Journal of the Senate

WEDNESDAY, APRIL 7, 2010

The Senate was called to order by the President.

Devotional Exercises

A moment of silence was observed in lieu of devotions.

Message from the House No. 47

A message was received from the House of Representatives by Ms. H. Gwynn Zakov, its Second Assistant Clerk, as follows:

Mr. President:

I am directed to inform the Senate that:

The House has passed House bills of the following titles:

H. 689. An act relating to the Uniform Common Interest Ownership Act.

H. 790. An act relating to capital construction and state bonding.

In the passage of which the concurrence of the Senate is requested.

The House has adopted House concurrent resolutions of the following titles:

H.C.R. 299. House concurrent resolution congratulating the 2010 Albert D. Lawton Intermediate School Vermont MATHCOUNTS competition championship team.

H.C.R. 300. House concurrent resolution congratulating Representative Carolyn Branagan on being named the 2010 Vermont Mother of the Year.

H.C.R. 301. House concurrent resolution in memory of U.S. Army 2nd Lt. Joseph Douglas Fortin of St. Johnsbury.

H.C.R. 302. House concurrent resolution congratulating the 2010 Mount Anthony Union High School Patriots Division I championship boys' Nordic ski team.

H.C.R. 303. House concurrent resolution congratulating the 2010 Mount Anthony Union High School Patriots championship wrestling team.

H.C.R. 304. House concurrent resolution congratulating the 2010 Mount Anthony Union High School Patriots Division I championship girls' Nordic ski team.

H.C.R. 305. House concurrent resolution congratulating the 2010 Norwich University Cadets ECAC East women's ice hockey championship team.

H.C.R. 306. House concurrent resolution congratulating Craftsbury Academy student Mael Le Scouezec on winning the 2010 Vermont State Individual Spelling Bee.

In the adoption of which the concurrence of the Senate is requested.

The House has considered concurrent resolution originating in the Senate of the following title:

S.C.R. 47. Senate concurrent resolution honoring Vermont Food Education Every Day (VT FEED) as an innovative partnership facilitating statewide farm to school programs emphasizing the importance of food and nutrition education for the health of our communities.

And has adopted the same in concurrence.

Message from the Governor

A message was received from His Excellency, the Governor, by David Coriell, Secretary of Civil and Military Affairs, as follows:

Mr. President:

I am directed by the Governor to inform the Senate that on the seventh day of April, 2010 he did not approve and *allowed to become law without his signature a bill* originating in the Senate of the following title:

S. 117. An act relating to the date of the primary election.

Text of Communication from Governor

The text of the communication from His Excellency, the Governor, whereby he *allowed to become law without his signature* **Senate Bill No. S. 117** to the Senate is as follows:

April 7, 2010

The Honorable David A. Gibson
Secretary of the Senate
State House
115 State Street, Drawer 33
Montpelier, VT 05633

Dear Mr. Gibson:

Pursuant to Chapter II, Section 11 of the Vermont Constitution, I will allow **S.117**, An Act Relating to the Date of the Primary Election, to become law *without my signature* for the reasons stated herein.

The very essence of a representative democracy is that those represented participate in the electoral process. It is the responsibility of elected officials to assure an electoral system that encourages such participation. Vermont's electoral process has long honored that responsibility.

But now, in the guise of assuring that the votes of our brave men and women in the military are counted, as of course they should be, the Legislature has passed S. 117, which in all likelihood will discourage voter participation.

For the past 95 years Vermont has held its primary election on the second Tuesday in September. That date has served us well and assured that while much of the primary campaigning may have been over the summer months, the election itself would be held "post Labor Day," and after summer vacations. S. 117 would have us hold the primary in August, when Vermonters often enjoy their hard-earned vacations and surely are not focused on an election.

It need not have happened. Neither the Secretary of State nor the Legislature properly explored alternatives to moving the date. In the 21st century, new technologies, such as the electronic transmission of ballots, can ensure that all Vermonters, military and civilian alike, receive their ballots, cast them and have them counted without changing the primary date. In a letter to Vermont's Secretary of State dated November 6, 2009, the Federal Voting Assistance Program of the U.S. Department of Defense reported that service members and overseas voters visited by six state election officials in the Middle East, Asia and Europe found "a strong preference for, and almost universal access to, email or internet voting procedures." Although the use of technology should be our goal, there are other options, such as counting absentee ballots mailed prior to the election for a period of time beyond Election Day, available during the short term. There is simply no need to change the date.

The argument that Vermont is strictly bound by federal law to change the date of our primary is not borne out by the actions of others. Of the 10 other states with primary elections on or later than Vermont's, only Minnesota has acted to change the date of its primary. The concern that the federal government will ignore the provisions of the law that authorize the grant of a waiver, or will somehow dictate to the states when to hold its election during the law's first year of implementation, does not appear to be shared by nine other states.

Further, most would agree that our election season is already too long. It is no secret that the two-year term for Governor has created an almost perpetual campaign. Even before those elected in 2008 were sworn in, some candidates had already announced their intentions to run for higher office in the next

election. For statewide offices the solution is to follow the suit of 48 other states by changing to a four-year term.

But for local races, where a four-year term is not realistic, moving the primary earlier will force candidates to decide earlier and campaign earlier – extending the already long campaign season.

Finally, changing election law which affects a current, on going election is a practice we have sought to avoid in the past. This sentiment was echoed by the Secretary of State with respect to whether the campaign finance laws should be amended this session in her statement that "it's not been the tradition to make a change in an election year."

Already many candidates for state and local office are seeking petition signatures to compete in their party's primary on forms provided by the Secretary of State that will be inaccurate once this bill becomes law. Many locations and web postings have advertised September 14th as the date of the primary election as well. While I would expect that when this law goes into effect, efforts will be made to clarify the new primary date, there is ample room for confusion among potential candidates and the public.

In regards to the legislative intent to eliminate the opportunity of an individual to run as an independent after running and losing a party primary election, a close reading of the bill suggests that, through error or otherwise, this purpose was not accomplished. S. 117 allows independent candidates to file for the general election up until three days after the primary election.

Despite these objections I am letting S. 117 go into law without my signature. It is evident that there is not the will this year to make our longstanding September primary work. I greatly regret that and encourage the Legislature and the next Secretary of State to carefully analyze the impact of the summer primary on voter participation. I would hope that creative and innovative approaches can be taken to maximize voter participation while ensuring the integrity of our electoral system.

Sincerely,

/s/ James H. Douglas

James H. Douglas
Governor

JHD/dmc

Bills Referred

House bills of the following titles were severally read the first time and referred:

H. 689.

An act relating to the Uniform Common Interest Ownership Act.

To the Committee on Judiciary.

H. 790.

An act relating to capital construction and state bonding.

To the Committee on Institutions.

Joint Resolution Placed on Calendar

J.R.S. 60.

Joint Senate resolution of the following title was offered, read the first time and is as follows:

By All Members of the Senate,

J.R.S. 60. Joint resolution honoring women veterans and requesting that state and federal officials work cooperatively to assure that women veterans receive the recognition, the health care services and other support services they need and deserve.

Whereas, March is Women's History Month, and

Whereas, women have served honorably and with courage in all of America's wars and conflicts since the American Revolution, and

Whereas, the United States military has evolved from a predominantly male force to a force of over 14 percent women who are currently serving on active duty and nearly 17 percent serving in the Reserves and National Guard, and

Whereas, the number of women veterans is expected to be nearly two million by 2020 and will constitute more than 10 percent of the veteran population, and

Whereas, given that an unprecedented number of women are serving in the military and participating in Operation Enduring Freedom and Operation Iraqi Freedom, the United States Department of Veterans Affairs (VA) is working to provide consistent, comprehensive and high-quality health care and benefits to women veterans of all eras, and

Whereas, there is now a growing need to improve health care services for women veterans, to ensure clinicians are properly trained to provide primary care and gender-specific care to women of all ages, and to identify innovative courses of treatment and solutions to administrative obstacles that are unique to women veterans, and

Whereas, with a rapidly increasing number of women serving in the military today and returning from deployments as seasoned veterans, some with exposure to combat, VA facilities and veterans' service organizations are working to ensure that the postdeployment mental and physical health needs unique to women veterans are also met, and

Whereas, women deserve to be acknowledged for their military service and treated with equal respect, not only during Women's History Month but throughout the year, *now therefore be it*

Resolved by the Senate and House of Representatives:

That the General Assembly encourages the Vermont Office of Veterans Affairs and its women veterans coordinator to work in conjunction with the National Foundation for Women Legislators, Inc. and the Center for Women Veterans at the United States Department of Veterans Affairs, to reach out to all women veterans in Vermont and to encourage them to bring their specific needs and concerns to the attention of state and federal officials, so that state legislators and state and federal officials can work together to identify unique issues impacting women veterans and to consider policy solutions that will improve the quality of life for women veterans in Vermont, *and be it further*

Resolved: That the General Assembly honors all of the women in this state who have heroically answered their call to duty and recognizes the important role women have played in shaping this great nation, *and be it further*

Resolved: That the Secretary of State be directed to send a copy of this resolution to the director and to the women veterans coordinator at the Vermont Office of Veterans Affairs, the United States Veterans Health Administration's women veterans program manager in White River Junction, and the National Foundation of Women Legislators, Inc. in Washington, D.C.

Thereupon, in the discretion of the President, under Rule 51, the joint resolution was placed on the Calendar for action the next legislative day.

Senate Resolution Placed on Calendar

S.R. 21.

Senate resolution of the following title was offered, read the first time and is as follows:

By Senators Miller, Ayer, Bartlett, Brock, Campbell, Carris, Choate, Cummings, Doyle, Flanagan, Flory, Giard, Hartwell, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, Mazza, McCormack, Mullin, Nitka, Racine, Scott, Sears, Shumlin, Snelling, Starr and White,

S.R. 21. Senate resolution honoring Dr. Nina Lynn Meyerhof for her international leadership as an educator and peace advocate.

Whereas, Dr. Nina Lynn Meyerhof is a distinguished international educator and peace advocate who works to bring the diverse "human family into holistic communication and mutual understanding," and

Whereas, the breadth of her professional activities is truly remarkable as she has traveled to nearly 50 nations, including Brazil, Ghana, Holland, India, Nepal, Spain, Switzerland and Thailand, often in concert with the United Nations and other leading international organizations, as a leader and facilitator of educational and intercultural programs designed to promote peace, and

Whereas, for Dr. Meyerhof, "peace is more than the absence of war," rather "it is a state of Being," and

Whereas, she graduated from the City College of New York, earned master's degrees in special education from Columbia University Teachers' College and in counseling from Keene State College, and she completed her formal education at the University of Massachusetts, which awarded her a certificate of advanced graduate studies in school psychology and a doctorate in educational policy, research and administration, and

Whereas, Dr. Meyerhof, who for many years resided in Newfane, served as the special education coordinator for the Windham Southeast Supervisory Union, and

Whereas, seeking to combine her interests in education and promoting peace and holistic communities, Dr. Meyerhof founded and is the president of South Burlington-based Children of the Earth, an educational nonprofit group that the United Nations has designated an official nongovernmental organization which promotes "global consciousness and cooperation, multi-cultural understanding, spiritual values, ethical living skills, and social responsibility," and

Whereas, under Dr. Meyerhof's leadership, Children of the Earth offers leadership programs focused on peace-making, educational workshops at national and international forums, and an international network of peace-building coalitions and the organization was a key player in the formation of the Vermont Peace Academy, and

Whereas, on September 11, 2001, Dr. Meyerhof happened to be in New York City and helped organize a "Kids Korner" at the Red Cross Amory and the pier as "a safe haven for the children of all the victims," and

Whereas, Dr. Meyerhof has authored or co-authored several books on topics related to peace and education and is the recipient of international awards for her work as a peace advocate, *now therefore be it*

Resolved by the Senate:

That the Senate of the State of Vermont honors Dr. Nina Lynn Meyerhof for her international leadership as an educator and peace advocate, *and be it further*

Resolved: That the Secretary of the Senate be directed to send a copy of this resolution to Dr. Nina Lynn Meyerhof at Children of the Earth in South Burlington.

Thereupon, in the discretion of the President, under Rule 51, the resolution was placed on the Calendar for action the next legislative day.

Bill Recommitted

S. 294.

Senate bill entitled:

An act relating to identification in electioneering communications and penalties for campaign finance violations.

Was taken up.

Thereupon, pending the question Shall the bill be amended as moved by Senator White on behalf of the Committee on Government Operations?, on motion of Senator Shumlin, the bill was recommitted to the Committee on Government Operations.

Bill Passed in Concurrence with Proposal of Amendment

H. 539.

House bill of the following title was read the third time and passed in concurrence with proposal of amendment:

An act relating to amending the charter of the town of Hartford.

Bills Passed in Concurrence

House bills of the following titles were severally read the third time and passed in concurrence:

H. 639. An act relating to motor vehicle insurance for volunteer drivers.

H. 658. An act relating to the issuance of certificates of need for home health agencies and addressing patient transportation services in certificate of need applications.

H. 766. An act relating to preventing duplication in certain public health records.

Third Reading; Consideration Postponed

House bill entitled:

H. 765.

An act relating to establishing the Vermont agricultural innovation authority.

Was read the third time.

Thereupon, pending the question, Shall the bill pass in concurrence with proposal of amendment?, on motion of Senator Choate consideration of the bill was postponed until the next legislative day.

Consideration Postponed

Joint Senate resolution entitled:

J.R.S. 47.

Joint resolution strongly urging the Republic of Turkey to recognize the right to religious freedom for all its residents and to end all discriminatory policies directed against the Ecumenical Patriarchate of the Orthodox Church.

Was taken up.

Thereupon, without objection consideration of the joint resolution was postponed until Tuesday, April 13, 2010.

S.R. 17.

Senator Miller, for the Committee on Economic Development, Housing and General Affairs, to which was referred joint Senate resolution entitled:

Senate resolution urging Congress to authorize alternative waivers to the 21-year-old minimum drinking age that do not entail federal highway funding penalties for states.

Reported recommending that the joint resolution be amended by striking out the resolution in its entirety and inserting in lieu thereof the following:

Senate resolution relating to underage drinking.

Whereas, in 1984, Congress enacted Public Law 97-364, which in Sec. 101(a) added 23 U.S.C. § 408(f)(6) to the United States Code that established the statutory basis for the federal penalty that withholds ten percent of a state's federal highway funding if the state's drinking age is lower than 21, and

Whereas, the current ten percent highway funding penalty prevents an open public debate about the effects of the 21-year-old drinking age as it impacts unlawful, unsupervised consumption of alcohol, and

Whereas, given the constitutional authority of states to regulate alcohol within their borders, Congress should work with the states to find solutions to address the growing problem of unsupervised, underage consumption and overconsumption of alcohol, and

Whereas, each state has unique qualities and residents that make a one-size-fits-all solution difficult, and each state should have the opportunity to develop a comprehensive program that addresses its unique situation, and *now therefore be it*

Resolved by the Senate:

That the Senate of the State of Vermont urges Congress to authorize the states to address the problems associated with underage consumption of alcohol by obtaining waivers from federal law to avoid triggering federal highway funding penalties, *and be it further*

Resolved: That the Secretary of the Senate be directed to send a copy of this resolution to the Vermont Congressional delegation.

And that when so amended the resolution ought to be adopted.

Thereupon, pending the question Shall the joint resolution be amended as moved by the Committee on Economic Development, Housing and General Affairs?, Senator Scott, moved that the rules be suspended and that the bill be committed to the Committee on Transportation, *intact*.

Thereupon, pending the question, Shall the bill be committed to the Committee on Transportation, *intact*?, Senator Scott requested and was granted leave to withdraw his motion.

Thereupon, pending the question, Shall the joint resolution be amended as moved by the Committee on Economic Development, Housing and General Affairs?, on motion of Senator Shumlin consideration of the bill was postponed until the next legislative day.

Bill Amended; Third Reading Ordered

S. 88.

Senator Racine, for the Committee on Health and Welfare, to which was referred Senate bill entitled:

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

Reported recommending that the bill be by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds that:

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

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

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

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

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

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

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

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

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

percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums. Most Vermonters are a job loss away from being uninsured.

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

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

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

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

* * * HEALTH CARE SYSTEM DESIGN * * *

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for health services for all Vermonters. All Vermonters must have access to comprehensive, quality health care. Systemic barriers must not prevent people from accessing necessary health care.

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

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

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

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

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

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

Sec. 3. GOALS OF HEALTH CARE REFORM

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

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

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

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

(A) are coordinated;

(B) focus on meeting community health needs;

(C) match service capacity to community needs;

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

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

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

(G) contain costs.

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

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

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

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

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

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

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

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

(G) increasing price and quality transparency.

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

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

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

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

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

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

Sec. 4. VERMONT HEALTH CARE BOARD

(a) Definitions. As used in this act:

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

(2) "Health service" means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services provided pursuant to a health care professional's order, services to assist in activities of daily living, services for mental health conditions, drug and alcohol abuse treatment, and prescription drugs.

(3) "Hospital" shall have the same meaning as in 18 V.S.A. § 1902 and may include a hospital located outside Vermont.

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

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

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

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

(b) Vermont health care board.

(1) Within 30 days of enactment, the Vermont health care board is created and shall have the powers and duties established by this section. The board shall consist of five members who have demonstrated expertise in health care systems or health care system design. The governor shall appoint two members of the board. The speaker of the house, and the president pro tempore of the senate shall each appoint one member. The fifth member shall be chosen by a majority of the appointed members. All appointments shall be completed no later than 30 days after enactment.

(2) A person in the employ of or holding any official relation to any health care provider or insurer, or engaged in the management of a health care provider or insurer, or owning stock, bonds, or other securities thereof, or who is, in any manner, connected with the operation of a health care provider or insurer shall not be a member of the board. In addition, no board member shall render professional health care services or make or perform any business contract with any health care provider or insurer if such service or contract relates to the business of the health care provider or insurer, except contracts made as an individual or family in the regular course of obtaining health care services.

(3) The office of legislative council shall provide the board with administrative support, including technical support for budget management, payroll and fiscal matters, clerical staff, and office space. The board shall contract with outside consultants to provide expertise necessary to do the analysis and design required by this act. The legislative council and joint fiscal office shall provide the board with legal and fiscal support.

(4) The board shall be considered a public body pursuant to 1 V.S.A. § 310 and shall be subject to the access to public records requirements in 1 V.S.A. §§ 315–320. After the public oversight panel publicly reports its proposals to the general assembly as required in Sec. 5 of this act, the board may be subject to public access requests for material relied upon in making its proposals with redactions of proprietary or confidential information as needed.

(5) The board shall cease to exist on June 30, 2011.

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

Sec. 5. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1) By January 1, 2011, the Vermont health care board shall propose to the general assembly and the governor at least three design options and an implementation plan for creating and integrating a health care system that meets the principles and goals outlined in Secs. 2 and 3 of this act. One option shall include the design of a government-administered and -financed health benefits system decoupled from employment, which prohibits insurance coverage for the health services provided by this system and allows for private

insurance coverage of supplemental health services only. Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to achieve implementation of the new system no later than July 1, 2012.

(2) The board shall review and consider the findings and reports from previous studies of health care reform in Vermont, including the Universal Access Plan Report from the health care authority, November 1, 1993; reports from the Hogan Commission; relevant studies provided to the state of Vermont by the Lewin Group; and studies and reports provided to the joint legislative commission on health care reform. In addition, the board shall consider existing health care systems in other states or countries as models.

(3) The board, the agency of human services, and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the board and its employees or consultants have the information necessary to create the design options. The board shall engage with interested parties, such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont.

(4) By December 1, 2010, the board shall release a draft of the design options to the public and provide 15 days for public review and the submission of comments on the design options. The board shall review and consider the public comments and revise the draft design options as necessary prior to the final submission to the general assembly and governor.

(b) Each of the design options shall include the following components as further described in Sec. 6 of this act:

(1) general administration of services;

(2) packages of health services, including cost-sharing;

(3) coordinated local delivery system;

(4) health system planning and public health;

(5) budgets;

(6) payment methods;

(7) process for payment amounts;

(8) financing;

(9) Medicaid and Medicare waiver proposals;

(10) a method to address compliance of the proposed design options with the Employee Retirement Income Security Act (ERISA), if necessary; and

(11) redesign of state agencies administering or regulating health care, health care professionals and providers, and other health-related services, if necessary to implement the efficient administration or oversight of the health care system.

(c) The Vermont health care board shall include in the proposal an analysis of each design option as compared to the current state of health care in Vermont, including the costs of providing health care to the uninsured and underinsured in Vermont, any potential savings from creating an integrated system of health care, the impacts on the current private and public insurance system, potential fiscal impacts to individuals and businesses, impacts on the state's economy, and the pros and cons of each design option and of no changes.

Sec. 6. HEALTH CARE SYSTEM DESIGN COMPONENTS

In creating the design options, the Vermont health care board shall consider the following components for each option:

(1) General administration of services. The board shall make a recommendation, where appropriate to the design option, on:

(A) the overall administrative design to insure all Vermonters have access to and coverage for affordable, quality health services through a public or private, single-payer, or multi-payer system;

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

(C) enrollment processes.

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

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

(2) Packages of Health services.

(A) Covered services. Each of the design options shall include access to and coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services. A design option may include more than one package of health services with the associated cost of each package and may include coverage for additional health services, such as home- and community-based services, services in nursing homes, or dental or vision services.

(B) Cost-sharing. Each of the design options shall consider options to provide for affordable, income-sensitive cost-sharing.

(3) Coordinated, local delivery systems.

(A) The design options shall ensure that the delivery of health care in Vermont is coordinated in order to provide health services to the citizens of Vermont, to improve health outcomes, and to improve the efficiency of the health care system by ensuring that health care professionals, hospitals, health care facilities and home- and community-based providers offer patient care in an integrated manner designed to optimize patient care at a lower cost and to reduce redundancies in the health care delivery system as a whole. The design options shall consider and include building on the delivery system initiatives that are part of the Blueprint for Health, such as the medical home pilot projects.

(B) The Vermont health care board shall include in each design option a recommendation for the improvement of the organization of the health care delivery system, including:

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

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

(4) Health system planning and public health.

(A) The Vermont health care board shall include in each of the design options an evaluation of the existing mechanisms for health system and facility planning and assessing quality indicators and outcomes, and of public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

(B) The board shall include recommendations for changes to existing mechanisms to ensure compatibility with the design options.

(5) Budgets. The Vermont health care board shall include in each option a recommendation for amending the unified health care budget as provided for in subdivision (A) of this subdivision (5) and to develop a global budget for a facility, provider, or part of the health care system as appropriate to that option and as provided for in subdivision (B).

(A) Unified health care budgets.

(i) The purpose of the unified health care budget is to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) The Vermont health care board shall propose recommendations to revise the unified health care budget provided for in 18 V.S.A. § 9406, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations.

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

(B) Global budgets. The board shall recommend whether a global budget is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination as appropriate to that option. The board shall also recommend the appropriate process and considerations for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.

(6) Payment methods.

(A) The Vermont health care board shall include a recommendation for the payment methods to be used for each health care sector which provides health services under each design option. The payment methods shall be aligned with the goals of this act and shall provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles.

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

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

(ii) capitated payments;

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

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

(v) diagnosis-related groups;

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

(vii) fee for service.

(7) Process for determining payment amounts.

(A) The Vermont health care board shall recommend a process for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should provide reasonable access to health services, provide sufficient uniform payment to health care professionals, reduce unnecessary care, and encourage the financial stability of health care professionals.

(B) When considering the payment methods in subdivision (6)(A) of this section, the Vermont health care board shall make recommendations for the appropriate process for each of the design options, including:

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

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

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

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

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

(C) To facilitate negotiation of payment amounts, the board may recommend the utilization of one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section. In authorizing the activities provided for in this section, the intent of the general assembly is to displace state and federal antitrust laws by granting state action immunity for actions that might otherwise be considered to be in violation of state or federal antitrust laws.

(8) Financing. The board shall include an estimate of any additional costs for providing access to and coverage for health services to the uninsured and underinsured, any estimated savings from streamlining the administration of health care, and financing proposals for sustainable revenue necessary for funding the system.

(9) Medicaid and Medicare waiver proposals. The board shall propose how to redesign the Global Commitment to Health Medicaid Section 1115 and the Choices for Care Long-Term Care waiver to be consistent with each design option in order to maximize federal participation and funding in the health care system. The board shall also include a proposal for a Medicare waiver where appropriate to the design option to ensure the participation of Medicare in all or part of the system proposed by that option.

(10) Employee Retirement Income Security Act (ERISA). The board shall propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options. In addition, assuming the absence of an ERISA exemption, the board shall consider how to design each option in compliance with ERISA.

(11) Evaluation of state agencies. The board shall evaluate redesigning the structure of state agencies administering or regulating health care, health care professionals, health care providers, or health insurers, or involved in other health-related services, such as public health or health resource planning. The purpose of the evaluation shall be to ensure the appropriate and efficient operation of state government and to ensure a single locus of responsibility for the health care system and for health care reform.

Sec. 7. APPROPRIATIONS

The amount of $300,000 is appropriated from the general fund to the office of legislative council in fiscal year 2011 for the health care board to accomplish the purposes of this act.

Sec. 8. EFFECTIVE DATE

This act shall take effect upon passage.

And that when so amended the bill ought to pass.

Senator Kitchel, for the Committee on Appropriations, to which the bill was referred, reported that the bill be amended as recommended by the Committee on Health and Welfare with the following amendments thereto:

First: In Sec. 1(12), by striking out the words "as a human right" at the end of the sentence

Second: In Sec. 2(1), by inserting at the end of the subdivision, the following sentence: All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time.

Third: By striking out Secs. 4 through 8 in their entirety and inserting in lieu thereof new Secs. 4 through 16 to read as follows:

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

§ 901. CREATION OF COMMISSION

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

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

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

* * *

Sec. 5. APPOINTMENT; COMMISSION ON HEALTH CARE REFORM

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

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1) By February 1, 2011, the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general

assembly and the governor at least two design options, including implementation plans, for creating a single system of health care which insures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multipayer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act.

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

(3) Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.

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

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

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

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

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

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

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

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

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

(2) coordinated local delivery systems;

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

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

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

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

(1) A payment system for health services.

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

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

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

(iii) one or more may be modeled after the health services offered under Medicaid; and

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

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

(i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding

process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination.

(ii) enrollment processes.

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

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

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

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

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

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

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

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

(II) capitated payments;

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

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

(V) diagnosis-related groups;

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

(VIII) fee for service.

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

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

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

(III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of

specialized health services that are not available locally to Vermonters.

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

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

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

(C) Cost-containment. Each design shall include cost reduction and containment mechanisms, which may include a fee assessed on insurers combined with a global budget to streamline administration of health services.

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

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

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

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

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

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

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

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

(5) A method to address compliance of the proposed design option or options with federal law, including the Employee Retirement Income Security Act (ERISA), if necessary.

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

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

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

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

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

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

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

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

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

(E) impacts on the state's economy;

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

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

* * * Immediate Cost-Containment Provisions * * *

Sec. 7. HOSPITAL BUDGETS

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

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

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

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

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

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

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

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

Sec. 8. 18 V.S.A. § 9453(c) is added to read:

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

Sec. 9. 18 V.S.A. § 9456(h)(2) is amended to read:

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

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

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

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

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

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

Sec. 10. REPEAL

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

Sec. 11. INSURANCE REGULATION; INTENT

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

Sec. 12. 8 V.S.A. § 4080a(h)(2)(D) is added to read:

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

Sec. 13. 8 V.S.A. § 4080b(h)(2)(D) is added to read:

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

Sec. 14. GRANT FUNDING

The staff director of the joint legislative commission on health care reform shall apply for grant funding, if available, for the design and implementation analysis provided for in Sec. 4 of this act. Any amounts received in grant funds, up to the amount appropriated in Sec. 15 of this act, shall offset the general fund appropriation by allowing any remaining general funds appropriated to revert to the general fund or reducing future general fund appropriations. Any grant funds received in excess of the appropriated amount may be used for the analysis.

Sec. 15. APPROPRIATION

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

Sec. 16. EFFECTIVE DATE

(a) This section and Secs. 1 through 6 and 14 of this act shall take effect upon passage.

(b) Secs. 7 through 13 and 15 shall take effect on July 1, 2010.

And that when so amended the bill ought to pass.

Thereupon, the bill was read the second time by title only pursuant to Rule 43, and pending the question, Shall the bill be amended as recommended by the Committee on Health and Welfare?, Senator Racine, on behalf of the Committee on Health and Welfare, requested and was granted leave to substitute an amendment for the recommendation of amendment of the Committee on Health and Welfare as follows:

By striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds that:

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

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

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

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

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

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

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

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

(9) In 2008, 15.4 percent of Vermonters with private insurance were underinsured, meaning that the out-of-pocket health insurance expenses exceeded five to 10 percent of a family's annual income depending on income level or that the annual deductible for the health insurance plan exceeded five percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums. Most Vermonters are a job loss away from being uninsured.

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

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

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

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

* * * HEALTH CARE SYSTEM DESIGN * * *

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

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

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

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

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

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

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

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

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

Sec. 3. GOALS OF HEALTH CARE REFORM

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

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

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

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

(A) are coordinated;

(B) focus on meeting community health needs;

(C) match service capacity to community needs;

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

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

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

(G) contain costs.

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

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

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

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

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

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

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

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

(G) increasing price and quality transparency.

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

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

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

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

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

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

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

§ 901. CREATION OF COMMISSION

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

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

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

* * *

Sec. 5. APPOINTMENT; COMMISSION ON HEALTH CARE REFORM

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

existing terms.

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

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

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

(3) Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.

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

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

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

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

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

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

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

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

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

(2) coordinated local delivery systems;

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

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

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

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

(1) A payment system for health services.

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

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

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

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

(B) Administration. The consultant shall include a recommendation

for:

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

(ii) enrollment processes.

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

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

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

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

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

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

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

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

(II) capitated payments;

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

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

(V) diagnosis-related groups;

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

(VIII) fee for service.

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

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

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

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

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

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

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

(D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the option may include a fee assessed on insurers combined with a global budget to streamline administration of health services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(E) impacts on the state's economy;

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

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

Sec. 7. GRANT FUNDING

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

appropriations. Any grant funds received in excess of the appropriated amount may be used for the analysis.

Sec. 8. APPROPRIATION

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

Sec. 9. EFFECTIVE DATES

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

(b) Sec. 8 shall take effect on July 1, 2010.

Thereupon, pending the question, Shall the substitute recommendation of amendment of the Committee on Health and Welfare be amended as recommended by the Committee on Appropriations?, Senators Kitchel and Bartlett requested and were granted leave to substitute an of amendment for the recommendation of amendment of the Committee on Appropriations as follows:

That the bill be amended as recommended by Senator Racine on behalf of the Committee on Health and Welfare, with the following amendments thereto:

First: By inserting seven new sections to be numbered Secs. 7a through 7g to read as follows:

Sec. 7a. HOSPITAL BUDGETS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7d. REPEAL

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

Sec. 7e. INSURANCE REGULATION; INTENT

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

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

(D) The commissioner may require a registered small group carrier to identify that percentage of a requested premium increase which is attributed to

the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care costs, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall be at the time of seeking a rate increase and shall be in the manner and form as directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

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

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

Second: In Sec. 9 (Effective Dates) by striking out subsection (b) in its entirety and inserting in lieu thereof a new subsection (b) to read as follows:

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

Thereupon, the question, Shall the bill be amended as recommended by Senator Racine on behalf of the Committee on Health and Welfare, as substituted?, was agreed to.

Thereupon, pending the question, Shall the bill be amended as recommended by Senators Kitchel and Bartlett, on behalf of the Committee on Appropriations, as substituted?, Senator Mullin requested that in the *first* proposal of amendment that Sec. 7a be voted on separately, which was agreed to.

Thereupon, the question, Shall the bill be amended as recommended by Senators Kitchel and Bartlett on behalf of the Committee on Appropriations in the *first* proposal of amendment Secs. 7b through 7g and the *second* proposal of amendment?, was agreed to on a roll call, Yeas 30, Nays 0.

Senator Flanagan having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Bartlett, Brock, Campbell, Carris, Choate, Cummings, Doyle, Flanagan, Flory, Giard,

Hartwell, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, Mazza, McCormack, Miller, Mullin, Nitka, Racine, Scott, Sears, Shumlin, Snelling, Starr, White.

Those Senators who voted in the negative were: None.

Thereupon, the question, Shall bill be amended as recommended by Senators Kitchel and Bartlett on behalf of the Committee on Appropriations in the *first* proposal of amendment Sec. 7a?, was agreed on a roll call, Yeas 21, Nays 9.

Senator Mullin having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Ashe, Bartlett, Campbell, Carris, Cummings, Flanagan, Giard, Hartwell, Illuzzi, Kitchel, Kittell, MacDonald, Mazza, McCormack, Miller, Racine, Sears, Shumlin, Snelling, Starr, White.

Those Senators who voted in the negative were: Ayer, Brock, Choate, Doyle, Flory, Lyons, Mullin, Nitka, Scott.

Thereupon, the pending question, Shall the bill be read a third time?, was decided in the affirmative on a roll call, Yeas 28, Nays 2.

Senator Campbell having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Bartlett, Campbell, Carris, Choate, Cummings, Doyle, Flanagan, Giard, Hartwell, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, Mazza, McCormack, Miller, Mullin, Nitka, Racine, Scott, Sears, Shumlin, Snelling, Starr, White.

Those Senators who voted in the negative were: *Brock, Flory.

*Senator Brock explained his vote as follows:

"I recognize and support strongly the need for meaningful health care reform and cost controls. However, I oppose this bill because it takes a flawed approach to achieving needed reform.

This bill creates three different health care system designs. But each design contains mandated elements eerily reminiscent of the 1930's central planning. The design specifications suggest unprecedented interference with personal choice and provider freedom. By structuring the commission as a creature solely controlled by the current legislative leadership, there is created a

genuine perception that this is a process dictated not by the need for independent professional expertise, but by political expediency. Especially in light of the manifest uncertainties arising from still little understood federal healthcare legislation, this bill takes the wrong approach at the wrong time."

Rules Suspended; Bills Messaged

On motion of Senator Shumlin, the rules were suspended, and the following bills were severally ordered messaged to the House forthwith:

H. 539, H. 639, H. 658, H. 766.

Message from the House No. 48

A message was received from the House of Representatives by Ms. H. Gwynn Zakov, its Second Assistant Clerk, as follows:

Mr. President:

I am directed to inform the Senate that:

The House has considered joint resolution originating in the Senate of the following title:

J.R.S. 59. Joint resolution relating to weekend adjournment.

And has adopted the same in concurrence.

The House has considered Senate proposal of amendment to House bill of the following title:

H. 456. An act relating to seasonal fuel assistance.

And has severally concurred therein with a further proposal of amendment thereto, in the adoption of which the concurrence of the Senate is requested.

The Governor has informed the House that on the April 7, 2010, he approved and signed a bill originating in the House of the following title:

H. 764. An act relating to the state teachers' retirement system of Vermont.

House Concurrent Resolutions

The following joint concurrent resolutions having been placed on the consent calendar on the preceding legislative day, and no Senator having requested floor consideration as provided by the Joint Rules of the Senate and House of Representatives, are hereby adopted in concurrence:

By Representatives Waite-Simpson and Jerman,

H.C.R. 299.

House concurrent resolution congratulating the 2010 Albert D. Lawton Intermediate School Vermont MATHCOUNTS competition championship team.

By Representative Howrigan and others,

By Senators Brock and Kittell,

H.C.R. 300.

House concurrent resolution congratulating Representative Carolyn Branagan on being named the 2010 Vermont Mother of the Year.

By All Members of the House,

By All Members of the Senate,

H.C.R. 301.

House concurrent resolution in memory of U.S. Army 2nd Lt. Joseph Douglas Fortin of St. Johnsbury.

By Representative Morrissey and others,

By Senators Hartwell and Sears,

H.C.R. 302.

House concurrent resolution congratulating the 2010 Mount Anthony Union High School Patriots Division I championship boys' Nordic ski team.

By Representative Morrissey and others,

By Senators Hartwell and Sears,

H.C.R. 303.

House concurrent resolution congratulating the 2010 Mount Anthony Union High School Patriots championship wrestling team.

By Representative Morrissey and others,

By Senators Hartwell and Sears,

H.C.R. 304.

House concurrent resolution congratulating the 2010 Mount Anthony Union High School Patriots Division I championship girls' Nordic ski team.

By Representative Donahue and others,

By Senators Cummings, Scott and Doyle,

H.C.R. 305.

House concurrent resolution congratulating the 2010 Norwich University Cadets ECAC East women's ice hockey championship team.

By Representatives Rodgers and Morley,

H.C.R. 306.

House concurrent resolution congratulating Craftsbury Academy student Mael Le Scouezec on winning the 2010 Vermont State Individual Spelling Bee.

[The full text of the House concurrent resolutions appeared in the House calendar addendum for April 2, 2010, and, if adopted in concurrence by the House, will appear in the volume of the Public Acts and Resolves to be published for this session of the sixty-ninth biennial session of the Vermont General Assembly.]

Adjournment

On motion of Senator Shumlin, the Senate adjourned until eleven o'clock and thirty minutes in the morning.