

House Calendar

Wednesday, March 23, 2011

78th DAY OF THE BIENNIAL SESSION

House Convenes at 9:30 A.M.

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ACTION CALENDAR

Action Postponed Until March 23, 2011

Third Reading

H. 201

An act relating to hospice and palliative care

Amendment to be offered by Rep. Till of Jericho to H. 201

By striking in Sec. 3 in its entirety and inserting in lieu thereof a new Sec. 3 to read:

Sec. 3. REQUEST FOR A WAIVER

The department of Vermont health access shall request and apply for a demonstration project or waiver from the Centers for Medicare and Medicaid Services to allow for the state to obtain federal Medicaid matching funds to provide for an “enhanced hospice access” benefit, whereby the definition of “terminal illness” is expanded from six months’ life expectancy to 12 months’ and participants may access hospice without being required to first discontinue curative therapy. The department shall also request and apply for a Medicare demonstration project or waiver from the Centers for Medicare and Medicaid Services to provide funding for the same enhanced hospice access benefit.

Amendment to be offered by Rep. Till of Jericho to H. 201

In Sec. 7, subdivision (b)(1), after “or provide patient consultations” by inserting “or does not regularly treat patients in need of palliative care.”

Favorable with Amendment

H. 202

An act relating to a single-payer and unified health system

Rep. Larson of Burlington, for the Committee on **Health Care**, recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. [Deleted.]

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

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

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

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

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

(1) No later than November 1, 2013, the Vermont health benefit exchange established in subchapter 1 of chapter 18 of Title 33 shall begin enrolling individuals and small employers for coverage beginning January 1, 2014. The intent of the general assembly is to establish the Vermont health benefit exchange in a manner such that it may become the foundation for a Green Mountain Care.

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

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

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

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

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

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

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

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

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

CHAPTER 220. GREEN MOUNTAIN CARE BOARD

Subchapter 1. Green Mountain Care Board

§ 9371. PRINCIPLES FOR HEALTH CARE REFORM

The general assembly adopts the following principles as a framework for

reforming health care in Vermont:

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.

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

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

(4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities. Other aspects of Vermont's health care infrastructure, including the educational and research missions of the state's academic medical center, must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.

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

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

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

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

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

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

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

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

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

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

§ 9372. PURPOSE

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

(1) improve the health of the population;

(2) enhance the patient experience of care; and

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

§ 9373. DEFINITIONS

As used in this chapter:

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

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

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

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

access plan, or any other state health care assistance program financed in whole or in part through a federal program.

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

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

§ 9374. BOARD MEMBERSHIP; AUTHORITY

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

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

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

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

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

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

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

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

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

(B) owning a stock, bond, or other security in an entity subject to supervision or regulation by the board that is purchased by or through a mutual

fund, blind trust, or other mechanism where a person other than the board member chooses the stock, bond, or security; or

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

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

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

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

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

§ 9375. DUTIES

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

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

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

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

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

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

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

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

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

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

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

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

(4) Review and approve, with recommendations from the commissioner of Vermont health access, the benefit package for qualified health benefit plans pursuant to chapter 18, subchapter 1 of Title 33. The board shall report to the

house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

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

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

(ii) for utilization of health services;

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

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

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

(B) The board shall develop the evaluation method pursuant to subdivision (A) of this subdivision (5) by October 15, 2013 and shall report the results of its evaluations and any resulting recommendations in its annual report as required by subsection (d) of this section.

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

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

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

committee on health care and the senate committee on health and welfare at least 10 days before issuing the approval.

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

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

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the status of efforts to implement the health care workforce development strategic plan pursuant to subdivision (b)(4) of this section, any substantive changes to the benefit package for qualified health benefit plans pursuant to subdivision (c)(3) of this section, the results of the systemwide performance and quality evaluations required by subdivision (c)(4) of this section, the rationale for any decision to impose or alter cost-sharing requirements for Green Mountain Care pursuant to subdivision (c)(6) of this section, and the extent and impacts of migration to Vermont for health services as described in subdivision (c)(8) of this section.

§ 9376. PAYMENT AMOUNTS; METHODS

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

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

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

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

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

§ 9377. PAYMENT REFORM; PILOTS

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

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

securities, and health care administration. The terms used in this section shall have the same meanings as in chapter 13 of this title.

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

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

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

(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

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

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

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

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

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

(c) Health insurer participation.

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

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

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

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

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

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

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

§ 9378. PUBLIC PROCESS

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

§ 9379. AGENCY COOPERATION

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

§ 9380. RULES

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

§ 9381. APPEALS

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

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

Subchapter 2. Green Mountain Care Board Nominating Committee

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

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

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

(A) Two members appointed by the governor.

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

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

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

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

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

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

(H) The state health care ombudsman.

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

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

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

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

administrative and communication skills, social consciousness, and public service.

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

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

§ 9391. NOMINATION PROCESS

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

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

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

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

(b) The health care ombudsman office shall:

* * *

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

* * *

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

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

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

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

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

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

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

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(5) "Gift" means:

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

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

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

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

* * *

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

* * *

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

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

(a)(1) Annually on or before October 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the fiscal year ending the previous June 30th the value, nature, purpose, and recipient information of:

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

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

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

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

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

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

* * *

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

(A) Information on allowable expenditures and gifts required to be disclosed under this section, which shall ~~be presented in both~~ present information in aggregate form; ~~and~~ by selected types of health care providers or individual health care providers, as prioritized each year by the office; and

showing the amounts expended on the Green Mountain Care board established in chapter 220 of this title.

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

(6) After issuance of the report required by subdivision (5) of this subsection and except as otherwise provided in subdivision (2)(A)(i) of this subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

* * *

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

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

CHAPTER 18. PUBLIC-PRIVATE UNIVERSAL
HEALTH CARE SYSTEM

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

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

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

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

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

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

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

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

(5) “Qualified employer” means an employer that:

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

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

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

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

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

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

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

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

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

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

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

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

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

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

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

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

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

(3) To the extent allowable under federal law, the Vermont health benefit exchange may offer health benefits to employees for injuries arising out

of or in the course of employment in lieu of medical benefits provided pursuant to chapter 9 of Title 21 (workers' compensation).

(c)(1) If the Vermont health benefit exchange is required by the secretary of the U.S. Department of Health and Human Services to contract with more than one health insurer, the Vermont health benefit exchange may determine an appropriate method to provide a unified, simplified administration system for health insurers offering qualified health benefit plans. The exchange may include claims administration, benefit management, billing, or other components in the unified system and may achieve simplification by contracting with a single entity for administration and management of all qualified health benefit plans, by licensing or requiring the use of particular software, by requiring health insurers to conform to a standard set of systems and rules, or by another method determined by the commissioner.

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

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

§ 1804. QUALIFIED EMPLOYERS

[Reserved.]

§ 1805. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) The employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to

be either unaffordable to the employee or not to provide the required minimum actuarial value.

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

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

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

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

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

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

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

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

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

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

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

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

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

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

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

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

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

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

(3) For qualified health benefit plans offered to employers, a deductible which meets the limitations provided in Section 1302 of the Affordable Care Act and any more restrictive deductible requirements specified by the secretary of human services by rule after consultation with the advisory board and after approval from the Green Mountain Care board established in chapter 220 of Title 18.

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

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

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

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

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

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

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

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

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

Affordable Care Act and any additional requirements specified by the secretary of human services by rule.

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

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

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

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

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

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

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

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

§ 1807. NAVIGATORS

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

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

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

(b) Navigators shall have the following duties:

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

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

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

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

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

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

§ 1808. FINANCIAL INTEGRITY

(a) The Vermont health benefit exchange shall:

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

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

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

§ 1809. PUBLICATION OF COSTS AND SATISFACTION SURVEYS

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

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

§ 1810. RULES

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

Subchapter 2. Green Mountain Care

§ 1821. PURPOSE

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

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

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

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

(4) reducing unnecessary administrative expenditures.

§ 1822. DEFINITIONS

For purposes of this subchapter:

- (1) “Agency” means the agency of human services.
- (2) “CHIP funds” means federal funds available under Title XXI of the Social Security Act.
- (3) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last one year or more; that requires ongoing clinical management; and that requires health services that attempt to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.
- (4) “Health care professional” means an individual, partnership, corporation, facility, or institution licensed or certified or otherwise authorized by Vermont law to provide professional health services.
- (5) “Health service” means any medically necessary treatment or procedure to maintain an individual’s physical or mental health or to diagnose or treat an individual’s physical or mental health condition, including services ordered by a health care professional and medically necessary services to assist in activities of daily living.
- (6) “Hospital” shall have the same meaning as in 18 V.S.A. § 1902 and may include hospitals located outside the state.
- (7) “Preventive care” means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.
- (8) “Primary care” means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include prenatal care and mental health and substance abuse treatment.
- (9) “Secretary” means the secretary of human services.
- (10) “Vermont resident” means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent. An individual shall not be considered to be

a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state.

§ 1823. ELIGIBILITY

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

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

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

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

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

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

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

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

(3) If an individual presumed eligible for Green Mountain Care pursuant to subdivision (1) of this subsection is later determined not to be eligible for

the program, the agency shall make reasonable efforts to recover from the individual the amounts expended for his or her care.

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

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

§ 1824. HEALTH BENEFITS

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

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

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

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

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

(B) Upon implementation of Green Mountain Care, the benefit package for individuals eligible for Medicaid or CHIP shall also include any optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc for which these individuals are eligible on January 1, 2014. Beginning with the second year of Green Mountain Care and going forward, the Green Mountain Care board may, consistent with federal law, modify these optional benefits, as long as at all times the benefit package for these individuals contains at least the benefits described in subdivision (A) of this subdivision (b)(1).

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

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

§ 1825. BLUEPRINT FOR HEALTH

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

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

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

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

§ 1826. ADMINISTRATION; ENROLLMENT

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

(2) The agency shall ensure that entities awarded contracts pursuant to this subsection do not have a financial incentive to restrict individuals' access to health services. The agency may establish performance measures that provide incentives for contractors to provide timely, accurate, transparent, and courteous services to individuals enrolled in Green Mountain Care and to health care professionals, where applicable.

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

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

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

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

(e) The agency shall seek permission from the Centers for Medicare and Medicaid Services to be the administrator for the Medicare program in Vermont. If the agency is unsuccessful in obtaining such permission, Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XVIII of the Social Security Act (Medicare).

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

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

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

(i) Green Mountain Care shall maintain a robust and adequate network of health care professionals located in Vermont or regularly serving Vermont residents, including mental health and substance abuse professionals. The agency shall contract with outside entities as needed to allow for the appropriate portability of coverage under Green Mountain Care for Vermont residents who are temporarily out of the state.

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

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

§ 1827. BUDGET PROPOSAL

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

§ 1828. GREEN MOUNTAIN CARE FUND

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

(b) Into the fund shall be deposited:

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

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

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

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

(d) All monies received by or generated to the fund shall be used only for:

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

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

§ 1829. IMPLEMENTATION; WAIVER

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

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

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

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

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

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

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

§ 401. COMPOSITION OF DEPARTMENT

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

Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY

UNIT

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

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

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

§ 402. MEDICAID AND EXCHANGE ADVISORY BOARD

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

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

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

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

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

(C) advocates for consumer organizations.

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

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

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

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

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

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

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

* * * Planning Initiatives * * *

Sec. 8. INTEGRATION PLAN

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

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

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

(B)(1) The statutory changes necessary to integrate the private insurance markets with the Vermont health benefit exchange, including whether to impose a moratorium on the issuance of new association policies prior to 2014, as well as whether to continue exemptions for associations pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health benefit exchange and if so, what criteria to use.

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

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

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

(2) Once Green Mountain Care is implemented, whether to allow employers and individuals to purchase coverage for supplemental health services from Green Mountain Care or to allow private insurers to provide supplemental insurance plans.

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

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

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

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

Sec. 9. FINANCING PLANS

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

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

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

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

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

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

(3) issues involving federal law and taxation;

(4) impacts of tax system changes:

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

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

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

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

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

HEALTH

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

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

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

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

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

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

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

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

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

Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

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

Sec. 13. WORKFORCE ISSUES

(a)(1) Currently, Vermont has a shortage of primary care professionals, and many practices are closed to new patients. It also experiences periodic and

geographic shortages of specialty care professionals necessary to ensure that Vermonters have reasonable access to a broad range of health services within the state. In order to ensure sufficient patient access now and in the future, it is necessary to plan for the implementation of Green Mountain Care and utilize Vermont's health care professionals to the fullest extent of their professional competence.

(2) The board of nursing, the board of medical practice, and the office of professional regulation, in consultation with the primary care workforce development committee established in Sec. 31 of No. 128 of the Acts of the 2009 Adj. Sess. (2010), shall collaborate to determine how to optimize the primary care workforce by reviewing the licensure process, scope of practice requirements, reciprocity of licensure, and efficiency of the licensing process, and by identifying any other barriers to augmenting Vermont's primary care workforce. No later than January 15, 2012, the boards and office shall provide to the house committee on health care and the senate committee on health and welfare joint recommendations for improving the primary care workforce through the boards' and office's rules and procedures.

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

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

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

(d) The department of Vermont health access, in consultation with the area health education centers, shall monitor the extent to which individual health care professionals begin and cease to practice in their applicable fields in Vermont during each state fiscal year. No later than February 15 of each year, the department shall report to the house committee on health care and the senate committee on health and welfare on the changes in the number of each type of health care professional practicing in Vermont during the preceding fiscal year.

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

* * * Cost Estimates * * *

Sec. 14. COST ESTIMATES

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

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

* * * Rate Review * * *

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

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates, and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, or in the case of a request for

a rate increase, until a decision by the Green Mountain Care board as provided herein, unless the commissioner shall sooner give his or her written approval thereto. Beginning July 1, 2013, prior to approving a rate increase, the commissioner shall seek approval for such rate increase from the Green Mountain Care board established in 18 V.S.A. chapter 220, which shall approve or disapprove the rate increase within 10 business days. The commissioner shall apply the decision of the health reform board as to rates referred to the board.

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the law of this state. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. In all other cases, the commissioner shall give his or her approval.

(3) After the expiration of such 30 days from the filing of any such form, premium rate or rule, the review period provided herein or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

(b) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file a summary applicable to the cumulative rate increase. The summary shall include a brief justification of any rate increase requested, information required by the Secretary of the U.S. Department of Health and Human Services (HHS) for rate increases over 10 percent, and any other information required by the commissioner. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

(c)(1) The commissioner shall provide information to the public on the department's website about the public availability of the filings and summaries required under this section.

(2) Beginning no later than January 1, 2012, the commissioner shall post the filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the department's website within five days of filing. The department shall provide an electronic mechanism for the public to comment on proposed rate increases over five percent. The public shall have 21 days from the posting of the summaries and filings to provide public comment. The department shall review and consider the public comments prior to the expiration of the review period pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for their consideration in approving any rate increases.

Sec. 15a. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate, or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 15b. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the commissioner for his or her approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the commissioner of a nonrefundable fee of \$50.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15c. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the commissioner of banking, insurance, securities, and health care administration under section 4584 of this title shall not thereafter issue a contract to a

subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by such commissioner. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the commissioner of a nonrefundable fee of \$50.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15d. 8 V.S.A. § 5104(a) is amended to read:

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The commissioner may request and shall receive any information that is needed to determine whether to approve the policy form or rate. In addition to any other information requested, the commissioner shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including but not limited to Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section 4062 of this title.

(2) The commissioner shall refuse to approve the form of evidence of coverage, filing or rate if it contains any provision which is unjust, unfair, inequitable, misleading or contrary to the law of the state or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

* * * Employer Benefit Information * * *

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

§ 2004. HEALTH BENEFIT COSTS

(a) Employers shall provide their employees with an annual statement indicating:

(1) the total monthly premium cost paid for any employer-sponsored health benefit plan;

(2) the employer's share and the employee's share of the total monthly premium; and

(3) any amount the employer contributes toward the employee's cost-sharing requirement or other out-of-pocket expenses.

(b) Notwithstanding the provisions of subsection (a) of this section, an employer who reports the cost of coverage under an employer-sponsored health benefit plan as required by 26 U.S.C. § 6051(a)(14) shall be deemed to be in full compliance with the requirements of this section.

* * * Consumer Protection * * *

Sec. 17. REVIEW OF BAN ON DISCRETIONARY CLAUSES

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting a National Association of Insurance Commissioners (NAIC) model act prohibiting insurers from using discretionary clauses in their health benefit contracts. The purpose of the NAIC model act is to prohibit insurance clauses that purport to reserve discretion to the insurer to interpret the terms of the policy, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare on the advantages and disadvantages of Vermont adopting the NAIC model act.

* * * Single Formulary * * *

Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

No later than January 15, 2012, the department of Vermont health access shall provide recommendations to the house committee on health care and the senate committee on health and welfare regarding:

(1) A single prescription drug formulary to be used by all payers of health services which allows for some variations for Medicaid due to the availability of rebates and discounts and which allows health care professionals prescribing drugs purchased pursuant to Section 340B of the Public Health Service Act to use the 340B formulary. The recommendations shall address the feasibility of requesting a waiver from Medicare Part D in order to ensure Medicare participation in the formulary, as well as the feasibility of enabling all prescription drugs purchased by or on behalf of Vermont residents to be

purchased through the Medicaid program or pursuant to the 340B drug pricing program.

(2) A single mechanism for negotiating rebates and discounts across payers using a single formulary, and the advantages and disadvantages of using a single formulary to achieve uniformity of coverage.

(3) A uniform set of drug management rules aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management. The standards for pharmacy benefit management shall address timely decisions, access to clinical peers, access to evidence-based rationales, exemption processes, and tracking and reporting data on pharmacy benefit manager and prescriber satisfaction.

Secs. 19-24. [Deleted.]

* * * Conforming Revisions * * *

Sec. 25. 3 V.S.A. § 2222a is amended to read:

§ 2222a. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY
AND AFFORDABILITY

(a) The secretary of administration shall be responsible for the coordination of health care system reform initiatives among executive branch agencies, departments, and offices.

(b) The secretary shall ensure that those executive branch agencies, departments, and offices responsible for the development, improvement, and implementation of Vermont's health care system reform do so in a manner that is timely, equitable, patient-centered, evidence-based, and seeks to inform and improve the quality and affordability of patient care and public health.

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

(1) The state's chronic care infrastructure, disease prevention, and management program contained in the blueprint for health established by chapter 13 of Title 18, the goal of which is to achieve a unified, comprehensive, statewide system of care that improves the lives of all Vermonters with or at risk for a chronic condition or disease.

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

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

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

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

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

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

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

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

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

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

(e) The secretary of administration or designee shall provide information and testimony on the activities included in this section to the health access oversight committee, the commission on health care reform, and to any legislative committee upon request.

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

§ 5. DUTIES OF DEPARTMENT OF HEALTH

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

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

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

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

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

(5) Seek accreditation through the Public Health Accreditation Board.

(6) Create a state health improvement plan and facilitate local health improvement plans in order to encourage the design of healthy communities and to promote policy initiatives that contribute to community, school, and workplace wellness, which may include providing assistance to employers for wellness program grants, encouraging employers to promote employee engagement in healthy behaviors, and encouraging the appropriate use of the health care system.

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

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

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

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

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

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

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

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

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

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

(a) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of health shall undertake such planning steps and other actions as are necessary to secure grants and other beneficial opportunities for Vermont provided by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

(b) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of Vermont health access shall undertake such planning steps as are necessary to ensure Vermont's participation in beneficial opportunities created by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

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

(d) Term of committee. The committee shall cease to exist on January 31, ~~2011~~ 2012.

Sec. 30. REPEAL

(a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective July 1, 2012.

(b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective July 1, 2011.

Sec. 31. APPROPRIATIONS

(a) In fiscal year 2012, the sum of \$807,182.00 in general funds and \$355,727.00 in federal funds is appropriated to the Green Mountain Care board to carry out its functions.

(b) In fiscal year 2012, the sum of \$48,000.00 is appropriated from the general fund to the secretary of administration for the malpractice proposal pursuant to Sec. 2(e) of this act.

Sec. 32. EFFECTIVE DATES

(a) Sec. 2 (strategic plan); Sec. 3, 18 V.S.A. chapter 220, subchapter 2 (Green Mountain Care board nominating committee); Secs. 8 (integration plan), 9 (financing plans); 10 (HIT); 11 (health planning); 12 (regulatory process); 13 (workforce); 14 (cost estimates); 17 (discretionary clauses); 18 (single formulary); 25 (health care reform); 26 (department of health); 28 (ACA grants); and 29 (primary care workforce committee) of this act and this section shall take effect on passage.

(b) Sec. 3, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Care board) and Secs. 3a (health care ombudsman), 3b (positions), 3c and 3d (manufacturers of prescribed products), 5 (DVHA), 6 (Health care eligibility), 30 (repeal), and 31 (appropriations) shall take effect on July 1, 2011.

(c)(1) Sec. 4 (Vermont health benefit exchange; Green Mountain Care) shall take effect on July 1, 2011.

(2) The Vermont health benefit exchange shall begin enrolling individuals no later than November 1, 2013 and shall be fully operational no later than January 1, 2014.

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

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

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

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

(D) Receipt of a waiver under Section 1332 of the Affordable Care Act pursuant to 33 V.S.A. § 1829(b).

(d) Sec. 7, 3 V.S.A. § 402 (Medicaid and exchange advisory board), shall take effect on July 1, 2012.

(e) Sec. 15 (rate review) shall take effect on October 1, 2011 and shall apply to all filings on and after October 1, 2011, except that the amendments to § 4062(c)(2) shall take effect on January 1, 2012 and shall apply to all filings on and after that date.

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

and that after passage the title of the bill be amended to read: “An act relating to a universal and unified health system”

(**Committee Vote: 8-3-0**)

Rep. Johnson of South Hero, for the Committee on **Appropriations**, recommends the bill ought to pass when amended as recommended by the Committee on **Health Care**.

(**Committee Vote: 7-3-1**)

Amendment to be offered by Rep. Browning of Arlington to H. 202

First: By adding a new Sec. 30 to read:

Sec. 30. 18 V.S.A. § 9408 is amended to read:

§ 9408. COMMON CLAIMS FORMS AND PROCEDURES

(a) No later than January 15, 1993, the commissioner shall adopt by rule uniform health insurance claims forms, and uniform standards and procedures for the processing of claims, including electronic claims forms submission and requests for prior authorization.

(b) Beginning on or before January 1, 2013, all health insurers shall use only the uniform claims forms, standards, and procedures established by the commissioner pursuant to subsection (a) of this section, regardless of whether a health plan is offered within or outside the Vermont health benefit exchange pursuant to 33 V.S.A. chapter 18, subchapter 1.

Second: By adding a new Sec. 31 to read:

Sec. 31. COMMON CLAIMS; ENFORCEMENT

(a) The commissioner of banking, insurance, securities, and health care administration, in consultation with health insurers licensed to do business in Vermont, shall develop uniform health insurance claims forms and uniform standards and procedures for claims processing as required by 18 V.S.A. § 9408.

(b) No later than January 15, 2013, the commissioner of banking, insurance, securities, and health care administration shall report to the house committee on health care and the senate committee on health and welfare on the uniform claims forms, standards, and procedures developed pursuant to

subsection (a) of this section and the department's mechanisms to enforce their usage by all health insurers licensed to do business in this state.

Third: By adding a new Sec. 32 to read:

Sec. 32. 33 V.S.A. chapter 19, subchapter 9 is added to read:

Subchapter 9. Medical Debt Revolving Loan Fund

§ 2091. MEDICAL DEBT REVOLVING LOAN FUND

(a) The medical debt revolving loan fund is established in the state treasury as a special fund to finance zero-interest loans to individuals experiencing extreme financial hardship as the direct result of medical debt.

(b) Into the fund shall be deposited:

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

(2) to the extent authorized under federal law, federal funds for Medicaid, Medicare, and the Vermont health benefit exchange established in chapter 18, subchapter 1 of this title; and

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

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

(d) All monies received by or generated to the fund shall be used only for:

(1) payments to health care providers; and

(2) zero-interest loans to individuals experiencing extreme financial hardship as the direct result of medical debt.

Fourth: By adding a Sec. 33 to read:

Sec. 33. 3 V.S.A. § 3903a is added to read:

§ 3903. MEDICAL DEBT; PAYMENTS; LOANS

(a) Not later than January 1, 2012, the director of the office of economic opportunity, in consultation with the commissioner of Vermont health access, shall establish a loan program to be administered by the designated community services agencies established under 3 V.S.A. § 3903. The purpose of the loans shall be to provide emergency assistance to individuals whose medical debt has

resulted in extreme financial hardship. The loans shall be used to assist individuals with meeting immediate and urgent individual and family needs.

(b) Recipients of the loans shall not be charged interest. The loan terms and conditions, as well as the program's eligibility criteria, shall be established by the director of the office of economic opportunity, in consultation with the commissioner of Vermont health access, and shall be consistent with the amount of money available in the medical debt revolving loan fund established in 33 V.S.A. § 2091.

(c) The director shall develop a process by which the funds provided to loan recipients may be paid directly to an applicable health care provider or providers in the full amount of a recipient's outstanding medical debt.

(d) Beginning December 1, 2013, each community services agency shall report annually to the director of economic opportunity and the commissioner of Vermont health access the status of the loans issued under this section, as well as any other information deemed relevant by the director and the commissioner. The director and the commissioner shall aggregate such information and report it to the governor and the general assembly not later than January 1 of each year beginning in 2013.

Fifth: By adding a Sec. 34 to read:

Sec. 34. OUTREACH AND ENROLLMENT

No later than January 15, 2012, the department of Vermont health access shall recommend to the house committee on health care and the senate committee on health and welfare additional outreach and enrollment efforts which the department may undertake to increase enrollment in the state's public health benefit programs. In developing its recommendations, the department shall consider the feasibility of enrolling eligible individuals at the point of service by requiring hospitals and other health care facilities licensed in this state to ask individuals without health care coverage who request or receive services at the facility to fill out a provided application for the state's health benefit programs, including Medicaid, Dr. Dynasaur, the Vermont health access plan, and Catamount Health.

Sixth: By renumbering existing Secs. 30, 31, and 32 to be Secs. 35, 36, and 37

Seventh: In redesignated Sec. 37, Effective Dates, in subsection (a), by inserting "30 (common claims forms); 31 (common claims; enforcement); 34 (outreach and enrollment)" following "29 (primary care workforce committee);" and in subsection (b) by striking "30 (repeal), and 31

(appropriations)” and inserting in lieu thereof “32 (medical debt revolving loan fund), 33 (loan program), 35 (repeal), and 36 (appropriations)”

Amendment to be offered by Rep. Browning of Arlington to H. 202

Sec. 1. STRATEGIC PLAN

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

(b)(1) No later than November 1, 2013, the Vermont health benefit exchange established in subchapter 1 of chapter 18 of Title 33 shall begin enrolling individuals and small employers for coverage beginning January 1, 2014.

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

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

(4) The secretary of administration shall supervise planning efforts, the reports of which are due on January 15, 2012, as provided in Sec. 11 and Secs. 13 through 16 of this act, including integration of multiple payers into the Vermont health benefit exchange; a continuation of the planning necessary to ensure an adequate, well-trained primary care workforce; necessary retraining for any employees dislocated from health care professionals or from health insurers due to the simplification in the administration of health care; and ~~unification~~ simplification of health system planning, regulation, and public health.

(5) The secretary shall supervise the planning efforts, reports of which are due January 15, 2013, as provided in Sec. 12 of this act for recruitment and retention programs for health care professionals and for covering the uninsured and underinsured through Medicaid and the Vermont health benefit exchange.

(c) No later than January 15, 2012, the secretary of administration or designee shall submit to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary a proposal to reform the medical malpractice system for Vermont. The proposal shall be

designed to address the incidence of defensive medicine, reduce health care costs, and maintain adequate protections for patients, shall reflect the secretary's or designee's consideration of a no-fault system, and shall take effect on or before January 1, 2014.

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

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

CHAPTER 220. GREEN MOUNTAIN HEALTH BOARD

Subchapter 1. Green Mountain Health Board

§ 9371. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.

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

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

(4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities. Other aspects of Vermont's health care infrastructure, including the educational and research missions of the state's academic medical center, must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.

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

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

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

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

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

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

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

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

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

§ 9372. PURPOSE

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

(1) improve the health of the population;

(2) enhance the patient experience of care; and

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

§ 9373. DEFINITIONS

As used in this chapter:

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

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

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

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

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

§ 9374. BOARD MEMBERSHIP; AUTHORITY

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

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

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

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

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

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

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

relationship with any person or interest in any entity subject to supervision or regulation by the board.

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

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

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

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

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

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

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

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

§ 9375. DUTIES

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

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

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

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

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

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

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

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

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

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

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

changes in payment methods and amounts, and other issues at the discretion of the board.

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

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

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

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

(ii) for utilization of health services;

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

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

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

(B) The board shall develop the evaluation method pursuant to subdivision (A) of this subdivision (5) by October 15, 2013 and shall report the results of its evaluations and any resulting recommendations in its annual report as required by subsection (d) of this section.

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the status of efforts to implement the health care workforce development strategic plan pursuant to subdivision (b)(4) of this section, any substantive changes to the benefit package for qualified health benefit plans pursuant to subdivision (c)(3) of this section, and the results of the systemwide performance and quality evaluations required by subdivision (c)(4) of this section.

§ 9376. PAYMENT AMOUNTS; METHODS

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

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

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

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

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

§ 9377. PAYMENT REFORM; PILOTS

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the

payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

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

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

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

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

(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

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

(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute

and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner.

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

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

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

(c) Health insurer participation.

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

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

(C) After the pilot projects are implemented, health insurers shall have appeal rights pursuant to section 9380 of this title.

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

(d) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the

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

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

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

§ 9378. AGENCY COOPERATION

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

§ 9379. RULES

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

§ 9380. APPEALS

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

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

Subchapter 2. Green Mountain Health Board Nominating Committee

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

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

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

(A) Two members appointed by the governor.

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

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

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

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

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

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

(H) The state health care ombudsman.

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

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

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

(d) The Green Mountain Health board nominating committee shall adopt rules under chapter 25 of Title 3 establishing the process, criteria, and standards for the nomination of qualified candidates for the chair and members of the Green Mountain Health board. The criteria and standards shall include

such factors as integrity, impartiality, health, experience, diligence, administrative and communication skills, social consciousness, and public service.

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

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

§ 9391. NOMINATION PROCESS

(a) Whenever a vacancy occurs on the Green Mountain Health board, or when an incumbent does not declare that he or she will be a candidate to succeed himself or herself, the Green Mountain Health board nominating committee shall select by majority vote, provided that a quorum is present, from the list of persons interested in serving on the Green Mountain Health board as many candidates as it deems qualified for the position or positions to be filled.

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

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

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

(b) The health care ombudsman office shall:

* * *

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

* * *

Sec. 4. GREEN MOUNTAIN HEALTH BOARD AND EXCHANGE POSITIONS

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

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

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

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

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

Sec. 5. 18 V.S.A. § 4631a is amended to read:

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED
PRODUCTS

(a) As used in this section:

* * *

(5) "Gift" means:

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

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

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

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

* * *

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

* * *

Sec. 6. 18 V.S.A. § 4632 is amended to read:

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

(a)(1) Annually on or before October 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the fiscal year ending the previous June 30th the value, nature, purpose, and recipient information of:

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

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

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

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

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

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

* * *

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

(A) Information on allowable expenditures and gifts required to be disclosed under this section, which shall ~~be presented in both~~ present information in aggregate form; ~~and~~ by selected types of health care providers or individual health care providers, as prioritized each year by the office; and

showing the amounts expended on the Green Mountain Health board established in chapter 220 of this title.

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

(6) After issuance of the report required by subdivision (5) of this subsection and except as otherwise provided in subdivision (2)(A)(i) of this subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

* * *

* * * Vermont Health Benefit Exchange * * *

Sec. 7. 33 V.S.A. chapter 18 is added to read:

CHAPTER 18. VERMONT HEALTH BENEFIT EXCHANGE

§ 1801. PURPOSE

(a) It is the intent of the general assembly to establish a Vermont health benefit exchange which meets the policy established in 18 V.S.A. § 9401.

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

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

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

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

(3) “Health benefit plan” means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for,

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

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

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

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

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

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

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

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

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

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

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

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

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

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

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

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

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

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

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

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

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

(c)(1) The Vermont health benefit exchange may determine an appropriate method to provide a unified, simplified administration system for health insurers offering qualified health benefit plans. The exchange may include

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

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

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

§ 1804. QUALIFIED EMPLOYERS

[Reserved.]

§ 1805. DUTIES AND RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

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

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

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

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

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

(3) For qualified health benefit plans offered to employers, a deductible which meets the limitations provided in Section 1302 of the Affordable Care Act and any more restrictive deductible requirements specified by the secretary of human services by rule after consultation with the advisory board and after approval from the Green Mountain Health board established in chapter 220 of Title 18.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 1807. NAVIGATORS

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

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

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

(b) Navigators shall have the following duties:

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

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

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

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

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

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

§ 1808. FINANCIAL INTEGRITY

(a) The Vermont health benefit exchange shall:

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

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

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

§ 1809. PUBLICATION OF COSTS AND SATISFACTION SURVEYS

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

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

§ 1810. RULES

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

Sec. 8. 33 V.S.A. § 401 is amended to read:

§ 401. COMPOSITION OF DEPARTMENT

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

Sec. 9. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY

UNIT

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

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

Sec. 10. 33 V.S.A. § 402 is added to read:

§ 402. MEDICAID AND EXCHANGE ADVISORY BOARD

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

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

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

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

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

(C) advocates for consumer organizations.

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

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

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

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

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

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

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

* * * Planning Initiatives * * *

Sec. 11. INTEGRATION PLAN

No later than January 15, 2012, the secretary of administration or designee shall make recommendations to the house committee on health care and the senate committee on health and welfare on how to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with the Vermont health benefit exchange established in chapter 18 of Title 33, including:

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

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

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

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

Sec. 12. FUNDING NEEDS

(a) The secretary of administration or designee shall report to the house committee on health care and the senate committees on health and welfare and on finance no later than January 15, 2013:

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

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

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

(4) funding mechanisms to ensure that operations of the Vermont health benefit exchange are self-sustaining.

Sec. 13. HEALTH INFORMATION TECHNOLOGY PLAN

(a) The secretary of administration or designee, in consultation with the Green Mountain Health board and the commissioner of Vermont health access,

shall review the health information technology plan required by 18 V.S.A. § 9351 to ensure that the plan reflects the creation of the Vermont health benefit exchange and any necessary development or modifications to public health information technology and data and to public health surveillance systems.

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

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

Sec. 14. HEALTH SYSTEM PLANNING, REGULATION, AND PUBLIC HEALTH

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

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

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

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

(B) recommending a plan to institute a public health impact assessment process to ensure appropriate consideration of the impacts on

public health resulting from major policy or planning decisions made by municipalities, local entities, and state agencies.

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

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

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

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

Sec. 15. PAYMENT REFORM; REGULATORY PROCESSES

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

Sec. 16. WORKFORCE ISSUES

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

(2) The board of nursing, the board of medical practice, and the office of professional regulation, in consultation with the primary care workforce development committee established in Sec. 31 of No. 128 of the Acts of the 2009 Adj. Sess. (2010), shall collaborate to determine how to optimize the primary care workforce by reviewing the licensure process, scope of practice requirements, reciprocity of licensure, and efficiency of the licensing process, and by identifying any other barriers to augmenting Vermont's primary care workforce. No later than January 15, 2012, the boards and office shall provide to the house committee on health care and the senate committee on health and welfare joint recommendations for improving the primary care workforce through the boards' and office's rules and procedures.

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

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

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

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

* * * Rate Review * * *

Sec. 17. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

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

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the law of this state. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which is ~~unjust, unfair, inequitable, misleading, or contrary to the law of this state~~ does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. ~~In all other cases, the commissioner shall give his or her approval.~~

(3) ~~After the expiration of such 30 days from the filing of any such form, premium rate or rule, the review period provided herein~~ or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 ~~days~~ days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

(b) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file

a summary applicable to the cumulative rate increase. The summary shall include a brief justification of any rate increase requested, information required by the Secretary of the U.S. Department of Health and Human Services (HHS) for rate increases over 10 percent, and any other information required by the commissioner. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

(c)(1) The commissioner shall provide information to the public on the department's website about the public availability of the filings and summaries required under this section.

(2) Beginning no later than January 1, 2012, the commissioner shall post the filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the department's website within five days of filing. The department shall provide an electronic mechanism for the public to comment on proposed rate increases over five percent. The public shall have 21 days from the posting of the summaries and filings to provide public comment. The department shall review and consider the public comments prior to the expiration of the review period pursuant to subsection (a) of this section. The department shall provide the Green Mountain Health board with the public comments for their consideration in approving any rate increases.

Sec. 18. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate, or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 19. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the commissioner for his or her approval prior to issuance or use. Prior to approval, there shall be a

public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the commissioner of a nonrefundable fee of \$50.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 20. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the commissioner of banking, insurance, securities, and health care administration under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by such commissioner. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the commissioner of a nonrefundable fee of \$50.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 21. 8 V.S.A. § 5104(a) is amended to read:

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The commissioner may request and shall receive any information that is needed to determine whether to approve the policy form or rate. In addition to any other information requested, the commissioner shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including but not limited to Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section 4062 of this title.

(2) The commissioner shall refuse to approve the form of evidence of coverage, filing or rate if it contains any provision which is unjust, unfair, inequitable, misleading or contrary to the law of the state or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, or fail to

meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

* * * Employer Benefit Information * * *

Sec. 22. 21 V.S.A. § 2004 is added to read:

§ 2004. HEALTH BENEFIT COSTS

(a) Employers shall provide their employees with an annual statement indicating:

(1) the total monthly premium cost paid for any employer-sponsored health benefit plan;

(2) the employer's share and the employee's share of the total monthly premium; and

(3) any amount the employer contributes toward the employee's cost-sharing requirement or other out-of-pocket expenses.

(b) Notwithstanding the provisions of subsection (a) of this section, an employer who reports the cost of coverage under an employer-sponsored health benefit plan as required by 26 U.S.C. § 6051(a)(14) shall be deemed to be in full compliance with the requirements of this section.

* * * Consumer Protection * * *

Sec. 23. REVIEW OF BAN ON DISCRETIONARY CLAUSES

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting a National Association of Insurance Commissioners (NAIC) model act prohibiting insurers from using discretionary clauses in their health benefit contracts. The purpose of the NAIC model act is to prohibit insurance clauses that purport to reserve discretion to the insurer to interpret the terms of the policy, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare on the advantages and disadvantages of Vermont adopting the NAIC model act.

* * * Single Formulary * * *

Sec. 24. SINGLE FORMULARY RECOMMENDATIONS

No later than January 15, 2012, the department of Vermont health access shall provide recommendations to the house committee on health care and the senate committee on health and welfare regarding:

(1) A single prescription drug formulary to be used by all payers of health services which allows for some variations for Medicaid due to the availability of rebates and discounts and which allows health care professionals prescribing drugs purchased pursuant to Section 340B of the Public Health Service Act to use the 340B formulary. The recommendations shall address the feasibility of requesting a waiver from Medicare Part D in order to ensure Medicare participation in the formulary, as well as the feasibility of enabling all prescription drugs purchased by or on behalf of Vermont residents to be purchased through the Medicaid program or pursuant to the 340B drug pricing program.

(2) A single mechanism for negotiating rebates and discounts across payers using a single formulary, and the advantages and disadvantages of using a single formulary to achieve uniformity of coverage.

(3) A uniform set of drug management rules aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management. The standards for pharmacy benefit management shall address timely decisions, access to clinical peers, access to evidence-based rationales, exemption processes, and tracking and reporting data on pharmacy benefit manager and prescriber satisfaction.

* * * Conforming Revisions * * *

Sec. 25. 3 V.S.A. § 2222a is amended to read:

§ 2222a. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY
AND AFFORDABILITY

(a) The secretary of administration shall be responsible for the coordination of health care system reform initiatives among executive branch agencies, departments, and offices.

(b) The secretary shall ensure that those executive branch agencies, departments, and offices responsible for the development, improvement, and implementation of Vermont's health care system reform do so in a manner that is timely, equitable, patient-centered, evidence-based, and seeks to inform and improve the quality and affordability of patient care and public health.

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

(1) The state's chronic care infrastructure, disease prevention, and management program contained in the blueprint for health established by

chapter 13 of Title 18, the goal of which is to achieve a unified, comprehensive, statewide system of care that improves the lives of all Vermonters with or at risk for a chronic condition or disease.

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

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

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

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

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

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

(8) Medicaid, the Vermont health access plan, Dr. Dynasaur, premium assistance programs for employer-sponsored insurance, VPharm, and Vermont Rx, which are established in chapter 19 of Title 33 and provide health care coverage to elderly, disabled, and low to middle income Vermonters.

(9) Catamount Health, established in 8 V.S.A. § 4080f, which provides a comprehensive benefit plan with a sliding-scale premium based on income to uninsured Vermonters.

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

(11) A reformation of the payment system for health care set forth in 18 V.S.A. chapter 220 in order to ensure that payment for services encourages health care quality and efficiency, and reduces unnecessary services.

~~(d) The secretary shall report to the commission on health care reform, the health access oversight committee, the house committee on health care, the senate committee on health and welfare, and the governor on or before December 1, 2006, with a five year strategic plan for implementing Vermont's~~

~~health care system reform initiatives, together with any recommendations for administration or legislation. Annually, beginning January 15, 2007, the secretary shall report to the general assembly on the progress of the reform initiatives.~~

(e) The secretary of administration or designee shall provide information and testimony on the activities included in this section to the health access oversight committee, the commission on health care reform, and to any legislative committee upon request.

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

§ 5. DUTIES OF DEPARTMENT OF HEALTH

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

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

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

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

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

(5) Seek accreditation through the Public Health Accreditation Board.

(6) Create a state health improvement plan and facilitate local health improvement plans in order to encourage the design of healthy communities and to promote policy initiatives that contribute to community, school, and workplace wellness, which may include providing assistance to employers for wellness program grants, encouraging employers to promote employee engagement in healthy behaviors, and encouraging the appropriate use of the health care system.

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

(a)(1) The commissioner shall establish and maintain a unified health care data base to enable the commissioner and the Green Mountain Health board to

carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title 8, including:

- (A) Determining the capacity and distribution of existing resources.
- (B) Identifying health care needs and informing health care policy.
- (C) Evaluating the effectiveness of intervention programs on improving patient outcomes.
- (D) Comparing costs between various treatment settings and approaches.
- (E) Providing information to consumers and purchasers of health care.
- (F) Improving the quality and affordability of patient health care and health care coverage.

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

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

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

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

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

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

Sec. 30. REPEAL

(a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective July 1, 2012.

(b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective July 1, 2011.

Sec. 31. APPROPRIATIONS

(a) In fiscal year 2012, the sum of \$807,182.00 in general funds and \$355,727.00 in federal funds is appropriated to the Green Mountain Health board to carry out its functions.

(b) In fiscal year 2012, the sum of \$48,000.00 is appropriated from the general fund to the secretary of administration for the malpractice proposal pursuant to Sec. 2(e) of this act.

Sec. 32. EFFECTIVE DATES

(a) Sec. 1 (strategic plan); Sec. 2, 18 V.S.A. chapter 220, subchapter 2 (Green Mountain Health board nominating committee); Secs. 11 (integration plan), 12 (funding needs); 13 (HIT); 14 (health planning); 15 (regulatory process); 16 (workforce); 23 (discretionary clauses); 24 (single formulary); 25 (health care reform); 26 (department of health); 28 (ACA grants); and 29 (primary care workforce committee) of this act and this section shall take effect on passage.

(b) Sec. 2, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Health board) and Secs. 3 (health care ombudsman), 4 (positions), 5 and 6 (manufacturers of prescribed products), 8 (DVHA), 9 (Health care eligibility), 30 (repeal), and 31 (appropriations) shall take effect on July 1, 2011.

(c)(1) Sec. 7 (Vermont health benefit exchange) shall take effect on July 1, 2011.

(2) The Vermont health benefit exchange shall begin enrolling individuals no later than November 1, 2013 and shall be fully operational no later than January 1, 2014.

(d) Sec. 10, 3 V.S.A. § 402 (Medicaid and exchange advisory board), shall take effect on July 1, 2012.

(e) Secs. 17-21 (rate review) shall take effect on October 1, 2011 and shall apply to all filings on and after October 1, 2011, except that the amendments to § 4062(c)(2) shall take effect on January 1, 2012 and shall apply to all filings on and after that date.

(f) Secs. 22 (health benefit information) and 27 (VHCURES) shall take effect on October 1, 2011.

and that after passage, the title of the bill be amended to read: “An act relating to strategic and sustainable health reform”

Amendment to be offered by Reps. Olsen of Jamaica, and Scheuermann of Stowe to H. 202

(d) In developing both financing plans required by subsection (a) of this section, the secretary of administration or designee shall ensure that for employers with self-insured health plans, neither the employer nor any employee shall be required to contribute to the financing for the Vermont health benefit exchange or Green Mountain Care if such employer or employee chooses not to participate in the applicable program.

Amendment to be offered by Rep. Donahue of Northfield to H. 202

First: In Sec. 4, 33 V.S.A. chapter 18, subchapter 2, in § 1824, Health Benefits, by striking subsection (b) in its entirety and inserting in lieu thereof the following:

(b)(1) For individuals eligible for Medicaid or CHIP, the benefit package shall include all benefits required by federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package. Individuals eligible for Medicaid may receive optional benefits pursuant to 42 U.S.C. § 1396d, and individuals eligible for CHIP may receive services covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc, only to the extent that these benefits or services are included in the Green Mountain Care benefit package. Except as provided in subdivision (2) of this subsection, at no time shall individuals eligible for Medicaid or CHIP receive additional optional Medicaid benefits or services covered under the state plan for CHIP in excess of those available in the Green Mountain Care benefit package.

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

(3) For individuals eligible for Medicare, the benefit package shall include the benefits provided to these individuals under federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

Second: In Sec. 4, 33 V.S.A. chapter 18, subchapter 2, in § 1826, Administration; Enrollment, by striking subsection (c) in its entirety and inserting in lieu thereof the following:

(c)(1) Except as otherwise provided in subdivision (2) of this subsection, a health insurer shall not offer or provide supplemental health insurance or

coverage for additional health services to an individual enrolled in Green Mountain Care.

(2) A health insurer may offer or provide supplemental health insurance or coverage for dental, vision, or hearing services or for long-term care to an individual enrolled in Green Mountain Care as long as these services are not covered under the Green Mountain Care benefit package. If at any time one or more of these benefits are included in the Green Mountain Care benefit package, no health insurer may offer supplemental health insurance or other supplemental coverage for the covered service.

Third: In Sec. 8, Integration Plan, in (a)(1)(B) by striking designations (1) and (2) inserting designations (i) and (ii), respectively and by striking subdivision (a)(2) and renumbering the remaining subdivisions accordingly

Action Postponed Until March 29, 2011

H. 258

An act relating to public participation in environmental enforcement proceedings.

Pending Action: Second reading of the bill.

NEW BUSINESS

Third Reading

H. 91

An act relating to the management of fish and wildlife

Amendment to be offered by Rep. Komline of Dorset to H. 91

in Sec. 5, by striking subdivision (c)(2)(B) in its entirety and inserting in lieu thereof the following:

(B) The fish and wildlife board shall adopt by rule a process by which the number of white-tailed deer and moose entrapped within the relevant captive hunt facility is reduced to zero by taking, as that term is defined in 10 V.S.A. § 4001, over a five-year period from September 1, 2011. The rule adopted by the fish and wildlife board under this subdivision shall specify:

(i) The number and type of white-tailed deer or moose to be taken in any season set by the board for the relevant captive hunt facility, subject to the following:

(I) The board shall not authorize the hunting or killing of the moose known as Pete and may authorize the relocation or transfer of such moose to an adequate facility;

(II) The number of white-tailed deer or moose authorized for taking should be reasonably equal in each of the five years from September 1, 2011, provided that all white-tailed deer or moose remaining at the facility in the fifth year shall be authorized for taking;

(III) In each year of the five-year period, the owner of the relevant captive cervidae facility shall present to the department of fish and wildlife for disease surveillance at least the number of white-tailed deer and moose authorized for taking by the fish and wildlife board under this subdivision (C)(2)(B)(i).

(ii) The process and protocol for a disease surveillance program at the relevant captive cervidae facility.

H. 411

An act relating to the application of Act 250 to agricultural fairs

H. 436

An act relating to tax changes, including income taxes, property taxes, economic development credits, health care-related tax provisions, and miscellaneous tax provisions.

Amendment to be offered by Rep. Wizowaty of Burlington to H. 436

that the bill be amended in Sec. 27, 32 V.S.A. § 7771 (rate of tax), in subsection (d), by striking out “125.5” and inserting in lieu thereof “162”

Amendment to be offered by Rep. Pearson of Burlington to H. 436

First: By adding a new section to be Sec. 36a to read:

Sec. 36a. 32 V.S.A. chapter 215 is added to read:

CHAPTER 215. SEVERANCE ROYALTIES

§ 8701. DEFINITIONS

As used in this chapter:

(1) “Groundwater” shall have the meaning set forth in 10 V.S.A. § 1416.

(2) “Manufacturer” means any processor, bottler, or other person who withdraws groundwater in the state of Vermont for the purpose of selling or reselling the groundwater for consumption by human beings.

(3) “Spring” shall have the meaning set forth in 10 V.S.A. § 1416.

(4) “Well” shall have the meaning set forth in 10 V.S.A. § 1416.

(5) “Withdraw” or “withdrawal” shall have the meaning set forth in 10 V.S.A. § 1416.

§ 8702. IMPOSITION OF GROUNDWATER WITHDRAWAL ROYALTY

There is hereby imposed on each manufacturer a groundwater withdrawal royalty of \$0.28 per gallon of groundwater withdrawn from a well or a spring within the state of Vermont for the purpose of sale or the purpose of sale to another for resale.

§ 8703. PAYMENT

Each manufacturer shall prepare and submit to the department a monthly report according to procedures established by the commissioner showing the total gallons of groundwater withdrawn during the preceding month and other information the commissioner may require. The groundwater withdrawal royalty shall be paid each month to the department at the same time the report is submitted.

§ 8704. RECORDS

Each manufacturer shall keep a record of all groundwater withdrawn in this state, and that record must be open at all times to inspection by the commissioner of taxes.

§ 8705. ENFORCEMENT

The groundwater withdrawal royalty imposed under this chapter shall be enforced using the enforcement and collection provisions set forth in chapter 103 of this title.

Second: In Sec. 37, by inserting in subdivision (6), after “(mandatory composite filing for pass-through entities with large number of nonresident owners)”, the words “and 36a (groundwater severance royalty)”

Amendment to be offered by Rep. Higley of Lowell to H. 436

striking out Secs. 23–26 in their entirety, and inserting in lieu thereof four new sections to be Secs. 23–26 to read as follows:

Sec. 23. [Deleted.]

Sec. 24. [Deleted.]

Sec. 25. [Deleted.]

Sec. 26. [Deleted.]

Amendment to be offered by Rep. Ancel of Calais to H. 436

First: In Sec. 7 (REPEAL), in subdivision (2), by striking “16 V.S.A. § 164(18)”

Second: By adding a Sec. 7a to read:

Sec. 7a. 16 V.S.A. § 164(18) is amended to read:

(18) Ensure that Vermont's students, including students enrolled in secondary technical education, have access to a substantially equal educational opportunity by developing a system to evaluate the equalizing effects of Vermont's education finance system and school quality standards under section 165 of this title. ~~Beginning in school year 2000 and every five years thereafter, or more often if requested by the general assembly, the state board shall report to the general assembly concerning the results of this evaluation and recommendations for change if needed.~~

Third: In Sec. 20, 32 V.S.A. § 5914(b), after the words “in excess of”, by striking “100” and inserting in lieu thereof “50”

Fourth: In Sec. 21, 32 V.S.A. § 5920(b), after the words “in excess of”, by striking “100” and inserting in lieu thereof “50”

Amendment to be offered by Rep. Wright of Burlington to H. 436

First: By adding a new section to be Sec. 13a to read:

Sec. 13a. HOMESTEAD PROPERTY TAX REFUND

(a) Any taxpayer who failed to timely file a homestead declaration may apply to the commissioner of taxes for a refund of amounts of property tax overpaid as a result of the failure to timely file a homestead declaration; provided, however, that the taxpayer shall have the burden of proving to the commissioner that one of the following substantially contributed to the taxpayer's failure to timely file:

(1) The taxpayer suffered from a serious medical illness or disability lasting at least from April 1 through September 1 of the tax year in question; or

(2) The taxpayer was given inaccurate information by an official of the taxpayer's municipality regarding the taxpayer's homestead status.

(b) Notwithstanding 16 V.S.A. § 4025(b), upon such an adequate showing of proof, the taxpayer shall be entitled to a refund, without interest, which the commissioner shall make from the education fund. The commissioner's determination as to the adequacy of the taxpayer's proof required in subdivision (a)(1) or (2) of this section shall be final.

Second: In Sec. 4, by inserting “and Sec. 13a (homestead property tax refund)” after the words “(definition of household income)”

Action Under Rule 52

J.R.H. 15

Joint resolution urging the Federal Communications Commission to protect the

financial viability of telephone service in rural communities

(For text see House Journal March 22, 2011)

NOTICE CALENDAR

Committee Bill for Second Reading

H. 438

An act relating to the department of banking, insurance, securities, and health care administration.

(Rep. Scheuermann of Stowe will speak for the Committee on Commerce and Economic Development.)

H. 439

An act relating to the bill-back authority of the department of public service and the public service board.

(Rep. Ralston of Middlebury will speak for the Committee on Commerce and Economic Development.)

H. 440

An act relating to creating an agency and secretary of education and amending the membership and purpose of the state board of education.

(Rep. Donovan of Burlington will speak for the Committee on Education.)

H. 441

An act relating to making appropriations for the support of government.

(Rep. Heath of Westford will speak for the Committee on Appropriations.)

Favorable with Amendment

H. 254

An act relating to consumer protection

Rep. Marcotte of Coventry, for the Committee on **Commerce and Economic Development**, recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 9 V.S.A. § 2466 is amended to read:

§ 2466. GOODS AND SERVICES APPEARING ON TELEPHONE BILL

~~(a) No~~ Except as provided in subsection (f) of this section, a seller shall not bill a consumer for goods or services that will appear as a charge on the person's local telephone bill without the consumer's express authorization bill for telephone service provided by any local exchange carrier.

~~(b) No later than the tenth business day after a seller has entered into a contract or other agreement with a consumer to sell or lease or otherwise provide for consideration goods or services that will appear as a charge on the consumer's local telephone bill, the seller shall send, or cause to be sent, to the consumer, by first class mail, postage prepaid, a notice of the contract or agreement.~~

~~(c) The notice shall clearly and conspicuously disclose:~~

~~(1) The nature of the goods or services to be provided;~~

~~(2) The cost of the goods or services;~~

~~(3) Information on how the consumer may cancel the contract or agreement;~~

~~(4) The consumer assistance address and telephone number specified by the attorney general;~~

~~(5) That the charges for the goods or services may appear on the consumer's local telephone bill; and~~

~~(6) Such other information as the attorney general may prescribe by rule.~~

~~(d) The notice shall be a separate document sent for the sole purpose of providing to the consumer the information required by subsection (c) of this section. The notice shall not be combined with any sweepstakes offer or other inducement to purchase goods or services.~~

~~(e) The sending of the notice required by this section is not a defense to a claim that a consumer did not consent to enter into the contract or agreement.~~

~~(f) No person shall arrange on behalf of a seller of goods or services, directly or through an intermediary, with a local exchange carrier, to bill a consumer for goods or services unless the seller complies with this section. This prohibition applies, but is not limited, to persons who aggregate consumer billings for a seller and to persons who serve as a clearinghouse for aggregated billings.~~

~~(g)(c)~~ Failure to comply with this section is an unfair and deceptive act and practice in commerce under this chapter.

~~(h)(d)~~ The attorney general may make rules and regulations to carry out the purposes of this section.

~~(e)~~ Nothing in this section limits the liability of any person under existing statutory or common law.

~~(f)(1)~~ This section shall apply to billing aggregators described in 30 V.S.A. § 231a, but shall not apply to: ~~sellers regulated by~~

(A) billing for goods or services marketed or sold by persons subject to the jurisdiction of the Vermont public service board under Title 30, other than section 231a of Title 30 30 V.S.A. § 203;

(B) billing for direct dial or dial around services initiated from the consumer's telephone; or

(C) operator-assisted telephone calls, collect calls, or telephone services provided to facilitate communication to or from correctional center inmates.

(2) Nothing in this section affects any rule issued by the Vermont public service board.

Sec. 2. 9 V.S.A. chapter 63, subchapter 1C is added to read:

Subchapter 1C. Discount Membership Programs

§ 2470aa. DEFINITIONS

In this subchapter:

(1) "Billing information" means any data that enables a seller of a discount membership program to access a consumer's credit or debit card, bank, or other account, but does not include the consumer's name, e-mail address, telephone number, or mailing address. For credit card and debit card accounts, billing information includes the full account number, card type, and expiration date, and, if necessary, the security code. For accounts at a financial institution, "billing information" includes the full account number and routing number, and, if necessary, the name of the financial institution holding the account.

(2) A "discount membership program" is a program that entitles consumers to receive discounts, rebates, rewards, or similar incentives on the purchase of goods or services or both, in whole or in part, from any third party.

§ 2470bb. APPLICABILITY

A discount membership program is a good or service within the meaning of subsection 2451a(b) of this chapter. This subchapter applies only to persons who are regularly and primarily engaged in trade or commerce in this state in connection with offering or selling discount membership programs. This

subchapter shall not apply to an electronic payment system, as defined in 9 V.S.A. 2480o, or to a financial institution, as defined in 8 V.S.A. 11101(32).

§ 2470cc. REQUIRED DISCLOSURES; CONSENT

(a) No person shall charge or attempt to charge a consumer for a discount membership program, or to renew a discount membership program beyond the term expressly agreed to by the consumer or the term permitted under section 2470ff of this title, whichever is shorter, unless:

(1) Before obtaining the consumer's billing information, the person has clearly and conspicuously disclosed to the consumer all material terms of the transaction, including:

(A) A description of the types of goods and services on which a discount is available;

(B) The name of the discount membership program and the name and address of the seller of the program;

(C) The amount, or a good faith estimate, of the typical discount on each category of goods and services;

(D) The cost of the program, including the amount of any periodic charges, how often such charges are imposed, and the method of payment;

(E) The right to cancel and to terminate the program, which shall be no more restrictive than as required by section 2470ee of this subchapter, and a toll-free telephone number and e-mail address that can be used to cancel the membership;

(F) The maximum length of membership, as described in section 2470ff of this subchapter;

(G) In the event that the program is offered on the Internet through a link or referral from another business's website, the fact that the seller is not affiliated with that business;

(H) The fact that periodic notices of the program billings will be emailed or mailed to the consumer, as the case may be, consistent with section 2470dd of this title; and

(2) The person has received express informed consent for the charge from the consumer whose credit or debit card, bank, or other account will be charged, by:

(A) Obtaining from the consumer:

(i) the consumer's billing information; and

(ii) the consumer's name and address and a means to contact the consumer; and

(B) Requiring the consumer to perform an additional affirmative action, such as clicking on an online confirmation button, checking an online box that indicates the consumer's consent to be charged the amount disclosed, or expressly giving consent over the telephone.

(b) A person who sells discount membership programs shall retain evidence of a consumer's express informed consent for at least three years after the consent is given.

§ 2470dd. PERIODIC NOTICES

(a) A person who periodically charges a consumer for a discount membership program shall send the consumer a notice of the charge no less frequently than every three months from the date of initial enrollment that clearly and conspicuously discloses:

(1) A description of the program;

(2) The name of the discount membership program and the name and address of the seller of the program;

(3) The cost of the program, including the amount of any periodic charges, how often such charges are imposed, and the method of payment;

(4) The right to cancel and to terminate the program, which shall be no more restrictive than as required by section 2470ee of this subchapter, and a toll-free number and e-mail address that can be used to cancel the membership; and

(5) The maximum length of membership, as described in section 2470ff of this subchapter.

(b) The notice specified in subsection (a) of this section:

(1) Shall be sent:

(A) To the consumer's last known e-mail address, if the consumer enrolled in the discount membership program online or by e-mail, with the subject line, "IMPORTANT INFORMATION ABOUT YOUR DISCOUNT PROGRAM BILLING," or substantially similar words, provided that the sender takes reasonable steps to verify that the e-mail has been opened; or

(B) Otherwise by first-class mail to the consumer's last known mailing address, with the heading on the enclosure and outside envelope, "IMPORTANT INFORMATION ABOUT YOUR DISCOUNT PROGRAM BILLING," or substantially similar words; and

(2) Shall not include any solicitation or advertising.

§ 2470ee. CANCELLATION AND TERMINATION

(a) In addition to any other right to revoke an offer, a consumer may cancel the purchase of a discount membership program until midnight on the 30th day after the date the consumer has given express informed consent to be charged for the program. If the consumer cancels within the 30-day period, the seller of the discount membership program shall, within ten days of receiving the notice of cancellation, provide a full refund to the consumer.

(b) Notice of cancellation shall be deemed given when deposited in a mailbox properly addressed and postage prepaid or when e-mailed to the e-mail address of the seller of the discount membership program.

(c) In addition to the right to cancel described in this subchapter, a consumer may terminate a discount membership program at any time by providing notice to the seller by one of the methods described in this section. In that case, the consumer shall not be obligated to make any further payments under the program and shall not be entitled to any discounts under the program for any period of time after the last month for which payment has been made.

(d) If the seller of a discount membership program cancels the program for any reason other than nonpayment by the consumer, the seller shall make pro rata reimbursement to the consumer of all periodic charges paid by the consumer for periods of time after cancellation. Prior to such cancellation, the seller shall first provide reasonable notice and an explanation of the cancellation in writing to the consumer.

§ 2470ff. MAXIMUM LENGTH OF PLAN

No person shall sell, or offer for sale, a discount membership program lasting longer than 18 months.

§ 2470gg. BILLING INFORMATION

No person who offers or sells discount membership programs shall obtain billing information relating to a consumer except directly from the consumer.

§ 2470hh. VIOLATIONS

(a) A violation of this subchapter is deemed to be a violation of section 2453 of this title.

(b) The attorney general has the same authority to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as is provided under subchapter 1 of this chapter.

Sec. 3. 9 V.S.A. § 2435 is amended to read:

§ 2435. NOTICE OF SECURITY BREACHES

(a) This section shall be known as the Security Breach Notice Act.

(b) Notice of breach.

(1) Except as set forth in subsection (d) of this section, any data collector that owns or licenses computerized personal information that includes personal information concerning a consumer shall notify the consumer that there has been a security breach following discovery or notification to the data collector of the breach. Notice of the security breach shall be made in the most expedient time possible and without unreasonable delay, consistent with the legitimate needs of the law enforcement agency, as provided in subdivision ~~(3)~~ (4) of this subsection, or with any measures necessary to determine the scope of the security breach and restore the reasonable integrity, security, and confidentiality of the data system.

(2) Any data collector that maintains or possesses computerized data containing personal information of a consumer that the ~~business data collector~~ does not own or license or any data collector that acts or conducts business in Vermont that maintains or possesses records or data containing personal information that the data collector does not own or license shall notify the owner or licensee of the information of any security breach immediately following discovery of the breach, consistent with the legitimate needs of law enforcement as provided in subdivision ~~(3)~~(4) of this subsection.

(3) A data collector or other entity subject to this subchapter, other than a person or entity licensed or registered with the department of banking, insurance, securities, and health care administration under Title 8 or this title, shall provide notice of a breach to the attorney general's office as follows:

(A)(i) The data collector shall notify the attorney general of the date of the security breach, the date of discovery of the breach, and provide a preliminary description of the breach within 14 business days of the data collector's discovery of the security breach, or when the data collector provides notice to consumers pursuant to this section, whichever is sooner.

(ii) If the date of the breach is unknown at the time notice is sent to the attorney general, the data collector shall send the attorney general the date of the breach as soon as it is known.

(iii) Unless otherwise ordered by a court of this state for good cause shown a notice provided under this subdivision (3)(A) shall not be disclosed to any person other than the authorized agent or representative of the attorney general, a state's attorney, or another law enforcement officer engaged

in legitimate law enforcement activities, without the consent of the data collector.

(B)(i) When the data collector provides notice of the breach pursuant to subdivision (1) of this subsection, the data collector shall notify the attorney general of the number of Vermont consumers affected, if known to the data collector, and shall provide a copy of the notice provided to consumers under subdivision (1) of this subsection.

(ii) The data collector may send to the attorney general a second copy of the consumer notice, from which is redacted the type of personal information that was subject to the breach, and which the attorney general shall use for any public disclosure of the breach.

(4) The notice to a consumer required by this subsection shall be delayed upon request of a law enforcement agency. A law enforcement agency may request the delay if it believes that notification may impede a law enforcement investigation, or a national or homeland security investigation or jeopardize public safety or national or homeland security interests. In the event law enforcement makes the request in a manner other than in writing, the data collector shall document such request contemporaneously in writing, including the name of the law enforcement officer making the request and the officer's law enforcement agency engaged in the investigation. A law enforcement agency shall promptly notify the data collector when the law enforcement agency no longer believes that notification may impede a law enforcement investigation, or a national or homeland security investigation or jeopardize public safety or national or homeland security interests. The data collector shall provide notice required by this section without unreasonable delay upon receipt of a written communication, which includes facsimile or electronic communication, from the law enforcement agency withdrawing its request for delay.

~~(4)~~(5) The notice to a consumer shall be clear and conspicuous. The notice shall include a description of each of the following, if known to the data collector:

(A) The incident in general terms.

(B) The type of personal information that was subject to the ~~unauthorized access or acquisition~~ security breach.

(C) The general acts of the ~~business~~ data collector to protect the personal information from further unauthorized access or acquisition.

(D) A toll-free telephone number that the consumer may call for further information and assistance.

(E) Advice that directs the consumer to remain vigilant by reviewing account statements and monitoring free credit reports.

(F) The approximate date of the security breach.

~~(5)~~(6) For purposes of this subsection, notice to consumers may be provided by one of the following methods:

* * *

Sec. 4. 9 V.S.A. chapter 63 is amended to read:

Chapter 63. CONSUMER ~~FRAUD~~ PROTECTION

* * *

§ 2453. PRACTICES PROHIBITED; ANTITRUST AND CONSUMER ~~FRAUD~~ PROTECTION

* * *

§ 2461e. REQUIREMENTS FOR GUARANTEED PRICE PLANS AND PREPAID CONTRACTS

(d) Private right of action under consumer ~~fraud~~ protection act. In addition to the remedies set forth in sections 2458 and 2461 of this title, a home heating oil, kerosene, or liquefied petroleum gas dealer may bring an action against its heating oil, kerosene, or liquefied petroleum gas suppliers for failing to honor its contract with the home heating oil, kerosene, or liquefied petroleum gas dealer. The home heating oil, kerosene, or liquefied petroleum gas dealer bringing the action may recover all remedies available to consumers under subsection 2461(b) of this title.

* * *

§ 2480q. PENALTIES

(a) The following penalties shall apply to violations of this subchapter:

* * *

(3) A violation of section 2480p of this subchapter shall be deemed a violation of ~~chapter 63 section 2453~~ section 2453 of this title, ~~the Consumer Fraud Act~~. The attorney general has the same authority to conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as provided under subchapter 1 ~~of chapter 63~~ of this title chapter.

* * *

Sec. 5. AMENDMENT OF TERM “CONSUMER FRAUD” TO READ

“CONSUMER PROTECTION”

In each of the following sections, and in the attorney general’s consumer fraud rules, the term “consumer fraud” is deleted wherever it appears and the term “consumer protection” is inserted in lieu thereof: 7 V.S.A. § 1010; 8 V.S.A. §§ 2706, 2709, and 2764; 9 V.S.A. § 2471; 18 V.S.A. §§ 1511, 1512, 4086, 4631, 4633, 4634, and 9473; 20 V.S.A. § 2757; and 33 §§ 1923 and 2010.

Sec. 6. 9 V.S.A. § 2465b is added to read:

§ 2465b. MISREPRESENTATION OF A FLORAL BUSINESS AS LOCAL

(a) In connection with the sale of floral products, it shall be an unlawful and deceptive act and practice in commerce in violation of section 2453 of this title for a floral business to misrepresent in an advertisement, on the internet, on a website, or in a listing of the floral business in a telephone directory or other directory assistance database the geographic location of the floral business as “local,” “locally owned,” or physically located within Vermont.

(b) A floral business is considered to misrepresent its geographic location that it is “local,” “locally owned,” or located within Vermont in violation of subsection (a) of this section if the floral business is not physically located in Vermont and:

(1) the advertisement, internet, website, or directory listing would lead a reasonable consumer to conclude that the floral business is physically located in Vermont; or

(2) the advertisement, internet, website, or directory listing uses the name of a floral business that is physically located in Vermont, with geographic terms that would lead a reasonable consumer to understand the advertised floral business to be physically located in Vermont.

(c) A retail floral business physically located in Vermont shall be deemed a consumer for the purposes of enforcing this section under §2461(b) of this chapter.

Sec. 7. 3 V.S.A. § 2222 is amended to read:

§ 2222. POWERS AND DUTIES; BUDGET AND REPORT

(a) In addition to the duties expressly set forth elsewhere by law the secretary shall:

* * *

(9) Submit to the general assembly concurrent with the governor’s annual budget request required under 32 V.S.A. § 306, a strategic plan for

information technology and information security which outlines the significant deviations from the previous year's ~~information technology~~ plan, and which details the plans for information technology activities of state government for the following fiscal year as well as the administration's financing recommendations for these activities. For purposes of this section, "information security" shall mean protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide integrity, confidentiality, and availability. All such plans shall be reviewed and approved by the commissioner of information and innovation prior to being included in the governor's annual budget request. The plan shall identify the proposed sources of funds for each project identified. The plan shall also contain a review of the state's information technology and information security and an identification of priority projects by agency. The plan shall include, for any proposed information technology activity with a cost in excess of \$100,000.00:

(A) a life-cycle costs analysis including planning, purchase and development of applications, the purchase of hardware and the ~~on-going~~ ongoing operation and maintenance costs to be incurred over the expected life of the systems; and a cost-benefit analysis which shall include acquisition costs as well as operational and maintenance costs over the expected life of the system;

(B) the cost savings ~~and/or~~ or service delivery improvements or both which will accrue to the public or to state government;

(C) a statement identifying any impact of the proposed new computer system on the privacy or disclosure of individually identifiable information;

(D) a statement identifying costs and issues related to public access to nonconfidential information;

(E) a statewide budget for all information technology activities with a cost in excess of ~~\$100,000~~ \$100,000.00.

(10) The secretary shall annually submit to the general assembly a five-year information technology and information security plan which indicates the anticipated information technology activities of the legislative, executive, and judicial branches of state government. For purposes of this section, "information technology activities" shall mean:

(A) the creation, collection, processing, storage, management, transmission, or conversion of electronic data, documents, or records;

(B) the design, construction, purchase, installation, maintenance, or operation of systems, including both hardware and software, which perform these activities.

Sec. 8. 22 V.S.A. § 901 is amended to read:

§ 901. DEPARTMENT OF INFORMATION AND INNOVATION

The department of information and innovation, created in 3 V.S.A. § 2283b, shall have all the responsibilities assigned to it by law, including the following:

(1) to provide direction and oversight for all activities directly related to information technology and information security, including telecommunications services, information technology equipment, software, accessibility, and networks in state government. For purposes of this section, “information security” is defined in 3 V.S.A. § 2222(a)(9);

(2) to manage an agencywide coordinated information technology and information security budget;

(3) to manage GOVnet and K-12net;

(4) to review all information technology and information security requests for proposal in accordance with agency of administration policies;

(5) to review and approve computer systems or computer system upgrades in all departments with a cost in excess of \$100,000.00, and annually submit to the general assembly a strategic plan for information technology and information security as required of the secretary of administration by 3 V.S.A. § 2222(a)(9);

(6) to review and approve information technology activities in all departments with a cost in excess of \$100,000.00, and annually submit to the general assembly a budget for information technology and information security as required of the secretary of administration by 3 V.S.A. § 2222(a)(9). For purposes of this section, “information technology activities” is defined in 3 V.S.A. § 2222(a)(10);

* * *

(11) to coordinate information technology and information security training within state government;

* * *

Sec. 9. EFFECTIVE DATE

This act shall take effect July 1, 2011.

(**Committee Vote: 10-0-1**)

Public Hearings

March 31, 2011 - 6:00 - 8:00 PM - House Chamber - Senate Committee on Health and Welfare - S. 57 Health Care Reform

Thursday, April 7, 2011 - Room 11 - 6 - 8 PM - Senate Health and Welfare Committee - S. 57 Health Care Reform - Business and Provider Hearing

Wednesday, March 30, 2011 - Room 11 - 6:00 - 8:00 PM - Senate Committee on Natural Resources and Energy - Energy Planning

House Appropriations Committee

Members' amendments to Fiscal Year 2012

Proposed Omnibus Appropriations Bill (H.441)

The House Appropriations Committee requests all members of the House, who intend to introduce amendments to the proposed FY 2012 omnibus appropriations bill (H.441), to meet with the committee in room 42 at 8:30 a.m. on either Thursday, March 24, before 2nd reading, OR Friday, March 25, before 3rd reading. If possible, please schedule a time with Theresa Utton-Jerman (828-5767, Room: 40 or tutton@leg.state.vt.us) to meet with the Committee.

Thursday, March 24, 2011 - Room - 11 - 6:00 - 8:00 PM - Senate Health and Welfare Committee - S. 57 Health Care Reform - Business and Provider hearing