waive any preexisting condition provisions for all individuals, and their dependents, who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to the common health care plan of the carrier approved by the commissioner. 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. Credit shall be given for prior coverage that occurred without a break in coverage of 63 days or more. For an eligible individual, as such term is defined in Section 2741 of Title XXVII of the Public Health Service Act, a registered nongroup~~

~~carrier shall not limit coverage of preexisting conditions.~~ Notwithstanding any provision of law to the contrary, a registered nongroup carrier shall not limit coverage of preexisting conditions which existed prior to the enrollment of an individual or his or her dependents in the plan.

* * *

(m) The commissioner shall disapprove any rates filed by any registered nongroup carrier, whether initial or revised, for nongroup insurance policies unless the anticipated loss ratios for the entire period for which rates are computed are at least ~~70~~ 90 percent. For the purpose of this section, "anticipated loss ratio" shall mean a comparison of earned premiums to losses incurred plus a factor for industry trend where the methodology for calculating trend shall be determined by the commissioner by rule.

* * * Miscellaneous Provisions * * *

Sec. 18. BLUEPRINT FOR HEALTH

The agency of human services shall apply to the Centers for Medicare and Medicaid Services to establish Medicare participation in the Blueprint for Health as part of the federal Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration project.

Sec. 19. 2 V.S.A. § 851 is amended to read:

§ 851. CREATION OF COMMITTEE

(a) A legislative health access oversight committee is created. The committee shall be appointed biennially and consist of ~~ten~~ 12 members: ~~five~~ six members of the house appointed by the speaker, not all from the same political party, and ~~five~~ six members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include two members from the house committee on human services, two members from the house committee on health care, one member from the house committee on ways and means, and one member from the house committee on appropriations. The senate appointees shall include three members from the senate committee on health and welfare, one member from the senate committee on finance, ~~and~~ one member from the senate committee on appropriations, and one member-at-large.

* * *

Sec. 20. 2 V.S.A. § 852(a) is amended to read:

(a) The health access oversight committee shall carry on a continuing review of the operation of the Medicaid program and all Medicaid waiver programs, including Green Mountain Care, that may affect the administration and beneficiaries of these programs.

Sec. 21. HEALTH CARE OMBUDSMAN

The agency of human services shall consult with the office of the health care ombudsman to ascertain the increased demand on the office's services as a result of the creation of Green Mountain Care and the individual responsibility requirement. As part of its fiscal year 2012 budget proposal, the agency shall propose increased funding for the office as needed to ensure adequate staffing and the provision of necessary consumer services.

* * * Technical Provision * * *

Sec. 22. STATUTORY REVISION AND RECODIFICATION

The legislative council shall revise the Vermont Statutes Annotated as necessary to reflect the purposes of this act, including modifying cross-references as necessary.

Sec. 23. REPEALS

(a) Subchapters 2 (Vermont Health Access Plan) and 3A (Catamount Health Assistance Program) of chapter 19 of Title 33 are repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act if later. Green Mountain Care, established in chapter 18 of Title 33, shall be the successor in interest to the Vermont health access plan, the employer-sponsored assistance program, and the Catamount Health assistance program. All funds remaining in the Catamount

Fund as of that date shall be transferred to the Green Mountain Care Trust Fund established by 33 V.S.A. § 1812.

(b) Section 2074 of subchapter 8 of chapter 19 of Title 33 (VermontRx) is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(c) Section 1903a (chronic care management program) of Title 33 is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act if later.

(d) Section 1998 (pharmacy best practices) of Title 33 is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(e) Section 1998a (pharmacy mail order) of Title 33 is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(f) Section 1999 (pharmacy consumer protection and prior authorization) of Title 33 is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(g) Section 2000 (pharmacy benefit management) of Title 33 is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(h) Section 2001 (report to legislature) of Title 33 is repealed effective July 1, 2010 or upon approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(i) Section 2002 (supplemental rebate) of Title 33 is repealed effective October 1, 2012 or 12 months after the approval of the waiver amendments provided for in Sec. 4(c) of this act, if later.

(j) Chapter 25 of Title 2 (joint legislative commission on health care reform) is repealed effective July 1, 2010.

(k) 8 V.S.A. § 4080c (health insurance safety net) is repealed effective November 1, 2012.

(l) 8 V.S.A. § 4080f (Catamount Health) is repealed effective November 1, 2012.

(m) 21 V.S.A. § 2003 (health care fund employer assessment) is repealed effective November 1, 2012.

Sec. 24. APPROPRIATION

In fiscal year 2012, the sum of $500,000.00 is appropriated to the department of health from the Green Mountain Care trust fund to be deposited in the Vermont health care educational loan repayment fund pursuant to section 10a of Title 18.

Sec. 25. EFFECTIVE DATES

(a) Sec. 1 (establishing Green Mountain Care) shall take effect July 1, 2010, except that:

(1) the commissioner of banking, insurance, securities, and health care administration and the secretary of human services may take steps beginning October 1, 2010, including rulemaking and collection of funds from insurers and from the Green Mountain Care trust fund, to ensure that the hospital global budget process established pursuant to subchapter 3 of chapter 18 of Title 33 will be operational for hospital fiscal year 2012;

(2) Green Mountain Care shall be implemented no later than October 1, 2011.

(3) the individual responsibility requirement established in subchapter 4 of chapter 18 of Title 33 shall take effect on April 1, 2012.

(b) Secs. 2 (certificate of need criteria) and 3 (hospital budget review) shall take effect July 1, 2010.

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

(d) Secs. 5 (Medicaid program changes) and 6 (repeal of Medicaid reports; prohibition on prescription co-payments) shall take effect upon the approval of the amendment to Vermont's Global Commitment for Health Medicaid Section 1115 waiver pursuant to Sec. 4(c) of this act.

(e) Sec. 7 (transitional provisions) shall take effect upon the approval of the amendment to Vermont's Global Commitment for Health Medicaid Section 1115 waiver pursuant to Sec. 4(c) of this act, except that subsection (d) of Sec. 7 (Catamount Health transition) shall take effect July 1, 2011 for individuals who are not receiving Catamount Health Assistance.

(f) Sec. 8 (applicability to collective bargaining agreements) shall take effect July 1, 2010.

(g) Secs. 9 (definitions of candy and soft drink), 10 (exclusion of candy and soft drinks from sales tax exemption, and 11 (allocation of tax on candy and soft drinks) shall take effect October 1, 2010.

(h) Sec. 12 (employer and employee contributions) shall take effect October 1, 2010.

(i) Sec. 13 (allocation of cigarette taxes) shall take effect July 1, 2011.

(j) Sec. 14 (health insurance coverage for dependents and young adults) shall take effect on October 1, 2010 and shall apply to all health insurance plans on and after October 1, 2010 on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than October 1, 2011.

(k) Sec. 15 (ban on preexisting condition exclusion for small group plans) shall take effect upon passage.

(l) Sec. 16 (anticipated loss ratios for small group plans) shall take effect upon passage.

(m) Sec. 17 (amendments to nongroup health plans) shall take effect upon passage.

(n) Sec. 18 (Blueprint for Health demonstration project) shall take effect upon passage.

(o) Sec. 19 (composition of health access oversight committee) shall take effect upon passage.

(p) Sec. 20 (health access oversight committee charge) shall take effect July 1, 2011.

(q) Sec. 21 (health care ombudsman staffing) shall take effect July 1, 2010.

(r) Sec. 22 (statutory revision authority) shall take effect upon passage.

(s) Sec. 23 (repeals) shall take effect upon passage.

(t) Sec. 24 (loan repayment appropriation) shall take effect July 1, 2010.

(u) This section shall take effect upon passage.