House Calendar

Friday, March 15, 2013

66th DAY OF THE BIENNIAL SESSION

House Convenes at 9:30 A.M.

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Consent Calendar

ORDERS OF THE DAY

ACTION CALENDAR

Favorable with Amendment

H. 315

An act relating to group health coverage for same-sex spouses

Rep. Poirier of Barre City, 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. 8 V.S.A. § 4063b is added to read:

§ 4063b. COVERAGE FOR EMPLOYEES OF AN EMPLOYER DOMICILED OUTSIDE OF VERMONT

(a) As used in this section:

(1) "Health insurance" shall have the same meaning as "group health insurance policy or subscriber contract" in section 4091a of this title.

(2) "Marriage" shall have the same meaning as in 15 V.S.A. § 8.

(3) "Party to a civil union" shall have the same meaning as in 15 V.S.A. § 1201.

(b) To the extent permitted under federal law, health insurance coverage provided to Vermont residents who work for an employer domiciled outside of Vermont shall not distinguish between parties to a civil union, married same-sex couples, and married opposite-sex couples.

Sec. 2. 21 V.S.A. § 495 is amended to read:

§ 495. UNLAWFUL EMPLOYMENT PRACTICE

* * *

(f) ~~The provisions of this section prohibiting discrimination on the basis of sexual orientation or gender identity shall not be construed to change the definition of family or dependent in an employee benefit plan.~~ [Repealed.]

* * *

Sec. 3. EFFECTIVE DATE

This act shall take effect on July 1, 2013.

(Committee Vote: 10-1-0)

Amendment to be offered by Rep. Morrissey of Bennington to H. 315

Rep. Morrissey moves that the bill be amended by adding a new Sec. 3 to read as follows:

Sec. 3. REPORT ON COSTS OF LITIGATION

The Office of the Attorney General shall track all costs, including the number of hours spent by its attorneys and other staff, incurred as a result of defending or settling any legal challenge filed that relates to the language in this act. On or before January 15 of each year, the Office shall report to the General Assembly its total defense and settlement costs related to this act for the preceding calendar year, as well as any amounts ordered by a court to be paid by the State.

and by renumbering the remaining section to be numerically correct

NOTICE CALENDAR

Committee Bill for Second Reading

H. 511

An act relating to "zappers" and automated sales suppression devices.

(Rep. Goodwin of Weston will speak for the Committee on **Judiciary.)**

Favorable with Amendment

H. 136

An act relating to cost-sharing for preventive services

Rep. Till of Jericho, 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. 8 V.S.A. § 4100a is amended to read:

§ 4100a. MAMMOGRAMS; COVERAGE REQUIRED

(a) Insurers shall provide coverage for screening by ~~low-dose~~ mammography for the presence of occult breast cancer, as provided by this subchapter. Benefits provided shall cover the full cost of the mammography service~~, subject to a co-payment no greater than the co-payment applicable to care or services provided by a primary care physician under the insured's policy, provided that no co-payment shall exceed $25.00. Mammography services~~ and shall not be subject to any co-payment, deductible, ~~or~~ coinsurance ~~requirements~~, or other cost-sharing requirement or additional charge.

(b) For females 40 years or older, coverage shall be provided for an annual screening. For females less than 40 years of age, coverage for screening shall be provided upon recommendation of a health care provider.

(c) After January 1, 1994, this section shall apply only to screening procedures conducted by test facilities accredited by the American College of Radiologists.

(d) For purposes of this subchapter:

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

(2) ~~"Low-dose mammography"~~ "Mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes. ~~The average radiation dose to the breast shall be the lowest dose generally recognized by competent medical authority to be practicable for yielding acceptable radiographic images.~~

(3) "Screening" includes the ~~low-dose~~ mammography test procedure and a qualified physician's interpretation of the results of the procedure, including additional views and interpretation as needed.

Sec. 2. 8 V.S.A. § 4100g is amended to read:

§ 4100g. COLORECTAL CANCER SCREENING, COVERAGE REQUIRED

(a) For purposes of this section:

(1) "Colonoscopy" means a procedure that enables a physician to examine visually the inside of a patient's entire colon and includes the concurrent removal of polyps, biopsy, or both.

(2) "Insurer" means insurance companies that provide health insurance as defined in subdivision 3301(a)(2) of this title, nonprofit hospital and medical services corporations, and health maintenance organizations. The term does not apply to coverage for specified disease or other limited benefit coverage.

(b) Insurers shall provide coverage for colorectal cancer screening, including:

(1) Providing an insured 50 years of age or older with the option of:

(A) Annual fecal occult blood testing plus one flexible sigmoidoscopy every five years; or

(B) One colonoscopy every 10 years.

(2) For an insured who is at high risk for colorectal cancer, colorectal cancer screening examinations and laboratory tests as recommended by the treating physician.

(c) For the purposes of subdivision (b)(2) of this section, an individual is at high risk for colorectal cancer if the individual has:

(1) A family medical history of colorectal cancer or a genetic syndrome predisposing the individual to colorectal cancer;

(2) A prior occurrence of colorectal cancer or precursor polyps;

(3) A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn's disease, or ulcerative colitis; or

(4) Other predisposing factors as determined by the individual's treating physician.

(d) ~~Benefits provided shall cover the colorectal cancer screening subject to a co-payment no greater than the co-payment applicable to care or services provided by a primary care physician under the insured's policy, provided that no co-payment shall exceed $100.00 for services performed under contract with the insurer.~~ Colorectal cancer screening services performed under contract with the insurer ~~also~~ shall not be subject to any co-payment, deductible, ~~or~~ coinsurance ~~requirements~~, or other cost-sharing requirement. In addition, an insured shall not be subject to any additional charge for any service associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:

(1) removal of tissue or other matter;

(2) laboratory services;

(3) physician services;

(4) facility use; and

(5) anesthesia.

(e) ~~If determined to be permitted by Centers for Medicare and Medicaid Services, for a patient covered under the Medicare program, the patient's out-of-pocket expenditure for a colorectal cancer screening shall not exceed $100.00, with the hospital or other health care facility where the screening is performed absorbing the difference between the Medicare payment and the Medicare negotiated rate for the screening.~~ [Deleted.]

Sec. 3. STATUTORY CONSTRUCTION; LEGISLATIVE INTENT

The express enumeration of the services associated with a procedure or test for colorectal cancer in 8 V.S.A. § 4100g(d) shall not be construed to suggest that those services should not also be covered as part of any other procedure or test, even if the provisions of law applicable to the other procedure or test do not expressly list the associated services in the same manner or to the same extent that they are enumerated in 8 V.S.A. § 4100g(d).

Sec. 4. EFFECTIVE DATE

This act shall take effect on passage.

(Committee Vote: 11-0-0)

H. 169

An act relating to relieving employers' experience-rating records

Rep. Bouchard of Colchester, 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. 21 V.S.A. § 1325 is amended to read:

§ 1325. EMPLOYERS' EXPERIENCE-RATING RECORDS; DISCLOSURE TO SUCCESSOR ENTITY~~; EMPLOYEE PAID $1,000.00 OR LESS DURING BASE PERIOD~~

(a)(1) The ~~commissioner~~ Commissioner shall maintain an experience-rating record for each employer. Benefits paid shall be charged against the experience-rating record of each subject employer who provided base-period wages to the eligible individual. Each subject employer's experience-rating charge shall bear the same ratio to total benefits paid as the total base-period wages paid by that employer bear to the total base-period wages paid to the individual by all base-period employers. The experience-rating record of an individual subject base-period employer shall not be charged for benefits paid to an individual under any of the following conditions:

~~(1)~~(A) The individual's employment with that employer was terminated under disqualifying circumstances.

~~(2)~~(B) The individual's employment or right to reemployment with that employer was terminated by retirement of the individual pursuant to a retirement or lump-sum retirement pay plan under which the age of mandatory retirement was agreed upon by the employer and its employees or by the bargaining agent representing those employees.

~~(3)~~(C) As of the date on which the individual filed an initial claim for benefits, the individual's employment with that employer had not been terminated or reduced in hours.

~~(4)~~(D) The individual was employed by that employer as a result of another employee taking leave under subchapter 4A of chapter 5 of this title, and the individual's employment was terminated as a result of the reinstatement of the other employee under subchapter 4A of chapter 5 of this title.

~~(5)~~(E) [Repealed.]

(2) If an individual's unemployment is directly caused by a major natural disaster declared by the President of the United States pursuant to 42 U.S.C. § 5122 and the individual would have been eligible for federal disaster unemployment assistance benefits but for the receipt of regular benefits, an employer shall be relieved of charges for benefits paid to the individual with respect to any week of unemployment occurring due to the natural disaster up to a maximum amount of four weeks.

* * *

Sec. 2. UNEMPLOYMENT COMPENSATION; EMPLOYERS AFFECTED BY NATURAL DISASTERS OCCURRING IN 2011

(a) The Department of Labor shall establish a system to provide unemployment compensation tax relief to employers paying a higher rate of contributions due to layoffs directly caused by federally declared natural disasters occurring in 2011.

(b) Unemployment compensation tax relief shall be available to an employer provided that the employer's employees were separated from employment as a direct result of the disaster. Benefits paid beyond eight weeks shall remain chargeable to the employer.

(c) The relief described in subsection (b) of this section shall not be available to employers electing to make payments in lieu of contributions pursuant to 21 V.S.A. § 1321.

(d) Benefit charge relief provided under subsections (a) and (b) of this section shall not result in the recalculation of previously assigned rate classes for nondisaster-impacted employers.

(e) The Department shall notify employers in the counties covered by the federal disaster relief declaration of the provisions of this section. An employer seeking relief shall apply to the Department within 20 days of notification by the Department. The application shall be made in a manner prescribed and approved by the Commissioner and shall be accompanied by a certified

statement of the employer that the employees were separated from employment as a direct result of the disaster and would have not been otherwise. False statements made in connection with the certification shall subject the employer to the provisions of 21 V.S.A. § 1369. The employer shall provide the Department with the name, address, last known phone number, and social security number of each employee alleged to have been separated from employment as a result of the disaster.

(f) If an employer's application for relief is denied, the employer may appeal the decision pursuant to 21 V.S.A. §§ 1348 and 1349.

Sec. 3. AUTHORIZATION OF LIMITED SERVICE POSITIONS

The Commissioner of Labor is authorized to hire two limited service positions in order to assist in providing the unemployment compensation tax relief in Sec. 2 of this act.

Sec. 4. APPROPRIATION

Up to $40,000.00 is appropriated to the Department of Labor for the costs of postage necessary to notify employers of the unemployment compensation tax relief program described in Sec. 2 of this act.

Sec. 5. EFFECTIVE DATE

This act shall take effect on passage.

(Committee Vote: 11-0-0)

H. 431

An act relating to mediation in foreclosure actions

Rep. Koch of Barre Town, for the Committee on **Judiciary,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 12 V.S.A. chapter 163, subchapter 9 is amended to read:

Subchapter 9. Mediation in Foreclosure Actions

§ 4631. MEDIATION PROGRAM ESTABLISHED

(a) This subchapter establishes a program to assure the availability of mediation and application of ~~the federal Home Affordable Modification Program ("HAMP")~~ government loss mitigation program requirements in actions for foreclosure of a mortgage on any dwelling house of four units or less that is occupied by the owner as a principal residence.

(b) The requirements of this subchapter shall apply ~~only~~ to all foreclosure actions ~~involving loans that are subject to the federal HAMP guidelines~~ on

dwelling houses of four units or less that are occupied by the owner as a principal residence unless:

(1) the loan involved is not subject to any government loss mitigation program requirements;

(2) prior to commencing the foreclosure action, the mortgagee or a representative of the mortgagee met with or made reasonable efforts to meet with the mortgagor in person in Vermont to discuss any applicable loss mitigation options; and

(3) the plaintiff in the foreclosure action certifies in its complaint that the requirements of subdivisions (1) and (2) of this subsection have been satisfied and describes its efforts to meet with the mortgagor in person to discuss applicable loss mitigation efforts.

(c) To be qualified to act as a mediator under this subchapter, an individual shall be licensed to practice law in the ~~state~~ State and shall be periodically required to ~~have taken a~~ take specialized, continuing legal education training ~~course~~ courses on foreclosure prevention or loss mitigation approved by the Vermont Bar Association.

(d) This subchapter shall not apply to a commercial loan.

(e) As used in this subchapter:

(1) "Commercial loan" means any loan described in 9 V.S.A. § 46(1), (2), or (3).

(2) "Government loss mitigation program" means:

(A) the federal Home Affordable Modification Program ("HAMP");

(B) any loss mitigation program for loans owned or guaranteed by government-sponsored entities such as the Federal National Mortgage Association (Fannie Mae), the Federal Home Loan Mortgage Corporation (Freddie Mac), the U.S. Federal Housing Administration, or the U.S. Department of Veterans Affairs;

(C) any loss mitigation program for loans guaranteed by the U.S. Department of Agriculture-Rural Development that are not owned by an instrumentality of the United States or the State of Vermont; or

(D) a settlement agreement with a government entity, or any state or federal law or regulation, regarding the notification, consideration, or offer of loss mitigation options.

§ 4632. OPPORTUNITY TO MEDIATE

(a) In an action for foreclosure ~~of a mortgage on any dwelling house of four units or less that is occupied by the owner as a principal residence~~ subject to this subchapter, whenever the mortgagor ~~enters an appearance in the case or~~ requests mediation prior to four months after judgment is entered and before the end of the redemption period specified in the decree, the court shall refer the case to mediation pursuant to this subchapter, except that the court may:

(1) for good cause, shorten the four-month period or thereafter decline to order mediation; or

(2) decline to order mediation if the mortgagor requests mediation after judgment has been entered and the court determines that the mortgagor is attempting to delay the case, or the court may for good cause decline to order mediation if the mortgagor requests mediation after judgment has been entered.

(b) Unless the mortgagee ~~agrees~~ and mortgagor agree otherwise or the court so orders for good cause shown, all mediation shall be completed prior to the expiration of the redemption period specified in the decree and within 120 days of the mediator's appointment. The redemption period shall not be stayed on account of pending mediation.

(c) In an action for foreclosure of a mortgage ~~on any dwelling house of four units or less that is occupied by the owner as a principal residence~~ subject to this subchapter, the mortgagee shall serve upon the mortgagor two copies of the notice described in subsection (d) of this section with the summons and complaint. The ~~supreme court~~ Supreme Court may by rule consolidate this notice with other foreclosure-related notices as long as the consolidation is consistent with the content and format of the notice under this subsection.

(d) The notice required by subsection (c) of this section shall:

(1) be on a form approved by the court administrator;

(2) advise the homeowner of the homeowner's rights in foreclosure proceedings under this subchapter;

(3) state the importance of participating in mediation even if the homeowner is currently communicating with the mortgagee or servicer;

(4) provide contact information for legal services; and

(5) incorporate a form that can be used by the homeowner to request mediation from the court.

(e) ~~The court may, on motion of a party, find that the requirements of this subchapter have been met and that the parties are not required to participate in mediation under this subchapter if the mortgagee files a motion and establishes~~

~~to the satisfaction of the court that it has complied with the applicable requirements of HAMP and supports its motion with sworn affidavits that:~~

~~(1) include the calculations and inputs required by HAMP and employed by the mortgagee; and~~

~~(2) demonstrate that the mortgagee or servicer met with the mortgagor in person or via videoconferencing or made reasonable efforts to meet with the mortgagor in person.~~

The Vermont Bar Association (VBA) shall have the authority to establish a fair and neutral mediator-selection process. If the mortgagee and mortgagor are unable to select a mediator through the selection process established by the VBA, the court shall appoint a qualified mediator for the case.

§ 4633. MEDIATION

(a) During all mediations under this subchapter:

(1) The parties shall address the available foreclosure prevention tools and, if disputed, the amount due on the note for the principal, interest, and costs or fees.

~~(1)~~(2) ~~the~~ The mortgagee shall use and consider available foreclosure prevention tools, including reinstatement, loan modification, forbearance, and short sale, and the ~~calculations, assumptions, and forms established by the HAMP guidelines, including all HAMP-related~~ applicable government loss mitigation program requirements and any related "net present value" calculations used in considering a loan modification conducted under this subchapter~~;~~.

~~(2)~~(3) ~~the~~ The mortgagee shall produce for the mortgagor and mediator ~~documentation of its consideration of the options available in this subdivision and subdivision (1) of this subsection, including the data used in and the outcome of any HAMP-related "net present value" calculation; and~~:

(A) if a modification or other agreement is not offered, an explanation why the mortgagor was not offered a modification or other agreement; and

(B) for any applicable government loss mitigation program, the criteria for the program and the inputs and calculations used in determining the homeowner's eligibility for a modification or other program.

~~(3)~~(4) ~~where~~ Where the mortgagee claims that a pooling and servicing or other similar agreement prohibits modification, the mortgagee shall produce a copy of the agreement. All agreement documents shall be confidential and shall not be included in the mediator's report.

(b)(1) In all mediations under this subchapter, the mortgagor shall make a good faith effort to provide to the mediator ~~20 days prior to the first mediation, or~~ within a time determined by the ~~mediator to be appropriate in order to allow for verification of the information provided by the mortgagee~~ court or mediator, information on his or her household income, and any other information required by ~~HAMP unless already provided~~ any applicable government loss mitigation program.

(2) Within 45 days of appointment, the mediator shall hold a premediation telephone conference to help the mortgagee and mortgagor complete any necessary document exchange and address other premediation issues. At the premediation telephone conference, the mediator shall at a minimum document and maintain records of the progress the mortgagee and mortgagor are making on financial document production, any review of information that occurs during the conference, any request for additional information, the anticipated time frame for submission of any additional information and the lender's review of the information, the scheduling of the mediation session, and which of the persons identified in subdivision (d)(1) of this section will be present in person at the mediation or that the parties and the mediator have agreed pursuant to subsection (e) of this section that personal presence at the mediation is not required.

(3) During the mediation, the mediator shall document and maintain records of:

(A) agreements about information submitted to the mediator;

(B) whether a modification or other foreclosure alternative is available and, if so, the terms of the modification;

(C) if a modification or other foreclosure alternative is not available, the reasons for the unavailability; and

(D) the steps necessary to finalize the mediation.

(c) The parties to a mediation under this subchapter shall cooperate in good faith under the direction of the mediator to produce the information required by subsections (a) and (b) of this section in a timely manner so as to permit the mediation process to function effectively.

(d)(1) The following persons shall participate in person or by telephone in any mediation under this subchapter:

(A) the mortgagee, or any other person, including the mortgagee's servicing agent, who meets the qualifications required by subdivision (2) of this subsection;

(B) counsel for the mortgagee; and

(C) the mortgagor, and counsel for the mortgagor, if represented.

(2) The mortgagee or mortgagee's servicing agent, if present, shall have:

(A) authority to agree to a proposed settlement, loan modification, or dismissal of the foreclosure action;

(B) real time access during the mediation to the mortgagor's account information and to the records relating to consideration of the options available in subdivisions ~~(a)(1) and (2)~~ (a)(2) and (a)(3) of this section, including the data and factors considered in evaluating each such foreclosure prevention tool; and

(C) the ability and authority to perform ~~necessary HAMP-related~~ government loss mitigation program-related "net present value" calculations and to consider other options available in subdivisions ~~(a)(1) and (2)~~ (a)(2) and (a)(3) of this section during the mediation.

(e) The mediator may permit a party identified in subdivision (d)(1) of this section to participate in mediation by telephone or videoconferencing. The mortgagee and mortgagor shall each have at least one of the persons identified in subdivision (d)(1) of this section present in person at the mediation unless all parties and the mediator agree otherwise in writing.

(f) The mediator may include in the mediation process under this subchapter any other person the mediator determines would assist in the mediation.

(g) Unless the ~~parties~~ mortgagee and mortgagor agree otherwise, all mediations under this subchapter shall take place in the county in which the foreclosure action is brought pursuant to subsection ~~4523(a)~~ 4932(a) of this title.

§ 4634. MEDIATION REPORT

(a) Within seven days of the conclusion of any mediation under this subchapter, the mediator shall report in writing the results of the process to the court and both parties, and shall provide a copy of the report to the Office of the Attorney General for data collection purposes. The report shall otherwise be confidential, and shall be exempt from public copying and inspection under 1 V.S.A. § 317.

(b) The report required by subsection (a) of this section shall not disclose the mediator's assessment of any aspect of the case or substantive matters discussed during the mediation, except as is required to report the information required by this section. The report shall contain all of the following items:

(1) The date on which the mediation was held, including the starting and finishing times.

(2) The names and addresses of all persons attending, showing their role in the mediation and specifically identifying the representative of each party who had decision-making authority.

(3) A summary of any substitute arrangement made regarding attendance at the mediation.

(4) All ~~HAMP-related "net present value" calculations and other foreclosure avoidance tool~~ applicable government loss mitigation program criteria, inputs, and calculations performed prior to or during the mediation and all information related to the requirements in subsection 4633(a) of this title.

(5) The results of the mediation, stating whether full or partial settlement was reached and appending any agreement of the parties.

(6)(A) A statement as to whether any person required under subsection ~~(d) of section~~ 4633(d) of this title to participate in the mediation failed to:

(i) attend the mediation;

(ii) make a good faith effort to mediate; or

(iii) supply documentation, information, or data as required by subsections 4633(a)–(c) of this title.

(B) If a statement is made under subdivision (6)(A) of this subsection (b), it shall be accompanied by a brief description of the applicable reason for the statement.

§ 4635. COMPLIANCE WITH OBLIGATIONS

(a) Upon receipt of a mediator's report required by subsection 4634(a) of this title, the court shall determine whether the mortgagee or servicer has complied with all of its obligations under subsection 4633(a) of this title, and, at a minimum, with any ~~modification obligations under HAMP~~ applicable government loss mitigation program requirements. The court may make such a determination without a hearing unless the court, in its discretion, determines that a hearing is necessary.

(b) If the mediator's report includes a statement under subdivision ~~4635(b)(6)~~ 4634(b)(6) of this title, or if the court makes a determination of noncompliance with the ~~obligations~~ requirements under subsection 4635(a) of this title, the court may impose appropriate sanctions against the noncomplying party, including:

(1) tolling of interest, fees, and costs;

(2) reasonable attorney's fees;

(3) monetary sanctions;

(4) dismissal without prejudice; and

(5) prohibiting the mortgagee from selling or taking possession of the property that is the subject of the action with or without opportunity to cure as the court deems appropriate.

(c) No mediator shall be required to testify in an action subject to this subchapter.

§ 4636. ~~EFFECT OF MEDIATION PROGRAM ON FORECLOSURE ACTIONS FILED PRIOR TO EFFECTIVE DATE~~

~~The court shall, on request of a party prior to judgment or on request of a party and showing of good cause after judgment, require mediation in any foreclosure action on a mortgage on any dwelling house of four units or less that is occupied by the owner as a principal residence that was commenced prior to the effective date of this subchapter but only up to 30 days prior to the end of the redemption period.~~ [Repealed.]

§ 4637. NO WAIVER OF RIGHTS; COSTS OF MEDIATION

(a) The parties' rights in a foreclosure action are not waived by their participation in mediation under this subchapter.

(b) The mortgagee shall pay the required costs for any mediation under this subchapter except that the mortgagor shall be responsible for mortgagor's own costs, including the cost of mortgagor's attorney, if any, and travel costs.

(c) If the foreclosure action results in a sale with a surplus, the mortgagee may recover the full cost of mediation to the extent of the surplus. Otherwise, the mortgagee may not shift to the mortgagor the costs of the mortgagee's or the servicing agent's attorney's fees or travel costs related to mediation but may shift up to one-half of the costs of the mediator.

Sec. 2. EFFECTIVE DATE

This act shall take effect on December 1, 2013 and shall apply to any mortgage foreclosure proceeding instituted after that date.

(Committee Vote: 11-0-0)

Favorable

H. 2

An act relating to the Governor's Snowmobile Council

Rep. McCarthy of St. Albans City, for the Committee on **Transportation,** recommends the bill ought to pass.

(Committee Vote: 10-0-1)

Committee Relieved

H. 107

An act relating to health insurance, Medicaid, and the Vermont Health Benefit Exchange

Rep. Woodward of Johnson, 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:

* * * Health Insurance * * *

Sec. 1. 8 V.S.A. § 4079 is amended to read:

§ 4079. GROUP INSURANCE POLICIES; DEFINITIONS

Group health insurance is hereby declared to be that form of health insurance covering one or more persons, with or without their dependents, and issued upon the following basis:

(1)(A) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least one employee of such employer, for the benefit of persons other than the employer. The term "employees," as used herein, shall be deemed to include the officers, managers, and employees of the employer, the partners, if the employer is a partnership, the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The term "employer," as used herein, may be deemed to include any municipal or governmental corporation, unit, agency, or department thereof and the proper officers as such, of any unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations.

(B) In accordance with section 3368 of this title, an employer domiciled in another jurisdiction that has more than 25 certificate- holder employees whose principal worksite and domicile is in Vermont and that is defined as a large group in its own jurisdiction and under the Patient Protection and Affordable

Care Act, Pub. L. No. 111-148, § 1304, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, may purchase insurance in the large group health insurance market for its Vermont-domiciled certificate-holder employees.

* * *

Sec. 2. 8 V.S.A. § 4089a is amended to read:

§ 4089a. MENTAL HEALTH CARE SERVICES REVIEW

* * *

(b) Definitions. As used in this section:

* * *

(4) "Review agent" means a person or entity performing service review activities within one year of the date of a fully compliant application for licensure who is either affiliated with, under contract with, or acting on behalf of a business entity in this ~~state; or a third party~~ State and who provides or administers mental health care benefits to ~~citizens of Vermont~~ members of health benefit plans subject to the Department's jurisdiction, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care physicians to coordinate delivery of services~~, authorized to offer health insurance policies or contracts in Vermont~~.

* * *

(g) ~~Members of the independent panel of mental health care providers shall be compensated as provided in 32 V.S.A. § 1010(b) and (c).~~ [Deleted.]

* * *

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

(d) For prescription drug benefits offered in conjunction with a high-deductible health plan (HDHP), the plan may not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles in effect for self-only and family coverage under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, except that a plan may offer first-dollar prescription drug benefits to the extent permitted under federal law. Once the foregoing expenditure amount has been met under the HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection (c) of this section.

Sec. 4. 8 V.S.A. § 4092(b) is amended to read:

(b) Coverage for a newly born child shall be provided without notice or additional premium for no less than ~~31~~ 60 days after the date of birth. If payment of a specific premium or subscription fee is required in order to have the coverage continue beyond such ~~31-day~~ 60-day period, the policy may require that notification of birth of newly born child and payment of the required premium or fees be furnished to the insurer or nonprofit service or indemnity corporation within a period of not less than ~~31~~ 60 days after the date of birth.

Sec. 5. 18 V.S.A. § 9418 is amended to read:

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

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

* * *

(17) "Product" means, to the extent permitted by state and federal law, one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

(A) ~~Health~~ health maintenance organization;

(B) ~~Preferred~~ preferred provider organization;

(C) ~~Fee-for-service~~ fee-for-service or indemnity plan;

(D) Medicare Advantage HMO plan;

(E) Medicare Advantage private fee-for-service plan;

(F) Medicare Advantage special needs plan;

(G) Medicare Advantage PPO;

(H) Medicare supplement plan;

(I) ~~Workers~~ workers compensation plan; or

(J) ~~Catamount Health; or~~

~~(K)~~ ~~Any~~ any other commercial health coverage plan or product.

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

(1) Pay or reimburse the claim.

(2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a

description of any additional information required for the health plan, contracting entity, or payer to determine liability for the claim.

(3) Pend a claim for services rendered to an enrollee during the second and third months of the consecutive three-month grace period required for recipients of advance payments of premium tax credits pursuant to 26 U.S.C. § 36B. In the event the enrollee pays all outstanding premiums prior to the exhaustion of the grace period, the health plan, contracting entity, or payer shall have 30 days following receipt of the outstanding premiums to proceed as provided in subdivision (1) or (2) of this subsection, as applicable.

* * *

* * * Catamount Health and VHAP * * *

Sec. 6. 8 V.S.A. § 4080d is amended to read:

§ 4080d. COORDINATION OF INSURANCE COVERAGE WITH MEDICAID

Any insurer as defined in section 4100b of this title is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. § 1396a (Section 1902 of the Social Security Act), herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders. ~~This section shall not apply to Catamount Health, as established by section 4080f of this title.~~

Sec. 7. 8 V.S.A. § 4080g(b) is amended to read:

(b) Small group plans.

* * *

(11)(A) A registered small group carrier may require that 75 percent or less of the employees or members of a small group with more than 10 employees participate in the carrier's plan. A registered small group carrier may require that 50 percent or less of the employees or members of a small group with 10 or fewer employees or members participate in the carrier's plan. A small group carrier's rules established pursuant to this subdivision shall be applied to all small groups participating in the carrier's plans in a consistent and nondiscriminatory manner.

(B) For purposes of the requirements set forth in subdivision (A) of this subdivision (11), a registered small group carrier shall not include in its calculation an employee or member who is already covered by another group health benefit plan as a spouse or dependent or who is enrolled in ~~Catamount Health,~~ Medicaid~~, the Vermont health access plan,~~ or Medicare. Employees or

members of a small group who are enrolled in the employer's plan and receiving premium assistance under ~~33 V.S.A. chapter 19~~ the Health Insurance Premium Payment program established pursuant to Section 1906 of the Social Security Act, 42 U.S.C. § 1396e, shall be considered to be participating in the plan for purposes of this subsection. If the small group is an association, trust, or other substantially similar group, the participation requirements shall be calculated on an employer-by-employer basis.

* * *

Sec. 8. 8 V.S.A. § 4088i is amended to read:

§ 4088i. COVERAGE FOR DIAGNOSIS AND TREATMENT OF EARLY CHILDHOOD DEVELOPMENTAL DISORDERS

(a)(1) A health insurance plan shall provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 21.

(2) Coverage provided pursuant to this section by Medicaid~~, the Vermont health access plan,~~ or any other public health care assistance program shall comply with all federal requirements imposed by the Centers for Medicare and Medicaid Services.

* * *

(f) As used in this section:

* * *

(7) "Health insurance plan" means Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this ~~state~~ State by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include benefit plans providing coverage for specific diseases or other limited benefit coverage.

* * *

Sec. 9. 8 V.S.A. § 4089j is amended to read:

§ 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS

* * *

(c) This section shall apply to Medicaid~~, the Vermont health access plan, the VScript pharmaceutical assistance program,~~ and any other public health care assistance program.

Sec. 10. 8 V.S.A. § 4089w is amended to read:

§ 4089w. OFFICE OF HEALTH CARE OMBUDSMAN

* * *

(h) As used in this section, "health insurance plan" means a policy, service contract or other health benefit plan offered or issued by a health insurer, as defined by 18 V.S.A. § 9402, and includes ~~the Vermont health access plan and~~ beneficiaries covered by the Medicaid program unless such beneficiaries are otherwise provided ombudsman services.

Sec. 11. 8 V.S.A. § 4099d is amended to read:

§ 4099d. MIDWIFERY COVERAGE; HOME BIRTHS

* * *

(d) As used in this section, "health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program offered or administered by the ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term shall not include policies or plans providing coverage for specific disease or other limited benefit coverage.

Sec. 12. 8 V.S.A. § 4100b is amended to read:

§ 4100b. COVERAGE OF CHILDREN

(a) As used in this subchapter:

(1) "Health plan" shall include~~, but not be limited to,~~ a group health plan as defined under Section 607(1) of the Employee Retirement Income Security Act of 1974~~,~~ and a nongroup plan as defined in section 4080b of this title~~, and a Catamount Health plan as defined in section 4080f of this title~~.

* * *

Sec. 13. 8 V.S.A. § 4100e is amended to read:

§ 4100e. REQUIRED COVERAGE FOR OFF-LABEL USE

* * *

(b) As used in this section, the following terms have the following meanings:

(1) "Health insurance plan" means a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont.

(2) "Health insurer" is defined by ~~section~~ 18 V.S.A. § 9402 ~~of Title 18~~. As used in this subchapter, the term includes the ~~state~~ State of Vermont and any agent or instrumentality of the ~~state~~ State that offers, administers, or provides financial support to state government, including Medicaid~~, the Vermont health access plan, the VScript pharmaceutical assistance program,~~ or any other public health care assistance program.

* * *

Sec. 14. 8 V.S.A. § 4100j is amended to read:

§ 4100j. COVERAGE FOR TOBACCO CESSATION PROGRAMS

* * *

(b) As used in this subchapter:

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program offered or administered by the ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

* * *

Sec. 15. 8 V.S.A. § 4100k is amended to read:

§ 4100k. COVERAGE FOR TELEMEDICINE SERVICES

* * *

(g) As used in this subchapter:

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program offered or administered by the ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

* * *

Sec. 16. 13 V.S.A. § 5574(b) is amended to read:

(b) A claimant awarded judgment in an action under this subchapter shall be entitled to damages in an amount to be determined by the trier of fact for each year the claimant was incarcerated, provided that the amount of damages shall not be less than $30,000.00 nor greater than $60,000.00 for each year the claimant was incarcerated, adjusted proportionally for partial years served. The damage award may also include:

(1) Economic damages, including lost wages and costs incurred by the claimant for his or her criminal defense and for efforts to prove his or her innocence.

(2) ~~Notwithstanding the income eligibility requirements of the Vermont Health Access Plan in section 1973 of Title 33, and notwithstanding the requirement that the individual be uninsured, up~~ Up to 10 years of eligibility for ~~the Vermont Health Access Plan using state-only funds~~ state-funded health coverage equivalent to Medicaid services.

* * *

Sec. 17. 18 V.S.A. § 1130 is amended to read:

§ 1130. IMMUNIZATION PILOT PROGRAM

(a) As used in this section:

* * *

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

* * *

Sec. 18. 18 V.S.A. § 3801 is amended to read:

§ 3801. DEFINITIONS

As used in this subchapter:

(1)(A) "Health insurer" shall have the same meaning as in section 9402 of this title and shall include:

(i) a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations;

(ii) an employer, a labor union, or another group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont; and

(iii) except as otherwise provided in section 3805 of this title, the ~~state~~ State of Vermont and any agent or instrumentality of the ~~state~~ State that offers, administers, or provides financial support to state government.

(B) The term "health insurer" shall not include Medicaid~~, the Vermont health access plan, Vermont Rx,~~ or any other Vermont public health care assistance program.

* * *

Sec. 19. 18 V.S.A. § 4474c(b) is amended to read:

(b) This chapter shall not be construed to require that coverage or reimbursement for the use of marijuana for symptom relief be provided by:

(1) a health insurer as defined by section 9402 of this title, or any insurance company regulated under Title 8;

(2) Medicaid~~, Vermont health access plan, and~~ or any other public health care assistance program;

(3) an employer; or

(4) for purposes of workers' compensation, an employer as defined in 21 V.S.A. § 601(3).

Sec. 20. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

* * *

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

* * *

Sec. 21. 18 V.S.A. § 9471 is amended to read:

§ 9471. DEFINITIONS

As used in this subchapter:

* * *

(2) "Health insurer" is defined by section 9402 of this title and shall include:

(A) a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations;

(B) an employer, labor union, or other group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont;

(C) the ~~state~~ State of Vermont and any agent or instrumentality of the ~~state~~ State that offers, administers, or provides financial support to state government; and

(D) Medicaid, ~~the Vermont health access plan, Vermont Rx,~~ and any other public health care assistance program.

* * *

Sec. 22. 33 V.S.A. § 1807(b) is amended to read:

(b) Navigators shall have the following duties:

* * *

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

* * *

(5) ~~Provide~~ 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~~ 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~~.~~; and

(7) ~~Provide~~ provide information about and facilitate employers' establishment of cafeteria or premium-only plans under Section 125 of the Internal Revenue Code that allow employees to pay for health insurance premiums with pretax dollars.

Sec. 23. 33 V.S.A. § 1901(b) is amended to read:

(b) ~~The secretary may charge a monthly premium, in amounts set by the general assembly, to each individual 18 years or older who is eligible for enrollment in the health access program, as authorized by section 1973 of this title and as implemented by rules. All premiums collected by the agency of human services or designee for enrollment in the health access program shall be deposited in the state health care resources fund established in section~~

~~1901d of this title. Any co-payments, coinsurance, or other cost sharing to be charged shall also be authorized and set by the general assembly.~~ [Deleted.]

Sec. 24. 33 V.S.A. § 1903a is amended to read:

§ 1903a. CARE MANAGEMENT PROGRAM

(a) The ~~commissioner~~ Commissioner of Vermont ~~health access~~ Health Access shall coordinate with the ~~director~~ Director of the Blueprint for Health to provide chronic care management through the Blueprint and, as appropriate, create an additional level of care coordination for individuals with one or more chronic conditions who are enrolled in Medicaid~~, the Vermont health access plan (VHAP),~~ or Dr. Dynasaur. The program shall not include individuals who are in an institute for mental disease as defined in 42 C.F.R. § 435.1009.

* * *

Sec. 25. 33 V.S.A. § 1997 is amended to read:

§ 1997. DEFINITIONS

As used in this subchapter:

* * *

(7) "State public assistance program"~~,~~ includes~~, but is not limited to,~~ the Medicaid program, ~~the Vermont health access plan,~~ VPharm, ~~VermontRx,~~ the ~~state children's health insurance program~~ State Children's Health Insurance Program, the ~~state~~ State of Vermont AIDS ~~medication assistance program~~ Medication Assistance Program, the General Assistance program, the ~~pharmacy discount plan program~~ Pharmacy Discount Plan Program, and the out-of-state counterparts to such programs.

Sec. 26. 33 V.S.A. § 1998(c)(1) is amended to read:

(c)(1) The ~~commissioner~~ Commissioner may implement the ~~pharmacy best practices and cost control program~~ Pharmacy Best Practices and Cost Control Program for any other health benefit plan within or outside this ~~state~~ State that agrees to participate in the program. For entities in Vermont, the ~~commissioner~~ Commissioner shall directly or by contract implement the program through a joint pharmaceuticals purchasing consortium. The joint pharmaceuticals purchasing consortium shall be offered on a voluntary basis no later than January 1, 2008, with mandatory participation by state or publicly funded, administered, or subsidized purchasers to the extent practicable and consistent with the purposes of this chapter, by January 1, 2010. If necessary, the ~~department of Vermont health access~~ Department of Vermont Health Access shall seek authorization from the Centers for Medicare and Medicaid to include purchases funded by Medicaid. "State or publicly funded purchasers"

shall include the ~~department of corrections~~ Department of Corrections, the ~~department of mental health~~ Department of Mental Health, Medicaid, ~~the Vermont Health Access Program (VHAP),~~ Dr. Dynasaur, ~~VermontRx,~~ VPharm, Healthy Vermonters, workers' compensation, and any other state or publicly funded purchaser of prescription drugs.

Sec. 27. 33 V.S.A. § 2004(a) is amended to read:

(a) Annually, each pharmaceutical manufacturer or labeler of prescription drugs that are paid for by the ~~department of Vermont health access~~ Department of Vermont Health Access for individuals participating in Medicaid, ~~the Vermont Health Access Program,~~ Dr. Dynasaur, or VPharm~~, or VermontRx~~ shall pay a fee to the ~~agency of human services~~ Agency of Human Services. The fee shall be 0.5 percent of the previous calendar year's prescription drug spending by the ~~department~~ Department and shall be assessed based on manufacturer labeler codes as used in the Medicaid rebate program.

* * * Vermont Health Benefit Exchange * * *

Sec. 28. 33 V.S.A. § 1804 is amended to read:

§ 1804. QUALIFIED EMPLOYERS

(a)(1) Until January 1, 2016, a qualified employer shall be an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 50 employees on working days during the preceding calendar year, ~~employed at least one and no more than 50 employees,~~ and the term "qualified employer" includes self-employed persons to the extent permitted under the Affordable Care Act. Calculation of the number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week.

* * *

(b)(1) From January 1, 2016 until January 1, 2017, a qualified employer shall be an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 100 employees on working days during the preceding calendar year~~, employed at least one and no more than 100 employees,~~ and the term "qualified employer" includes self-employed persons to the extent permitted under the Affordable Care Act. ~~Calculation of the number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week~~ The number of employees shall be calculated using the method set forth in 26 U.S.C. § 4980H(c)(2)(E).

* * *

Sec. 29. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

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

* * *

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

* * *

(12) ~~Consistent with federal law, crediting the amount of any free choice voucher provided pursuant to Section 10108 of the Affordable Care Act to the monthly premium of the plan in which a qualified employee is enrolled and collecting the amount credited from the offering employer.~~ [Deleted.]

* * *

Sec. 30. 33 V.S.A. § 1811(a) is amended to read:

(a) As used in this section:

* * *

(3)(A) Until January 1, 2016, "small employer" means an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 50 employees on working days during the preceding calendar year, ~~employs at least one and no more than 50 employees~~. The term includes self-employed persons to the extent permitted under the Affordable Care Act. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. An employer may continue to participate in the ~~exchange~~ Exchange even if the employer's size grows beyond 50 employees as long as the employer continuously makes qualified health benefit plans in the Vermont ~~health benefit exchange~~ Health Benefit Exchange available to its employees.

(B) Beginning on January 1, 2016, "small employer" means an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 100 employees on working days during the preceding calendar year, ~~employs at least one and no more than 100 employees~~. The term includes self-employed persons to the extent permitted under the Affordable Care Act. ~~Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week~~ The number of employees shall be calculated using the method set forth in 26 U.S.C. § 4980H(c)(2)(E). An employer may continue to participate in the ~~exchange~~ Exchange even if the employer's size grows beyond 100 employees as long as

the employer continuously makes qualified health benefit plans in the Vermont ~~health benefit exchange~~ Health Benefit Exchange available to its employees.

* * * Medicaid and CHIP * * *

Sec. 31. 33 V.S.A. § 2003(c) is amended to read:

(c) As used in this section:

(1) "Beneficiary" means any individual enrolled in the Healthy Vermonters program.

(2) "Healthy Vermonters beneficiary" means any individual Vermont resident without adequate coverage:

(A) who is at least 65 years of age, or is disabled and is eligible for Medicare or Social Security disability benefits, with household income equal to or less than 400 percent of the federal poverty level, as calculated ~~under the rules of the Vermont health access plan, as amended~~ using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B); or

(B) whose household income is equal to or less than 350 percent of the federal poverty level, as calculated ~~under the rules of the Vermont Health access plan, as amended~~ using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B).

* * *

Sec. 32. 33 V.S.A. § 2072(a) is amended to read:

(a) An individual shall be eligible for assistance under this subchapter if the individual:

(1) is a resident of Vermont at the time of application for benefits;

(2) is at least 65 years of age or is an individual with disabilities as defined in subdivision 2071(1) of this title; and

(3) has a household income, when calculated ~~in accordance with the rules adopted for the Vermont health access plan under No. 14 of the Acts of 1995, as amended~~ using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B), no greater than 225 percent of the federal poverty level.

* * * Health Information Exchange * * *

Sec. 33. 18 V.S.A. § 707(a) is amended to read:

(a) No later than July 1, 2011, hospitals shall participate in the Blueprint for Health by creating or maintaining connectivity to the ~~state's~~ State's health information exchange network as provided ~~for~~ in this section and in section 9456 of this title. ~~The director of health care reform or designee and the~~

~~director of the Blueprint shall establish criteria by rule for this requirement consistent with the state health information technology plan required under section 9351 of this title. The criteria shall not require a hospital to create a level of connectivity that the state's exchange is not able to support.~~

Sec. 34. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

(a) The ~~board~~ Board shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter~~,~~ and in accordance with a schedule established by the ~~board~~ Board. ~~The board shall require the submission of documentation certifying that the hospital is participating in the Blueprint for Health if required by section 708 of this title.~~

(b) In conjunction with budget reviews, the ~~board~~ Board shall:

* * *

(10) require each hospital to provide information on administrative costs, as defined by the ~~board~~ Board, including specific information on the amounts spent on marketing and advertising costs; and

(11) require each hospital to create or maintain connectivity to the State's health information exchange network in accordance with the criteria established by the Vermont Information Technology Leaders, Inc., pursuant to subsection 9352(i) of this title, provided that the Board shall not require a hospital to create a level of connectivity that the State's exchange is unable to support.

* * *

Sec. 34a. 18 V.S.A. § 9352(i) is amended to read:

(i) Certification of meaningful use and connectivity.

(1) To the extent necessary to support Vermont's health care reform goals or as required by federal law, VITL shall be authorized to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont.

(2) VITL shall establish criteria for creating or maintaining connectivity to the State's health information exchange network. VITL shall provide the criteria annually by March 1 to the Green Mountain Care Board established pursuant to chapter 220 of this title.

* * * Special Funds * * *

Sec. 35. 18 V.S.A. § 9382 is added to read:

§ 9382. REGULATORY AND SUPERVISION FUND

(a) There is hereby created a fund to be known as the Green Mountain Care Board Regulatory and Supervision Fund for the purpose of providing the financial means for the Green Mountain Care Board to administer this chapter and chapter 221 of this title. The Fund shall be managed pursuant to 32 V.S.A. chapter 7, subchapter 5.

(1) All fees and assessments received by the Board in the course of administering its duties shall be credited to the Green Mountain Care Board Regulatory and Supervision Fund.

(2) All fines and administrative penalties received by the Board in the course of administering its duties shall be deposited directly into the General Fund.

(b) All payments from the Green Mountain Care Board Regulatory and Supervision Fund for the maintenance of staff and associated expenses, including contractual services as necessary, shall be disbursed from the State Treasury only upon warrants issued by the Commissioner of Finance and Management after receipt of proper documentation regarding services rendered and expenses incurred.

(c) The Commissioner of Finance and Management may anticipate receipts to the Green Mountain Care Board Regulatory and Supervision Fund and issue warrants based thereon.

Sec. 36. 18 V.S.A. § 9404 is amended to read:

§ 9404. ADMINISTRATION ~~OF THE DIVISION~~

(a) The ~~commissioner~~ Commissioner shall supervise and direct the execution of all laws vested in the ~~division~~ Department by ~~virtue of~~ this chapter, and shall formulate and carry out all policies relating to this chapter.

(b) ~~The commissioner may delegate the powers and assign the duties required by this chapter as the commissioner may deem appropriate and necessary for the proper execution of the provisions of this chapter, including the review and analysis of certificate of need applications and hospital budgets; however, the commissioner shall not delegate the commissioner's quasi-judicial and rulemaking powers or authority, unless the commissioner has a personal or financial interest in the subject matter of the proceeding.~~

~~(c) The commissioner may employ professional and support staff necessary to carry out the functions of the commissioner, and may employ consultants and contract with individuals and entities for the provision of services.~~

~~(d)~~ The ~~commissioner~~ Commissioner may:

(1) ~~Apply~~ apply for and accept gifts, grants, or contributions from any person for purposes consistent with this chapter~~.~~;

(2) ~~Adopt~~ adopt rules necessary to implement the provisions of this chapter~~.~~; and

(3) ~~Enter~~ enter into contracts and perform such acts as are necessary to accomplish the purposes of this chapter.

~~(e)~~(c) There is hereby created a fund to be known as the ~~division of health care administration regulatory and supervision fund~~ Health Care Administration Regulatory and Supervision Fund for the purpose of providing the financial means for the ~~commissioner of financial regulation~~ Commissioner of Financial Regulation to administer this chapter and 33 V.S.A. § 6706. All fees and assessments received by the ~~department~~ Department pursuant to such administration shall be credited to this ~~fund~~ Fund. All fines and administrative penalties, however, shall be deposited directly into the ~~general fund~~ General Fund.

(1) All payments from the ~~division of health care administration regulatory and supervision fund~~ Health Care Administration Regulatory and Supervision Fund for the maintenance of staff and associated expenses, including contractual services as necessary, shall be disbursed from the ~~state treasury~~ State Treasury only upon warrants issued by the ~~commissioner of finance and management~~ Commissioner of Finance and Management, after receipt of proper documentation regarding services rendered and expenses incurred.

(2) The ~~commissioner of finance and management~~ Commissioner of Finance and Management may anticipate receipts to the ~~division of health care administration regulatory and supervision fund~~ Health Care Administration Regulatory and Supervision Fund and issue warrants based thereon.

* * * Health Resource Allocation Plan * * *

Sec. 37. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION PLAN

(a) No later than January 1, 2005, the ~~secretary of human services~~ Secretary of Human Services or designee, in consultation with the ~~commissioner~~ Chair of the Green Mountain Care Board and health care professionals and after receipt of public comment, shall adopt a ~~state health plan~~ State Health Plan that sets forth the health goals and values for the ~~state~~ State. The ~~secretary~~ Secretary may amend the ~~plan~~ Plan as the ~~secretary~~ Secretary deems necessary and appropriate. The ~~plan~~ Plan shall include health promotion, health protection, nutrition, and disease prevention priorities for the ~~state~~ State, identify available

human resources as well as human resources needed for achieving the ~~state's~~ State's health goals and the planning required to meet those needs, and identify geographic parts of the ~~state~~ State needing investments of additional resources in order to improve the health of the population. The ~~plan~~ Plan shall contain sufficient detail to guide development of the ~~state health resource allocation plan~~ State Health Resource Allocation Plan. Copies of the ~~plan~~ Plan shall be submitted to members of the ~~senate and house committees on health and welfare~~ Senate and House Committees on Health and Welfare no later than January 15, 2005.

(b) On or before July 1, 2005, the ~~commissioner~~ Green Mountain Care Board, in consultation with the ~~secretary of human services~~ Secretary of Human Services, shall submit to the ~~governor~~ Governor a four-year ~~health resource allocation plan~~ Health Resource Allocation Plan. The ~~plan~~ Plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

(1) The ~~plan~~ Plan shall include:

(A) A statement of principles reflecting the policies enumerated in sections 9401 and 9431 of this chapter to be used in allocating resources and in establishing priorities for health services.

(B) Identification of the current supply and distribution of hospital, nursing home, and other inpatient services; home health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services, including primary care resources, federally qualified health centers, and free clinics; major medical equipment; and health screening and early intervention services.

(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the ~~commissioner~~ Green Mountain Care Board shall consider at least the following factors:

(i) the values and goals reflected in the ~~state health plan~~ State Health Plan;

(ii) the needs of the population on a statewide basis;

(iii) the needs of particular geographic areas of the ~~state~~ State, as identified in the ~~state health plan~~ State Health Plan;

(iv) the needs of uninsured and underinsured populations;

(v) the use of Vermont facilities by out-of-state residents;

(vi) the use of out-of-state facilities by Vermont residents;

(vii) the needs of populations with special health care needs;

(viii) the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners;

(ix) the cost impact of these resource requirements on health care expenditures; ~~the services appropriate for the four categories of hospitals described in subdivision 9402(12) of this title;~~

(x) the overall quality and use of health care services as reported by the Vermont ~~program for quality in health care~~ Program for Quality in Health Care and the Vermont ~~ethics network~~ Ethics Network;

(xi) the overall quality and cost of services as reported in the annual hospital community reports;

(xii) individual hospital four-year capital budget projections; and

(xiii) the four-year projection of health care expenditures prepared by the ~~division~~ Board.

(2) In the preparation of the ~~plan~~ Plan, the ~~commissioner~~ ~~shall assemble an advisory committee of no fewer than nine nor more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, payers, third-party payers, and consumer representatives~~ Green Mountain Care Board shall convene the Green Mountain Care Board General Advisory Committee established pursuant to subdivision 9374(e)(1) of this title. The ~~advisory committee~~ Green Mountain Care Board General Advisory Committee shall review drafts and provide recommendations to the ~~commissioner~~ Board during the development of the ~~plan~~ Plan. ~~Upon adoption of the plan, the advisory committee shall be dissolved.~~

(3) The ~~commissioner~~ Board, with the ~~advisory committee~~ Green Mountain Care Board General Advisory Committee, shall conduct at least five public hearings, in different regions of the state, on the ~~plan~~ Plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the ~~commissioner~~ Board shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the ~~commissioner~~ Board shall publish in the manner prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place and period during which to direct written comments to the ~~commissioner~~

Board. In addition, the ~~commissioner~~ Board may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(4) The ~~commissioner~~ Board shall develop a mechanism for receiving ongoing public comment regarding the ~~plan~~ Plan and for revising it every four years or as needed.

(5) The ~~commissioner~~ Board in consultation with appropriate health care organizations and state entities shall inventory and assess existing state health care data and expertise, and shall seek grants to assist with the preparation of any revisions to the ~~health resource allocation plan~~ Health Resource Allocation Plan.

(6) The ~~plan~~ Plan or any revised ~~plan~~ Plan proposed by the ~~commissioner~~ Board shall be the ~~health resource allocation plan~~ Health Resource Allocation Plan for the ~~state~~ State after it is approved by the ~~governor~~ Governor or upon passage of three months from the date the ~~governor~~ Governor receives the ~~plan~~ proposed Plan, whichever occurs first, unless the ~~governor~~ Governor disapproves the ~~plan~~ proposed Plan, in whole or in part. If the ~~governor~~ Governor disapproves, he or she shall specify the sections of the ~~plan~~ proposed Plan which are objectionable and the changes necessary to meet the objections. The sections of the ~~plan~~ proposed Plan not disapproved shall become part of the ~~health resource allocation plan~~ Health Resource Allocation Plan.

* * * Hospital Community Reports * * *

Sec. 38. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The ~~commissioner~~ Commissioner of Health, in consultation with representatives from hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules establishing a standard format for community reports, as well as the contents, which shall include:

* * *

(b) On or before January 1, 2005, and annually thereafter beginning on June 1, 2006, the board of directors or other governing body of each hospital licensed under chapter 43 of this title shall publish on its website, making paper copies available upon request, its community report in a uniform format approved by the ~~commissioner,~~ Commissioner of Health and in accordance with the standards and procedures adopted by rule under this section~~, and shall hold one or more public hearings to permit community members to comment on the report. Notice of meetings shall be by publication, consistent with 1~~

~~V.S.A. § 174~~. Hospitals located outside this ~~state~~ State which serve a significant number of Vermont residents, as determined by the ~~commissioner~~ Commissioner of Health, shall be invited to participate in the community report process established by this subsection.

(c) The community reports shall be provided to the ~~commissioner~~ Commissioner of Health. The ~~commissioner~~ Commissioner of Health shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators.

Sec. 39. TEMPORARY SUSPENSION

Notwithstanding the requirements of 18 V.S.A. § 9405b, the Commissioner of Financial Regulation may suspend publication of the hospital community reports in calendar year 2013 in order to effectuate the transfer of responsibility from the Department of Financial Regulation to the Department of Health.

* * * VHCURES * * *

Sec. 40. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE DATABASE

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

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

(B) ~~Identifying~~ identifying health care needs and informing health care policy~~.~~;

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

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

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

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

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to

consumers transparent health care price information, quality information, and such other information as the ~~commissioner~~ Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

(B) ~~The commissioner shall convene a working group composed of the commissioner of mental health, the commissioner of Vermont health access, health care consumers, the office of the health care ombudsman, employers and other payers, health care providers and facilities, the Vermont program for quality in health care, health insurers, and any other individual or group appointed by the commissioner to advise the commissioner on the development and implementation of the consumer health care price and quality information system.~~

~~(C)~~ The ~~commissioner~~ Commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this state to file with the ~~commissioner~~ Commissioner a consumer health care price and quality information plan in accordance with rules adopted by the ~~commissioner~~ Commissioner.

~~(D)~~(C) The ~~commissioner~~ Board shall adopt such rules as are necessary to carry out the purposes of this subdivision. The ~~commissioner's~~ Board's rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the ~~commissioner~~ Board determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The ~~regulations~~ rules shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this ~~state~~ State, and health care utilization and costs for services provided to Vermont residents in another ~~state~~ State.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the ~~commissioner~~ Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter (hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed ~~by the commissioner~~.

(d) The ~~commissioner~~ Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The ~~commissioner~~ Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The ~~commissioner~~ Board may impose an administrative penalty of not more than $10,000.00 each for those violations the ~~commissioner~~ Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the ~~commissioner~~ Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the ~~commissioner~~ Board in accordance with standards and procedures adopted by the ~~commissioner~~ Board by rule:

(A) their health insurance claims data, provided that the ~~commissioner~~ Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this ~~state~~ State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance Portability and Accountability Act ("HIPAA") shall be governed exclusively by the ~~rules~~ regulations adopted thereunder in 45 ~~CFR~~ C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the ~~commissioner~~ Board in a form and in a manner prescribed by the ~~commissioner~~ Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The ~~commissioner~~ Board shall collaborate with the ~~agency of human services~~ Agency of Human Services and participants in ~~agency of human services~~ the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of ~~limited use~~ limited-use data sets, the criteria and procedures to ensure that HIPAA compliant ~~limited use~~ limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the ~~commissioner~~ Board may prescribe by ~~regulation~~ rule, the Vermont ~~program for quality in health care~~ Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont ~~rogram for quality in health care~~ Program for Quality in Health Care shall agree to abide by the rules and procedures established by the ~~commissioner~~ Board for access to the data. The ~~commissioner's~~ Board's rules may limit

access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the ~~commissioner~~ Commissioner shall submit a recommendation to the ~~general assembly~~ General Assembly for conducting a survey of the health insurance status of Vermont residents.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the ~~state~~ State of Vermont or an agency or instrumentality of the ~~state~~ State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The ~~commissioner~~ Board may adopt rules to carry out the provisions of this subsection, including ~~standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner and~~ criteria for the required filing of such claims data, eligibility data, provider files, and other information as the ~~commissioner~~ Board determines to be necessary to carry out the purposes of this section and this chapter.

* * * Cost-Shift Reporting * * *

Sec. 41. 18 V.S.A. § 9375(d) is amended to read:

(d) Annually on or before January 15, the ~~board~~ Board shall submit a report of its activities for the preceding ~~state fiscal~~ calendar year to the ~~house committee on health care and the senate committee on health and welfare~~ House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

(A) any changes to the payment rates for health care professionals pursuant to section 9376 of this title~~,~~;

(B) any new developments with respect to health information technology~~,~~;

(C) the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications~~,~~;

(D) the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations~~,~~;

(E) the process and outcome measures used in the evaluation~~,~~;

(F) any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

(G) any recommendations for modifications to Vermont statutes~~,~~; and

(H) any actual or anticipated impacts on the work of the ~~board~~ Board as a result of modifications to federal laws, regulations, or programs.

(2) The report shall identify how the work of the ~~board~~ Board comports with the principles expressed in section 9371 of this title.

Sec. 42. 2000 Acts and Resolves No. 152, Sec. 117b is amended to read:

Sec. 117b. MEDICAID COST SHIFT REPORTING

(a) It is the intent of this section to measure the elimination of the Medicaid cost shift. For hospitals, this measurement shall be based on a comparison of the difference between Medicaid and Medicare reimbursement rates. For other health care providers, an appropriate measurement shall be developed that includes an examination of the Medicare rates for providers. In order to achieve the intent of this section, it is necessary to establish a reporting and tracking mechanism to obtain the facts and information necessary to quantify the Medicaid cost shift, to evaluate solutions for reducing the effect of the Medicaid cost shift in the commercial insurance market, to ensure that any reduction in the cost shift is passed on to the commercial insurance market, to assess the impact of such reductions on the financial health of the health care delivery system, and to do so within a sustainable utilization growth rate in the Medicaid program.

(b) ~~By~~ Notwithstanding 2 V.S.A. § 20(d), annually on or before December 15, ~~2000, and annually thereafter, the commissioner of banking, insurance,~~

~~securities, and health care administration, the secretary of human services~~ the chair of the Green Mountain Care Board, the Commissioner of Vermont Health Access, and each acute care hospital shall file with the ~~joint fiscal committee~~ Joint Fiscal Committee, in the manner required by the ~~committee~~ Committee, such information as is necessary to carry out the purposes of this section. Such information shall pertain to the provider delivery system to the extent it is available.

(c) ~~By December 15, 2000, and annually thereafter, the~~ The report of hospitals to the ~~joint fiscal committee~~ Joint Fiscal Committee under subsection (b) of this section shall include information on how they will manage utilization in order to assist the ~~agency of human services~~ Department of Vermont Health Access in developing sustainable utilization growth in the Medicaid program.

~~(d) By December 15, 2000, the commissioner of banking, insurance, securities, and health care administration shall report to the joint fiscal committee with recommendations on mechanisms to assure that appropriations intended to address the Medicaid cost shift will result in benefits to commercial insurance premium payers in the form of lower premiums than they otherwise would be charged.~~

~~(e) The first $250,000.00 resulting from declines in caseload and utilization related to hospital costs, as determined by the commissioner of social welfare, from the funds allocated within the Medicaid program appropriation for hospital costs in fiscal year 2001 shall be reserved for cost shift reduction for hospitals.~~

* * * Workforce Planning Data * * *

Sec. 43. 26 V.S.A. § 1353 is amended to read:

§ 1353. POWERS AND DUTIES OF THE BOARD

The ~~board~~ Board shall have the following powers and duties to:

* * *

(10) As part of the license application or renewal process, collect data necessary to allow for workforce strategic planning required under 18 V.S.A. chapter 222.

Sec. 44. WORKFORCE PLANNING; DATA COLLECTION

(a) The Board of Medical Practice shall collaborate with the Director of Health Care Reform in the Agency of Administration, the Vermont Medical Society, and other interested stakeholders to develop data elements for the Board to collect pursuant to 26 V.S.A. § 1353(10) to allow for the workforce strategic planning required under 18 V.S.A. chapter 222. The data elements

shall be consistent with any nationally developed or required data in order to simplify collection and minimize the burden on applicants.

(b) The Office of Professional Regulation, the Board of Nursing, and other relevant professional boards shall collaborate with the Director of Health Care Reform in the Agency of Administration in the collection of data necessary to allow for workforce strategic planning required under 18 V.S.A. chapter 222. The boards shall develop the data elements in consultation with the Director and with interested stakeholders. The data elements shall be consistent with any nationally developed or required data elements in order to simplify collection and minimize the burden on applicants. Data shall be collected as part of the licensure process to minimize administrative burden on applicants and the State.

* * * Administration * * *

Sec. 45. 8 V.S.A. § 11(a) is amended to read:

(a) General. The ~~department of financial regulation~~ Department of Financial Regulation created by 3 V.S.A. ~~section 212,~~ § 212 shall have jurisdiction over and shall supervise:

(1) Financial institutions, credit unions, licensed lenders, mortgage brokers, insurance companies, insurance agents, broker-dealers, investment advisors, and other similar persons subject to the provisions of this title and 9 V.S.A. chapters 59, 61, and 150.

(2) The administration of health care~~, including oversight of the quality and cost containment of health care provided in this state, by conducting and supervising the process of health facility certificates of need, hospital budget reviews, health care data system development and maintenance, and funding and cost containment of health care~~ as provided in 18 V.S.A. chapter 221.

* * * Miscellaneous Provisions * * *

Sec. 46. 33 V.S.A. § 1901(h) is added to read:

(h) To the extent required to avoid federal antitrust violations, the Department of Vermont Health Access shall facilitate and supervise the participation of health care professionals and health care facilities in the planning and implementation of payment reform in the Medicaid and SCHIP programs. The Department 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 Department 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.

Sec. 47. 33 V.S.A. § 1901b is amended to read:

§ 1901b. PHARMACY PROGRAM ENROLLMENT

(a) The ~~department of Vermont health access~~ Department of Vermont Health Access and the ~~department for children and families~~ Department for Children and Families shall monitor actual caseloads, revenue, and expenditures~~;~~; anticipated caseloads, revenue, and expenditures~~;~~; and actual and anticipated savings from implementation of the preferred drug list, supplemental rebates, and other cost containment activities in each state pharmaceutical assistance program, including VPharm ~~and VermontRx~~. ~~The departments~~ When applicable, the Departments shall allocate supplemental rebate savings to each program proportionate to expenditures in each program. ~~During the second week of each month, the department of Vermont health access shall report such actual and anticipated caseload, revenue, expenditure, and savings information to the joint fiscal committee and to the health care oversight committee.~~

(b)~~(1) If at any time expenditures for VPharm and VermontRx are anticipated to exceed the aggregate amount of state funds expressly appropriated for such state pharmaceutical assistance programs during any fiscal year, the department of Vermont health access shall recommend to the joint fiscal committee and notify the health care oversight committee of a plan to cease new enrollments in VermontRx for individuals with incomes over 225 percent of the federal poverty level.~~

~~(2) If at any time expenditures for VPharm and VermontRx are anticipated to exceed the aggregate amount of state funds expressly appropriated for such state pharmaceutical assistance programs during any fiscal year, even with the cessation of new enrollments as provided for in subdivision (1) of this subsection, the department of Vermont health access shall recommend to the joint fiscal committee and notify the health health care oversight committee of a plan to cease new enrollments in the VermontRx for individuals with incomes more than 175 percent and less than 225 percent of the federal poverty level.~~

~~(3) The determinations of the department of Vermont health access under subdivisions (1) and (2) of this subsection shall be based on the information and projections reported monthly under subsection (a) of this section, and on the official revenue estimates under 32 V.S.A. § 305a. An enrollment cessation plan shall be deemed approved unless the joint fiscal committee disapproves the plan after 21 days notice of the recommendation and financial analysis of the department of Vermont health access.~~

~~(4) Upon the approval of or failure to disapprove an enrollment cessation plan by the joint fiscal committee, the department of Vermont health access shall cease new enrollment in VermontRx for the individuals with incomes at the appropriate level in accordance with the plan.~~

~~(c)(1) If at any time after enrollment ceases under subsection (b) of this section expenditures for VermontRx, including expenditures attributable to renewed enrollment, are anticipated, by reason of increased federal financial participation or any other reason, to be equal to or less than the aggregate amount of state funds expressly appropriated for such state pharmaceutical assistance programs during any fiscal year, the department of Vermont health access shall recommend to the joint fiscal committee and notify the health care oversight committee of a plan to renew enrollment in VermontRx, with priority given to individuals with incomes more than 175 percent and less than 225 percent, if adequate funds are anticipated to be available for each program for the remainder of the fiscal year.~~

~~(2) The determination of the department of Vermont health access under subdivision (1) of this subsection shall be based on the information and projections reported monthly under subsection (a) of this section, and on the official revenue estimates under 32 V.S.A. § 305a. An enrollment renewal plan shall be deemed approved unless the joint fiscal committee disapproves the plan after 21 days notice of the recommendation and financial analysis of the department of Vermont health access.~~

~~(3) Upon the approval of, or failure to disapprove an enrollment renewal plan by the joint fiscal committee, the department of Vermont health access shall renew enrollment in VermontRx in accordance with the plan.~~

~~(d)~~ As used in this section~~:~~.

~~(1) "State~~ "state pharmaceutical assistance program" means any health assistance programs administered by the ~~agency of human services~~ Agency of Human Services providing prescription drug coverage, including the Medicaid program, ~~the Vermont health access plan,~~ VPharm, ~~VermontRx,~~ the ~~state children's health insurance program~~ State Children's Health Insurance Program, the ~~state~~ State of Vermont AIDS ~~medication assistance program~~ Medication Assistance Program, the General Assistance program, the ~~pharmacy discount plan program~~ Pharmacy Discount Plan Program, and any other health assistance programs administered by the ~~agency~~ Agency providing prescription drug coverage.

~~(2) "VHAP" or "Vermont health access plan" means the programs of health care assistance authorized by federal waivers under Section 1115 of the Social~~

~~Security Act, by No. 14 of the Acts of 1995, and by further acts of the General Assembly.~~

~~(3) "VHAP-Pharmacy" or "VHAP-Rx" means the VHAP program of state pharmaceutical assistance for elderly and disabled Vermonters with income up to and including 150 percent of the federal poverty level (hereinafter "FPL").~~

~~(4) "VScript" means the Section 1115 waiver program of state pharmaceutical assistance for elderly and disabled Vermonters with income over 150 and less than or equal to 175 percent of FPL, and administered under subchapter 4 of chapter 19 of this title.~~

~~(5) "VScript-Expanded" means the state-funded program of pharmaceutical assistance for elderly and disabled Vermonters with income over 175 and less than or equal to 225 percent of FPL, and administered under subchapter 4 of chapter 19 of this title.~~

Sec. 48. 2012 Acts and Resolves No. 171, Sec. 2c, is amended to read:

Sec. 2c. EXCHANGE OPTIONS

In approving benefit packages for the Vermont health benefit exchange pursuant to 18 V.S.A. ~~§ 9375(b)(7)~~ § 9375(b)(9), the Green Mountain Care ~~board~~ Board shall approve a full range of cost-sharing structures for each level of actuarial value. To the extent permitted under federal law, the ~~board~~ Board shall also allow health insurers to establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by an insured to programs of health promotion and disease prevention pursuant to 33 V.S.A. § 1811(f)(2)(B).

Sec. 49. 2012 Acts and Resolves No. 171, Sec. 41(e), is amended to read:

(e) ~~33~~ 18 V.S.A. chapter 13, subchapter 2 (payment reform pilots) is repealed on passage.

* * * Transfer of Positions * * *

Sec. 50. TRANSFER OF POSITIONS

(a) On or before July 1, 2013, the Department of Financial Regulation shall transfer positions numbered 290071, 290106, and 290074 and associated funding to the Green Mountain Care Board for the administration of the health care database.

(b) On or before July 1, 2013, the Department of Financial Regulation shall transfer position number 297013 and associated funding to the Agency of Administration.

(c) On or after July 1, 2013, the Department of Financial Regulation shall transfer one position and associated funding to the Department of Health for the purpose of administering the hospital community reports in 18 V.S.A. § 9405b. The Department of Financial Regulation shall continue to collect funds for the publication of the reports pursuant to 18 V.S.A. § 9415 and shall transfer the necessary funds annually to the Department of Health.

* * * Emergency Rulemaking * * *

Sec. 51. EMERGENCY RULEMAKING

The Agency of Human Services may adopt emergency rules pursuant to 3 V.S.A. § 844 prior to the operation of the Vermont Health Benefit Exchange in order to conform Vermont's rules regarding operation of the Exchange to emerging federal guidance and regulations implementing the provisions of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). The need for timely compliance with federal laws and guidance prior to operation of the Vermont Health Benefit Exchange shall be deemed to meet the standard for the adoption of emergency rules required pursuant to 3 V.S.A. § 844(a).

* * * Repeals * * *

Sec. 52. REPEALS

(a) 8 V.S.A. § 4080f (Catamount Health) is repealed on January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers on Medicare and Medicaid Services.

(b) 18 V.S.A. § 708 (health information technology certification process) is repealed on passage.

(c) 33 V.S.A. § chapter 19, subchapter 3a (Catamount Health Assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers for Medicare and Medicaid Services.

(d) 33 V.S.A. § 2074 (VermontRx) is repealed on January 1, 2014.

(e) 18 V.S.A. § 9403 (Division of Health Care Administration) is repealed on July 1, 2013.

* * * Effective Dates * * *

Sec. 53. EFFECTIVE DATES

(a) Secs. 2 (mental health care services review), 3 (prescription drug

deductibles), 33–34a (health information exchange), 39 (temporary suspension of hospital reports), 40 (VHCURES), 43 and 44 (workforce planning), 46 (DVHA antitrust provision), 48 (Exchange options), 49 (correction to payment reform pilot repeal), 50 (transfer of positions), 51 (emergency rules), and 52 (repeals) of this act and this section shall take effect on passage.

(b) Sec. 1 (interstate employers) and Secs. 28–30 (employer definitions) shall take effect on October 1, 2013 for the purchase of insurance plans effective for coverage beginning January 1, 2014.

(c) Secs. 4 (newborn coverage), 5 (grace period for premium payment), 6–27 (Catamount and VHAP), 31 (Healthy Vermonters), 32 (VPharm), and 47 (pharmacy program enrollment) shall take effect on January 1, 2014.

(d) All remaining sections of this act shall take effect on July 1, 2013.

and that after passage the title of the bill be amended to read: "An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board".

(Committee Vote: 8-3-0)

Amendment to be offered by Rep. Browning of Arlington to H. 107

Rep. Browning of Arlington moves that the bill be amended as follows:

First: By adding Secs. 42a–42d to read:

* * * Health Care Professionals' Rates and Practice Locations * * *

Sec. 42a. INTENT

It is the intent of the General Assembly to recruit and retain a highly qualified health care workforce to provide high-quality health care services in this State. Every Vermont resident should have the ability to enter into voluntary financial arrangements with the health care professionals of his or her choice. In addition, every Vermont health care professional should have the ability to establish his or her practice where and when he or she chooses.

Sec. 42b. 18 V.S.A. § 9382 is added to read:

§ 9382. LIMITATIONS ON AUTHORITY

The Green Mountain Care Board shall not:

(1) adopt, by rule or any other mechanism, maximum rates that health care professionals may accept that would interfere with the ability of any Vermont resident to enter into a voluntary financial arrangement with the Vermont-licensed health care professional of his or her choice; or

(2) place any restrictions on the location in which a health care professional practices, unless the restriction is directly related to an agreement with the professional to practice in a specific region in return for full or partial repayment of his or her educational loans.

Sec. 42c. 18 V.S.A. § 9375 is amended to read:

§ 9375. DUTIES

(a) The ~~board~~ Board shall execute its duties consistent with the principles expressed in ~~18 V.S.A. §~~ section 9371 of this title.

(b) The ~~board~~ Board shall have the following duties:

* * *

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

* * *

Sec. 42d. 18 V.S.A. § 9376 is amended to read:

§ 9376. PAYMENT AMOUNTS; METHODS

(a) It is the intent of the ~~general assembly~~ General Assembly to:

(1) 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~~;

(2) eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably; and

(3) protect the ability of each Vermont resident to enter into voluntary financial arrangements with the Vermont-licensed health care professionals of his or her choice.

(b)(1) The ~~board~~ Board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the ~~board~~ Board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care

professionals. In establishing rates, the ~~board~~ Board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the ~~state~~ State, and the need for health care professionals in particular areas of the ~~state~~ State, particularly in underserved geographic or practice shortage areas.

(2)(A) Nothing in this subsection shall be construed to limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection from a patient without health insurance or other coverage for the service or services received.

(B) Nothing in this subsection shall be construed to limit the ability of a Vermont resident to enter into a voluntary financial arrangement with the Vermont-licensed health care professionals of his or her choice; provided, however, that no such voluntary financial agreement shall be binding on a health insurer, Medicaid, or any other entity paying health care claims on the resident's behalf.

* * *

Second: In Sec. 53, Effective Dates, in subsection (a), following "40 (VHCURES)," by inserting "42a–42d (rates and practice locations),"

Consent Calendar

Concurrent Resolutions for Adoption Under Joint Rule 16a

The following concurrent resolutions have been introduced for approval by the Senate and House and will be adopted automatically unless a Senator or Representative requests floor consideration before today's adjournment. Requests for floor consideration in either chamber should be communicated to the Secretary's office and/or the House Clerk's office, respectively. For text of resolutions, see Addendum to House Calendar and Senate Calendar of 3/14/2013.

H.C.R. 52

House concurrent resolution commemorating the sestercentennial anniversary of the town of Orwell

H.C.R. 53

House concurrent resolution commemorating the bicentennial anniversary of the Old Round Church in Richmond and the 40th anniversary of the Richmond Historical Society

H.C.R. 54

House concurrent resolution honoring Dennis McCarthy for his exemplary municipal public service career

H.C.R. 55

House concurrent resolution honoring Jamaica Village School principal Janet Hamilton

H.C.R. 56

House concurrent resolution commending the heroic rescue efforts and sacrifice of Alton Lombard Sr. and also the Vermont State Police for its continuing search for his remains in Lake Champlain

H.C.R. 57

House concurrent resolution commemorating the sestercentennial anniversary of the town of Bolton

H.C.R. 58

House concurrent resolution congratulating the town of Colchester on its sestercentennnial anniversary

H.C.R. 59

House concurrent resolution commemorating the 250th anniversary of the Town of Jericho

H.C.R. 60

House concurrent resolution commemorating the sestercentennial anniversary of the Town of Underhill

Information Notice

CROSSOVER DEADLINES

The following bill reporting deadlines are established for the 2013 session:

(1) From the standing committee of last reference, excluding the Committees on Appropriations and Ways and Means, all House bills must be reported out of committee on or before March 15, 2013.

(2) House bills referred pursuant to House Rule 35a, must be reported out of the Committees on Appropriations and Ways and Means on or before March 22, 2013.