

1 H.107

2 Senator Lyons moves that the Senate Proposal of Amendment be further
3 amended by striking out all after the enacting clause and inserting in lieu
4 thereof the following:

5 * * * Health Insurance * * *

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

7 § 4079. GROUP INSURANCE POLICIES; DEFINITIONS

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

11 (1)(A) Under a policy issued to an employer, who shall be deemed the
12 policyholder, insuring at least one employee of such employer, for the benefit
13 of persons other than the employer. The term “employees,” as used herein,
14 shall be deemed to include the officers, managers, and employees of the
15 employer, the partners, if the employer is a partnership, the officers, managers,
16 and employees of subsidiary or affiliated corporations of a corporation
17 employer, and the individual proprietors, partners, and employees of
18 individuals and firms, the business of which is controlled by the insured
19 employer through stock ownership, contract, or otherwise. The term
20 “employer,” as used herein, may be deemed to include any municipal or
21 governmental corporation, unit, agency, or department thereof and the proper

1 officers as such, of any unincorporated municipality or department thereof, as
2 well as private individuals, partnerships, and corporations.

3 (B) In accordance with section 3368 of this title, an employer
4 domiciled in another jurisdiction that has more than 25 certificate-holder
5 employees whose principal worksite and domicile is in Vermont and that is
6 defined as a large group in its own jurisdiction and under the Patient Protection
7 and Affordable Care Act, Pub.L. No. 111-148, § 1304, as amended by the
8 Health Care and Education Reconciliation Act of 2010, Pub.L. No. 111-152,
9 may purchase insurance in the large group health insurance market for its
10 Vermont-domiciled certificate-holder employees.

11 * * *

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

13 § 4089a. MENTAL HEALTH CARE SERVICES REVIEW

14 * * *

15 (b) Definitions. As used in this section:

16 * * *

17 (4) “Review agent” means a person or entity performing service review
18 activities within one year of the date of a fully compliant application for
19 licensure who is either affiliated with, under contract with, or acting on behalf
20 of a business entity in this state; or a third party State and who provides or
21 administers mental health care benefits to ~~citizens of Vermont~~ members of

1 health benefit plans subject to the Department’s jurisdiction, including a health
2 insurer, nonprofit health service plan, health insurance service organization,
3 health maintenance organization or preferred provider organization, including
4 organizations that rely upon primary care physicians to coordinate delivery of
5 services, ~~authorized to offer health insurance policies or contracts in Vermont.~~

6 * * *

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

9 * * *

10 Sec. 3. 8 V.S.A. § 4089i is amended to read:

11 * * *

12 (d) For prescription drug benefits offered in conjunction with a
13 high-deductible health plan (HDHP), the plan may not provide prescription
14 drug benefits until the expenditures applicable to the deductible under the
15 HDHP have met the amount of the minimum annual deductibles in effect for
16 self-only and family coverage under Section 223(c)(2)(A)(i) of the Internal
17 Revenue Code of 1986 for self-only and family coverage, respectively, except
18 that a plan may offer first-dollar prescription drug benefits to the extent
19 permitted under federal law. Once the foregoing expenditure amount has been
20 met under the HDHP, coverage for prescription drug benefits shall begin, and

1 the limit on out-of-pocket expenditures for prescription drug benefits shall be
2 as specified in subsection (c) of this section.

3 (e)(1) A health insurance or other health benefit plan offered by a health
4 insurer or by a pharmacy benefit manager on behalf of a health insurer that
5 provides coverage for prescription drugs and uses step-therapy protocols shall
6 not require failure on the same medication on more than one occasion for
7 continuously enrolled members or subscribers.

8 (2) Nothing in this subsection shall be construed to prohibit the use of
9 tiered co-payments for members or subscribers not subject to a step-therapy
10 protocol.

11 (f)(1) A health insurance or other health benefit plan offered by a health
12 insurer or by a pharmacy benefit manager on behalf of a health insurer that
13 provides coverage for prescription drugs shall not require, as a condition of
14 coverage, use of drugs not indicated by the federal Food and Drug
15 Administration for the condition diagnosed and being treated under supervision
16 of a health care professional.

17 (2) Nothing in this subsection shall be construed to prevent a health care
18 professional from prescribing a medication for off-label use.

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

20 (b) Coverage for a newly born child shall be provided without notice or
21 additional premium for no less than ~~31~~ 60 days after the date of birth. If

1 payment of a specific premium or subscription fee is required in order to have
2 the coverage continue beyond such ~~31-day~~ 60-day period, the policy may
3 require that notification of birth of newly born child and payment of the
4 required premium or fees be furnished to the insurer or nonprofit service or
5 indemnity corporation within a period of not less than ~~31~~ 60 days after the date
6 of birth.

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

8 § 9418. PAYMENT FOR HEALTH CARE SERVICES

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

10 * * *

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

- 15 (A) ~~Health~~ health maintenance organization;
- 16 (B) ~~Preferred~~ preferred provider organization;
- 17 (C) ~~Fee-for-service~~ fee-for-service or indemnity plan;
- 18 (D) Medicare Advantage HMO plan;
- 19 (E) Medicare Advantage private fee-for-service plan;
- 20 (F) Medicare Advantage special needs plan;
- 21 (G) Medicare Advantage PPO;

- 1 (H) Medicare supplement plan;
- 2 (I) ~~Workers~~ workers compensation plan; or
- 3 (J) ~~Catamount Health; or~~
- 4 ~~(K) Any~~ any other commercial health coverage plan or product.

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

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

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

12 (3) Pend a claim for services rendered to an enrollee during the second
13 and third months of the consecutive three-month grace period required for
14 recipients of advance payments of premium tax credits pursuant to 26 U.S.C.
15 § 36B. In the event the enrollee pays all outstanding premiums prior to the
16 exhaustion of the grace period, the health plan, contracting entity, or payer
17 shall have 30 days following receipt of the outstanding premiums to proceed as
18 provided in subdivision (1) or (2) of this subsection, as applicable.

19 * * *

1 Sec. 5a. 18 V.S.A. § 9418b(g)(4) is amended to read:

2 (4) A health plan shall respond to a completed prior authorization request
3 from a prescribing health care provider within 48 hours for urgent requests and
4 within ~~420 hours~~ two business days of receipt for non-urgent requests. The health
5 plan shall notify a health care provider of or make available to a health care
6 provider a receipt of the request for prior authorization and any needed missing
7 information within 24 hours of receipt. If a health plan does not, within the time
8 limits set forth in this section, respond to a completed prior authorization request,
9 acknowledge receipt of the request for prior authorization, or request missing
10 information, the prior authorization request shall be deemed to have been granted.

11 * * * Standardized Claims and Edits * * *

12 Sec. 5b. STANDARDIZED HEALTH INSURANCE CLAIMS AND EDITS

13 (a)(1) As part of moving away from fee-for-service and toward other models
14 of payment for health care services in Vermont, the Green Mountain Care Board,
15 in consultation with the Department of Vermont Health Access, health care
16 providers, health insurers, and other interested stakeholders, shall develop a
17 complete set of standardized edits and payment rules based on Medicare or on
18 another set of standardized edits and payment rules appropriate for use in
19 Vermont. The Board and the Department shall adopt by rule the standards and
20 payment rules that health care providers, health insurers, and other payers shall

1 use beginning on January 1, 2015 and that Medicaid shall use beginning on
2 January 1, 2017.

3 (2) The Green Mountain Care Board and the Department of Vermont
4 Health Access shall report to the General Assembly on or before February 15,
5 2014 on the progress toward a complete set of standardized edits and payment
6 rules.

7 (b) The Department of Vermont Health Access's request for proposals for the
8 Medicaid Management Information System (MMIS) claims payment system shall
9 ensure that the MMIS will:

10 (1) have the capability to include uniform edit standards and payment rules
11 developed pursuant to this section; and

12 (2) include full transparency of edit standards, payment rules, prior
13 authorization guidelines, and other utilization review provisions, including the
14 source or basis in evidence for the standards and guidelines.

15 (c)(1) The Department of Vermont Health Access shall ensure that contracts
16 for benefit management and claims management systems in effect on January 1,
17 2017 include full transparency of edit standards, payment rules, prior
18 authorization guidelines, and other utilization review provisions, including the
19 source or basis in evidence for the standards and guidelines.

20 (2) The Department of Financial Regulation shall ensure that beginning on
21 January 1, 2015, health insurers and their subcontractors for benefit management

1 and claim management systems include full transparency of edit standards,
2 payment rules, prior authorization guidelines, and other utilization review
3 provisions, including the source or basis in evidence for the standards and
4 guidelines. In addition to any other remedy available to the Commissioner under
5 Title 8 or Title 18, a health insurer, subcontractor, or other person who violates the
6 requirements of this section may be assessed an administrative penalty of not
7 more than \$2,000.00 for each day of noncompliance.

8 (d) As used in this section:

9 (1) “Health care provider” means a person, partnership, corporation,
10 facility, or institution licensed or certified or authorized by law to administer
11 health care in this State.

12 (2) “Health insurer” means a health insurance company, a nonprofit
13 hospital or medical service corporation, a managed care organization, and, to the
14 extent permitted under federal law, any administrator of an insured, self-insured,
15 or publicly funded health care benefit plan offered by a public or private entity.

16 * * * Health Insurance Rate Review * * *

17 Sec. 5c. 8 V.S.A. § 4062 is amended to read:

18 § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

19 (a)(1) No policy of health insurance or certificate under a policy filed by an
20 insurer offering health insurance as defined in subdivision 3301(a)(2) of this
21 title, a nonprofit hospital or medical service corporation, health maintenance

1 organization, or a managed care organization and not exempted by subdivision
2 3368(a)(4) of this title shall be delivered or issued for delivery in this state
3 State, nor shall any endorsement, rider, or application which becomes a part of
4 any such policy be used, until:

5 ~~(A)~~ a copy of the form; and of the rules for the classification of risks
6 has been filed with the Department of Financial Regulation and a copy of the
7 premium rates, and rules for the classification of risks pertaining thereto have
8 has been filed with the commissioner of financial regulation Green Mountain
9 Care Board; and

10 ~~(B)~~ a decision by the Green Mountain Care board Board has been
11 applied by the commissioner as provided in subdivision (2) of this subsection
12 issued a decision approving, modifying, or disapproving the proposed rate.

13 (2)(A) ~~Prior to approving a rate pursuant to this subsection, the~~
14 ~~commissioner shall seek approval for such rate from the Green Mountain Care~~
15 ~~board established in 18 V.S.A. chapter 220. The commissioner shall make a~~
16 ~~recommendation to the Green Mountain Care board about whether to approve,~~
17 ~~modify, or disapprove the rate within 30 days of receipt of a completed~~
18 ~~application from an insurer. In the event that the commissioner does not make~~
19 ~~a recommendation to the board within the 30-day period, the commissioner~~
20 ~~shall be deemed to have recommended approval of the rate, and the Green~~

1 ~~Mountain Care board shall review the rate request pursuant to subdivision (B)~~
2 ~~of this subdivision (2).~~

3 ~~(B) The Green Mountain Care board~~ Board shall review rate requests
4 ~~forwarded by the commissioner pursuant to subdivision (A) of this subdivision~~
5 ~~(2) and shall approve, modify, or disapprove a rate request within 30~~ 90
6 calendar days of receipt of the commissioner's recommendation or, in the
7 absence of a recommendation from the commissioner, the expiration of the
8 30-day period following the department's receipt of the completed application.
9 ~~In the event that the board does not approve or disapprove a rate within 30~~
10 ~~days, the board shall be deemed to have approved the rate request~~ after receipt
11 of an initial rate filing from an insurer. If an insurer fails to provide necessary
12 materials or other information to the Board in a timely manner, the Board may
13 extend its review for a reasonable additional period of time, not to exceed 30
14 calendar days.

15 ~~(C) The commissioner shall apply the decision of the Green~~
16 ~~Mountain Care board as to rates referred to the board within five business days~~
17 ~~of the board's decision.~~

18 (B) Prior to the Board's decision on a rate request, the Department of
19 Financial Regulation shall provide the Board with an analysis and opinion on
20 the impact of the proposed rate on the insurer's solvency and reserves.

1 (3) ~~The commissioner~~ Board shall ~~review policies and rates to determine~~
2 whether a ~~policy or rate~~ is affordable, promotes quality care, promotes access
3 to health care, protects insurer solvency, and is not unjust, unfair, inequitable,
4 misleading, or contrary to the laws of this state State. ~~The commissioner shall~~
5 notify ~~in writing the insurer which has filed any such form, premium rate, or~~
6 rule if it contains any provision which does not meet the standards expressed in
7 this section. ~~In such notice, the commissioner shall state that a hearing will be~~
8 ~~granted within 20 days upon written request of the insurer.~~ In making this
9 determination, the Board shall consider the analysis and opinion provided by
10 the Department of Financial Regulation pursuant to subdivision (2)(B) of this
11 subsection.

12 (b) ~~The commissioner may, after a hearing of which at least 20 days'~~
13 ~~written notice has been given to the insurer using such form, premium rate, or~~
14 ~~rule, withdraw approval on any of the grounds stated in this section. For~~
15 ~~premium rates, such withdrawal may occur at any time after applying the~~
16 ~~decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C)~~
17 ~~of this section. Disapproval pursuant to this subsection shall be effected by~~
18 ~~written order of the commissioner which shall state the ground for disapproval~~
19 ~~and the date, not less than 30 days after such hearing when the withdrawal of~~
20 ~~approval shall become effective.~~

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

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

19 (2)(A) Beginning no later than January 1, ~~2012~~ 2014, the ~~commissioner~~
20 Board shall post the rate filings pursuant to subsection (a) of this section and
21 summaries pursuant to subsection ~~(e)~~(b) of this section on the ~~department's~~

1 Board's website within five calendar days of filing. The Board shall also
2 establish a mechanism by which members of the public may request to be
3 notified automatically each time a proposed rate is filed with the Board.

4 (B) ~~The department~~ Board shall provide an electronic mechanism for
5 the public to comment on ~~proposed rate increases over five percent~~ all rate
6 filings. ~~The public shall have 21 days from the posting of the summaries and~~
7 ~~filings to provide~~ Board shall accept public comment on each rate filing from
8 the date on which the Board posts the rate filing on its website pursuant to
9 subdivision (A) of this subdivision (2) until 15 calendar days after the Board
10 posts on its website the analyses and opinions of the Department of Financial
11 Regulation and of the Board's consulting actuary, if any, as required by
12 subsection (d) of this section. ~~The department~~ Board shall review and consider
13 the public comments prior to ~~submitting the policy or rate for the Green~~
14 ~~Mountain Care board's approval pursuant to subsection (a) of this section~~. ~~The~~
15 ~~department shall provide the Green Mountain Care board with the public~~
16 ~~comments for its consideration in approving any rates~~ issuing its decision.

17 (3)(A) In addition to the public comment provisions set forth in this
18 subsection, the Office of the Health Care Advocate established in 18 V.S.A.
19 § 229, acting on behalf of health insurance consumers in this State, may,
20 within 30 calendar days after the Board receives an insurer's rate request

1 pursuant to this section, submit to the Board, in writing, suggested questions
2 regarding the filing for the Board to provide to its contracting actuary, if any.

3 (B) The Office of the Health Care Advocate may also submit to the
4 Board written comments on an insurer's rate request. The Board shall post the
5 comments on its website and shall consider the comments prior to issuing its
6 decision.

7 (e)(d)(1) No later than 60 calendar days after receiving an insurer's rate
8 request pursuant to this section, the Green Mountain Care Board shall make
9 available to the public the insurer's rate filing, the Department's analysis and
10 opinion of the effect of the proposed rate on the insurer's solvency, and the
11 analysis and opinion of the rate filing by the Board's contracting actuary,
12 if any.

13 (2) The Board shall post on its website, after redacting any confidential
14 or proprietary information relating to the insurer or to the insurer's rate filing:

15 (A) all questions the Board poses to its contracting actuary, if any,
16 and the actuary's responses to the Board's questions; and

17 (B) all questions the Board, the Board's contracting actuary, if any,
18 or the Department poses to the insurer and the insurer's responses to those
19 questions.

1 (e) Within 30 calendar days after making the rate filing and analysis
2 available to the public pursuant to subsection (d) of this section, the Board
3 shall:

4 (1) conduct a public hearing, at which the Board shall:

5 (A) call as witnesses the Commissioner of Financial Regulation or
6 designee and the Board’s contracting actuary, if any, unless all parties agree to
7 waive such testimony; and

8 (B) provide an opportunity for testimony from the insurer; the Office
9 of the Health Care Advocate; and members of the public;

10 (2) at a public hearing, announce the Board’s decision of whether to
11 approve, modify, or disapprove the proposed rate; and

12 (3) issue its decision in writing.

13 (f)(1) The insurer shall notify its policyholders of the Board’s decision in a
14 timely manner, as defined by the Board by rule.

15 (2) Rates shall take effect on the date specified in the insurer’s rate
16 filing.

17 (3) If the Board has not issued its decision by the effective date specified
18 in the insurer’s rate filing, the insurer shall notify its policyholders of its
19 pending rate request and of the effective date proposed by the insurer in its rate
20 filing.

1 (g) An insurer, the Office of the Health Care Advocate, and any member of
2 the public with party status, as defined by the Board by rule, may appeal a
3 decision of the Board approving, modifying, or disapproving the insurer's
4 proposed rate to the Vermont Supreme Court.

5 ~~(h)(1) The following provisions of this~~ This section shall apply only to
6 policies for major medical insurance coverage and shall not apply to policies
7 for specific disease, accident, injury, hospital indemnity, dental care, vision
8 care, disability income, long-term care, or other limited benefit coverage; to
9 Medicare supplemental insurance; or

10 ~~(A) the requirement in subdivisions (a)(1) and (2) of this section for~~
11 ~~the Green Mountain Care board's approval on rate requests;~~

12 ~~(B) the review standards in subdivision (a)(3) of this section as to~~
13 ~~whether a policy or rate is affordable, promotes quality care, and promotes~~
14 ~~access to health care; and~~

15 ~~(C) subsections (c) and (d) of this section.~~

16 ~~(2) The exemptions from the provisions described in subdivisions (1)(A)~~
17 ~~through (C) of this subsection shall also apply to benefit plans that are paid~~
18 ~~directly to an individual insured or to his or her assigns and for which the~~
19 ~~amount of the benefit is not based on potential medical costs or actual costs~~
20 ~~incurred.~~

1 ~~(3) Medicare supplemental insurance policies shall be exempt only from~~
2 ~~the requirement in subdivisions (a)(1) and (2) of this section for the Green~~
3 ~~Mountain Care board's approval on rate requests and shall be subject to the~~
4 ~~remaining provisions of this section.~~

5 (i) Notwithstanding the procedures and timelines set forth in subsections
6 (a) through (e) of this section, the Board may establish, by rule, a streamlined
7 rate review process for certain rate decisions, including proposed rates
8 affecting fewer than a minimum number of covered lives and proposed rates
9 for which a de minimis increase, as defined by the Board by rule, is sought.

10 Sec. 5d. 8 V.S.A. § 4062a is amended to read:

11 § 4062a. FILING FEES

12 Each filing of a policy, contract, or document form or premium rates or
13 rules, submitted pursuant to section 4062 of this title, shall be accompanied by
14 payment to the ~~commissioner~~ Commissioner or the Green Mountain Care
15 Board, as appropriate, of a nonrefundable fee of \$50.00 \$150.00.

16 Sec. 5e. 8 V.S.A. § 4089b(d)(1)(A) is amended to read:

17 (d)(1)(A) A health insurance plan that does not otherwise provide for
18 management of care under the plan, or that does not provide for the same
19 degree of management of care for all health conditions, may provide coverage
20 for treatment of mental health conditions through a managed care organization
21 provided that the managed care organization is in compliance with the rules

1 adopted by the ~~commissioner~~ Commissioner that assure that the system for
2 delivery of treatment for mental health conditions does not diminish or negate
3 the purpose of this section. In reviewing rates and forms pursuant to section
4 4062 of this title, the ~~commissioner~~ Commissioner or the Green Mountain Care
5 Board established in 18 V.S.A. chapter 220, as appropriate, shall consider the
6 compliance of the policy with the provisions of this section.

7 Sec. 5f. 8 V.S.A. § 4512(b) is amended to read:

8 (b) Subject to the approval of the ~~commissioner~~ Commissioner or the
9 Green Mountain Care Board established in 18 V.S.A. chapter 220, as
10 appropriate, a hospital service corporation may establish, maintain, and operate
11 a medical service plan as defined in section 4583 of this title. The
12 ~~commissioner~~ Commissioner or the Board may refuse approval if the
13 ~~commissioner~~ Commissioner or the Board finds that the rates submitted are
14 excessive, inadequate, or unfairly discriminatory, fail to protect the hospital
15 service corporation's solvency, or fail to meet the standards of affordability,
16 promotion of quality care, and promotion of access pursuant to section 4062 of
17 this title. The contracts of a hospital service corporation which operates a
18 medical service plan under this subsection shall be governed by chapter 125 of
19 this title to the extent that they provide for medical service benefits, and by this
20 chapter to the extent that the contracts provide for hospital service benefits.

1 Sec. 5g. 8 V.S.A. § 4513(c) is amended to read:

2 (c) In connection with a rate decision, the ~~commissioner~~ Green Mountain
3 Care Board may also make reasonable supplemental orders to the corporation
4 and may attach reasonable conditions and limitations to such orders as ~~he~~ the
5 Board finds, on the basis of competent and substantial evidence, necessary to
6 ~~insure~~ ensure that benefits and services are provided at minimum cost under
7 efficient and economical management of the corporation. The ~~commissioner~~
8 Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and
9 9376, the Green Mountain Care Board, shall not set the rate of payment or
10 reimbursement made by the corporation to any physician, hospital, or other
11 health care provider.

12 Sec. 5h. 8 V.S.A. § 4515a is amended to read:

13 § 4515a. FORM AND RATE FILING; FILING FEES

14 Every contract or certificate form, or amendment thereof, including the rates
15 charged therefor by the corporation shall be filed with the ~~commissioner~~
16 Commissioner or the Green Mountain Care Board established in 18 V.S.A.
17 chapter 220, as appropriate, for his or her the Commissioner's or the Board's
18 approval prior to issuance or use. Prior to approval, there shall be a public
19 comment period pursuant to section 4062 of this title. In addition, each such
20 filing shall be accompanied by payment to the ~~commissioner~~ Commissioner or

1 the Board, as appropriate, of a nonrefundable fee of ~~\$50.00~~ \$150.00 and the
2 plain language summary of rate increases pursuant to section 4062 of this title.
3 Sec. 5i. 8 V.S.A. § 4584(c) is amended to read:

4 (c) In connection with a rate decision, the ~~commissioner~~ Green Mountain
5 Care Board may also make reasonable supplemental orders to the corporation
6 and may attach reasonable conditions and limitations to such orders as ~~he or~~
7 ~~she~~ the Board finds, on the basis of competent and substantial evidence,
8 necessary to ~~insure~~ ensure that benefits and services are provided at minimum
9 cost under efficient and economical management of the corporation. The
10 ~~commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A.
11 §§ 9375 and 9376, the Green Mountain Care Board, shall not set the rate of
12 payment or reimbursement made by the corporation to any physician, hospital,
13 or other health care provider.

14 Sec. 5j. 8 V.S.A. § 4587 is amended to read:

15 § 4587. FILING AND APPROVAL OF CONTRACTS

16 A medical service corporation which has received a permit from the
17 ~~commissioner of financial regulation~~ Commissioner of Financial Regulation
18 under section 4584 of this title shall not thereafter issue a contract to a
19 subscriber or charge a rate therefor which is different from copies of contracts
20 and rates originally filed with such ~~commissioner~~ Commissioner and approved
21 by him or her at the time of the issuance to such medical service corporation of

1 its permit, until it has filed copies of such contracts which it proposes to issue
2 and the rates it proposes to charge therefor and the same have been approved
3 by ~~such commissioner~~ the Commissioner or the Green Mountain Care Board
4 established in 18 V.S.A. chapter 220, as appropriate. Prior to approval, there
5 shall be a public comment period pursuant to section 4062 of this title. Each
6 such filing of a contract or the rate therefor shall be accompanied by payment
7 to the ~~commissioner~~ Commissioner or the Board, as appropriate, of a
8 nonrefundable fee of ~~\$50.00~~ \$150.00. A medical service corporation shall file
9 a plain language summary of rate increases pursuant to section 4062 of this
10 title.

11 Sec. 5k. 8 V.S.A. § 5104 is amended to read:

12 § 5104. FILING AND APPROVAL OF RATES AND FORMS;

13 SUPPLEMENTAL ORDERS

14 (a)(1) A health maintenance organization which has received a certificate
15 of authority under section 5102 of this title shall file and obtain approval of all
16 policy forms and rates as provided in sections 4062 and 4062a of this title.

17 This requirement shall include the filing of administrative retentions for any
18 business in which the organization acts as a third party administrator or in any
19 other administrative processing capacity. The ~~commissioner~~ Commissioner or
20 the Green Mountain Care Board, as appropriate, may request and shall receive
21 any information that the ~~commissioner~~ Commissioner or the Board deems

1 necessary to evaluate the filing. In addition to any other information
2 requested, the ~~commissioner~~ Commissioner or the Board shall require the
3 filing of information on costs for providing services to the organization's
4 Vermont members affected by the policy form or rate, including Vermont
5 claims experience, and administrative and overhead costs allocated to the
6 service of Vermont members. Prior to approval, there shall be a public
7 comment period pursuant to section 4062 of this title. A health maintenance
8 organization shall file a summary of rate filings pursuant to section 4062 of
9 this title.

10 (2) The ~~commissioner~~ Commissioner or the Board shall refuse to
11 approve, ~~or to seek the Green Mountain Care board's approval of,~~ the form of
12 evidence of coverage, filing, or rate if it contains any provision which is unjust,
13 unfair, inequitable, misleading, or contrary to the law of the ~~state~~ State or plan
14 of operation, or if the rates are excessive, inadequate or unfairly
15 discriminatory, fail to protect the organization's solvency, or fail to meet the
16 standards of affordability, promotion of quality care, and promotion of access
17 pursuant to section 4062 of this title. No evidence of coverage shall be offered
18 to any potential member unless the person making the offer has first been
19 licensed as an insurance agent in accordance with chapter 131 of this title.

20 (b) In connection with a rate decision, the ~~commissioner~~ Board may also,
21 ~~with the prior approval of the Green Mountain Care board established in~~

1 ~~18 V.S.A. chapter 220~~, make reasonable supplemental orders and may attach
2 reasonable conditions and limitations to such orders as the ~~commissioner~~
3 Board finds, on the basis of competent and substantial evidence, necessary to
4 ~~insure~~ ensure that benefits and services are provided at reasonable cost under
5 efficient and economical management of the organization. The ~~commissioner~~
6 Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and
7 9376, the Green Mountain Care Board, shall not set the rate of payment or
8 reimbursement made by the organization to any physician, hospital, or health
9 care provider.

10 Sec. 51. 18 V.S.A. § 9375(b) is amended to read:

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

12 * * *

13 (6) Approve, modify, or disapprove requests for health insurance rates
14 pursuant to 8 V.S.A. § 4062 ~~within 30 days of receipt of a request for approval~~
15 ~~from the commissioner of financial regulation~~, taking into consideration the
16 requirements in the underlying statutes, changes in health care delivery,
17 changes in payment methods and amounts, protecting insurer solvency, and
18 other issues at the discretion of the ~~board~~ Board;

19 * * *

1 Sec. 5m. 18 V.S.A. § 9381 is amended to read:

2 § 9381. APPEALS

3 (a)(1) The Green Mountain Care ~~board~~ Board shall adopt procedures for
4 administrative appeals of its actions, orders, or other determinations. Such
5 procedures shall provide for the issuance of a final order and the creation of a
6 record sufficient to serve as the basis for judicial review pursuant to subsection
7 (b) of this section.

8 ~~(2) Only decisions by the board shall be appealable under this~~
9 ~~subsection. Recommendations to the board by the commissioner of financial~~
10 ~~regulation pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.~~

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

16 (c) If an appeal or other petition for judicial review of a final order is not
17 filed in connection with an order of the Green Mountain Care ~~board~~ Board
18 pursuant to subsection (b) of this section, the ~~chair~~ Chair may file a certified
19 copy of the final order with the clerk of a court of competent jurisdiction. The
20 order so filed has the same effect as a judgment of the court and may be
21 recorded, enforced, or satisfied in the same manner as a judgment of the court.

1 policyholders, or certificate holders. ~~This section shall not apply to Catamount~~
2 ~~Health, as established by section 4080f of this title.~~

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

4 (b) Small group plans.

5 * * *

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

14 (B) For purposes of the requirements set forth in subdivision (A) of
15 this subdivision (11), a registered small group carrier shall not include in its
16 calculation an employee or member who is already covered by another group
17 health benefit plan as a spouse or dependent or who is enrolled in ~~Catamount~~
18 ~~Health~~, Medicaid, ~~the Vermont health access plan~~, or Medicare. Employees or
19 members of a small group who are enrolled in the employer's plan and
20 receiving premium assistance under ~~33 V.S.A. chapter 19~~ the Health Insurance
21 Premium Payment program established pursuant to Section 1906 of the Social

1 18 V.S.A. § 9402, as well as Medicaid, ~~the Vermont health access plan,~~ and
2 any other public health care assistance program offered or administered by the
3 ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term
4 shall not include policies or plans providing coverage for specific disease or
5 other limited benefit coverage.

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

7 § 4100b. COVERAGE OF CHILDREN

8 (a) As used in this subchapter:

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

13 * * *

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

15 § 4100e. REQUIRED COVERAGE FOR OFF-LABEL USE

16 * * *

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

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

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

2 § 3801. DEFINITIONS

3 As used in this subchapter:

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

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

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

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

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

17 * * *

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

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

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

* * *

(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;

* * *

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

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

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

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

14 (b) ~~The secretary may charge a monthly premium, in amounts set by the~~
15 ~~general assembly, to each individual 18 years or older who is eligible for~~
16 ~~enrollment in the health access program, as authorized by section 1973 of this~~
17 ~~title and as implemented by rules. All premiums collected by the agency of~~
18 ~~human services or designee for enrollment in the health access program shall~~
19 ~~be deposited in the state health care resources fund established in section~~
20 ~~1901d of this title. Any co-payments, coinsurance, or other cost sharing to be~~
21 ~~charged shall also be authorized and set by the general assembly. [Deleted.]~~

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

2 § 1903a. CARE MANAGEMENT PROGRAM

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

10 * * *

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

12 § 1997. DEFINITIONS

13 As used in this subchapter:

14 * * *

15 (7) “State public assistance program”; includes, ~~but is not limited to~~, the
16 Medicaid program, ~~the Vermont health access plan~~, VPharm, ~~VermontRx~~, the
17 ~~state children’s health insurance program~~ State Children’s Health Insurance
18 Program, the ~~state~~ State of Vermont AIDS ~~medication assistance program~~
19 Medication Assistance Program, the General Assistance program, the
20 ~~pharmacy discount plan program~~ Pharmacy Discount Plan Program, and the
21 out-of-state counterparts to such programs.

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

2 (c)(1) The ~~commissioner~~ Commissioner may implement the ~~pharmacy best~~
3 ~~practices and cost control program~~ Pharmacy Best Practices and Cost Control
4 Program for any other health benefit plan within or outside this ~~state~~ State that
5 agrees to participate in the program. For entities in Vermont, the
6 ~~commissioner~~ Commissioner shall directly or by contract implement the
7 program through a joint pharmaceuticals purchasing consortium. The joint
8 pharmaceuticals purchasing consortium shall be offered on a voluntary basis
9 no later than January 1, 2008, with mandatory participation by state or publicly
10 funded, administered, or subsidized purchasers to the extent practicable and
11 consistent with the purposes of this chapter, by January 1, 2010. If necessary,
12 the ~~department of Vermont health access~~ Department of Vermont Health
13 Access shall seek authorization from the Centers for Medicare and Medicaid to
14 include purchases funded by Medicaid. “State or publicly funded purchasers”
15 shall include the ~~department of corrections~~ Department of Corrections, the
16 ~~department of mental health~~ Department of Mental Health, Medicaid, the
17 ~~Vermont Health Access Program (VHAP)~~, Dr. Dynasaur, ~~VermontRx~~,
18 VPharm, Healthy Vermonters, workers’ compensation, and any other state or
19 publicly funded purchaser of prescription drugs.

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

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

10 * * * Vermont Health Benefit Exchange * * *

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

12 § 1804. QUALIFIED EMPLOYERS

13 (a)(1) Until January 1, 2016, a qualified employer shall be an ~~employer~~
14 entity which, on at least 50 percent of its employed an average of not more
15 than 50 employees on working days during the preceding calendar year,
16 ~~employed at least one and no more than 50 employees~~, and the term “qualified
17 employer” includes self-employed persons to the extent permitted under the
18 Affordable Care Act. Calculation of the number of employees of a qualified
19 employer shall not include a part-time employee who works fewer than
20 30 hours per week or a seasonal worker as defined in 26 U.S.C.
21 § 4980H(c)(2)(B).

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21

* * *

(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).

* * *

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.

* * *

1 to or less than 400 percent of the federal poverty level, as calculated ~~under the~~
2 ~~rules of the Vermont health access plan, as amended~~ using modified adjusted
3 gross income as defined in 26 U.S.C. § 36B(d)(2)(B); or

4 (B) whose household income is equal to or less than 350 percent of
5 the federal poverty level, as calculated ~~under the rules of the Vermont Health~~
6 ~~access plan, as amended~~ using modified adjusted gross income as defined in
7 26 U.S.C. § 36B(d)(2)(B).

8 * * *

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

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

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

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

15 (3) has a household income, when calculated ~~in accordance with the~~
16 ~~rules adopted for the Vermont health access plan under No. 14 of the Acts of~~
17 ~~1995, as amended~~ using modified adjusted gross income as defined in
18 26 U.S.C. § 36B(d)(2)(B), no greater than 225 percent of the federal poverty
19 level.

1 Sec. 32a. MODIFIED ADJUSTED GROSS INCOME; LEGISLATIVE
2 INTENT

3 It is the intent of the General Assembly that individuals receiving benefits
4 under the Healthy Vermonters and VPharm programs on the date that the
5 method of income calculation changes from VHAP rules to modified adjusted
6 gross income as described in Secs. 31 and 32 of this act should not lose
7 eligibility for the applicable program solely as a result of the change in the
8 income calculation method.

9 * * * Health Information Exchange * * *

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

11 (a) No later than July 1, 2011, hospitals shall participate in the Blueprint
12 for Health by creating or maintaining connectivity to the ~~state's~~ State's health
13 information exchange network as provided ~~for~~ in this section and in section
14 9456 of this title. ~~The director of health care reform or designee and the~~
15 ~~director of the Blueprint shall establish criteria by rule for this requirement~~
16 ~~consistent with the state health information technology plan required under~~
17 ~~section 9351 of this title. The criteria shall not require a hospital to create a~~
18 ~~level of connectivity that the state's exchange is not able to support.~~

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

2 § 9456. BUDGET REVIEW

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

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

9 * * *

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

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

19 * * *

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

21 (i) Certification of meaningful use and connectivity.

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

5 (2) VITL, in consultation with health care providers and health care
6 facilities, shall establish criteria for creating or maintaining connectivity to the
7 State’s health information exchange network. VITL shall provide the criteria
8 annually by March 1 to the Green Mountain Care Board established pursuant
9 to chapter 220 of this title.

10 * * * Hospital Energy Efficiency * * *

11 Sec. 35. HOSPITALS; ENERGY EFFICIENCY

12 (a) In this section, “hospital” shall have the same meaning as in 18 V.S.A.
13 § 1902.

14 (b) On or before July 1, 2014, each hospital shall present an energy
15 efficiency action plan to the Green Mountain Care Board. The action plan
16 shall include specific measures to be undertaken which may include energy
17 audits, periodic benchmarking to track performance over time, and energy
18 savings goals. The action plan shall be consistent with the hospital’s strategic
19 goals, capital plans, and previous energy efficiency initiatives, if any.

20 (c) When conducting an energy assessment or audit, the hospital shall use
21 assessment and audit methodologies approved by the energy efficiency entity

1 or entities appointed under 30 V.S.A. § 209(d)(2) to serve the area in which the
2 building or structure is located. These methodologies shall meet standards that
3 are consistent with those contained in 30 V.S.A. § 218c.

4 (d) The energy efficiency entities appointed under 30 V.S.A. § 209(d)(2) to
5 serve the area in which the building or structure is located shall provide
6 assistance to hospitals in the development of their action plans and presentation
7 to the Green Mountain Care Board. This assistance shall be provided pursuant
8 to the entities' obligations under 30 V.S.A. § 209(d) and (e) and implementing
9 Public Service Board orders.

10 * * * Office of the Health Care Advocate * * *

11 Sec. 35a. 18 V.S.A. chapter 229 is added to read:

12 CHAPTER 229. OFFICE OF THE HEALTH CARE ADVOCATE

13 § 9601. DEFINITIONS

14 As used in this chapter:

15 (1) “Green Mountain Care Board” or “Board” means the Board
16 established in chapter 220 of this title.

17 (2) “Health insurance plan” means a policy, service contract, or other
18 health benefit plan offered or issued by a health insurer and includes
19 beneficiaries covered by the Medicaid program unless they are otherwise
20 provided with similar services.

1 (3) “Health insurer” shall have the same meaning as in section 9402 of
2 this title.

3 § 9602. OFFICE OF THE HEALTH CARE ADVOCATE; COMPOSITION

4 (a) The Agency of Administration shall establish the Office of the Health
5 Care Advocate by contract with any nonprofit organization.

6 (b) The Office shall be administered by the Chief Health Care Advocate,
7 who shall be an individual with expertise and experience in the fields of health
8 care and advocacy. The Advocate may employ legal counsel, administrative
9 staff, and other employees and contractors as needed to carry out the duties of
10 the Office.

11 § 9603. DUTIES AND AUTHORITY

12 (a) The Office of the Health Care Advocate shall:

13 (1) Assist health insurance consumers with health insurance plan
14 selection by providing information, referrals, and assistance to individuals
15 about means of obtaining health insurance coverage and services. The Office
16 shall accept referrals from the Vermont Health Benefit Exchange and
17 Exchange navigators created pursuant to 33 V.S.A. chapter 18, subchapter 1, to
18 assist consumers experiencing problems related to the Exchange.

19 (2) Assist health insurance consumers to understand their rights and
20 responsibilities under health insurance plans.

1 (3) Provide information to the public, agencies, members of the General
2 Assembly, and others regarding problems and concerns of health insurance
3 consumers as well as recommendations for resolving those problems and
4 concerns.

5 (4) Identify, investigate, and resolve complaints on behalf of individual
6 health insurance consumers, and assist those consumers with filing and pursuit
7 of complaints and appeals.

8 (5) Provide information to individuals regarding their obligations and
9 responsibilities under the Patient Protection and Affordable Care Act (Public
10 Law 111-148).

11 (6) Analyze and monitor the development and implementation of
12 federal, state, and local laws, rules, and policies relating to patients and health
13 insurance consumers.

14 (7) Facilitate public comment on laws, rules, and policies, including
15 policies and actions of health insurers.

16 (8) Suggest policies, procedures, or rules to the Green Mountain Care
17 Board in order to protect patients' and consumers' interests.

18 (9) Promote the development of citizen and consumer organizations.

19 (10) Ensure that patients and health insurance consumers have timely
20 access to the services provided by the Office.

1 (11) Submit to the General Assembly and the Governor on or before
2 January 1 of each year a report on the activities, performance, and fiscal
3 accounts of the Office during the preceding calendar year.

4 (b) The Office of the Health Care Advocate may:

5 (1) Review the health insurance records of a consumer who has
6 provided written consent. Based on the written consent of the consumer or his
7 or her guardian or legal representative, a health insurer shall provide the Office
8 with access to records relating to that consumer.

9 (2) Pursue administrative, judicial, and other remedies on behalf of any
10 individual health insurance consumer or group of consumers.

11 (3) Represent the interests of the people of the State in cases requiring a
12 hearing before the Green Mountain Care Board established in chapter 220 of
13 this title.

14 (4) Adopt policies and procedures necessary to carry out the provisions
15 of this chapter.

16 (5) Take any other action necessary to fulfill the purposes of this
17 chapter.

18 (c) The Office of the Health Care Advocate shall be able to speak on behalf
19 of the interests of health care and health insurance consumers and to carry out
20 all duties prescribed in this chapter without being subject to any retaliatory

1 action; provided, however, that nothing in this subsection shall limit the
2 authority of the Agency of Administration to enforce the terms of the contract.

3 § 9604. DUTIES OF STATE AGENCIES

4 All state agencies shall comply with reasonable requests from the Office of
5 the Health Care Advocate for information and assistance. The Agency of
6 Administration may adopt rules necessary to ensure the cooperation of state
7 agencies under this section.

8 § 9605. CONFIDENTIALITY

9 In the absence of written consent by a complainant or an individual using
10 the services of the Office or by his or her guardian or legal representative or
11 the absence of a court order, the Office of the Health Care Advocate, its
12 employees, and its contractors shall not disclose the identity of the complainant
13 or individual.

14 § 9606. CONFLICTS OF INTEREST

15 The Office of the Health Care Advocate, its employees, and its contractors
16 shall not have any conflict of interest relating to the performance of their
17 responsibilities under this chapter. For the purposes of this chapter, a conflict
18 of interest exists whenever the Office of the Health Care Advocate, its
19 employees, or its contractors or a person affiliated with the Office, its
20 employees, or its contractors:

1 (1) have a direct involvement in the licensing, certification, or
2 accreditation of a health care facility, health insurer, or health care provider;

3 (2) have a direct ownership interest or investment interest in a health
4 care facility, health insurer, or health care provider;

5 (3) are employed by or participating in the management of a health care
6 facility, health insurer, or health care provider; or

7 (4) receive or have the right to receive, directly or indirectly,
8 remuneration under a compensation arrangement with a health care facility,
9 health insurer, or health care provider.

10 § 9607. FUNDING; INTENT

11 (a) The Office of the Health Care Advocate shall specify in its annual
12 report filed pursuant to this chapter the sums expended by the Office in
13 carrying out its duties, including identifying the specific amount expended for
14 actuarial services.

15 (b) It is the intent of the General Assembly that the Office of the Health
16 Care Advocate shall maximize the amount of federal and grant funds available
17 to support the activities of the Office.

18 Sec. 35b. 18 V.S.A. § 9374(f) is amended to read:

19 (f) In carrying out its duties pursuant to this chapter, the ~~board~~ Board shall
20 seek ~~the advice of the state health care ombudsman established in 8 V.S.A.~~
21 ~~§ 4089w~~ from the Office of the Health Care Advocate. The ~~state health care~~

1 ~~ombudsman~~ Office shall advise the ~~board~~ Board regarding the policies,
2 procedures, and rules established pursuant to this chapter. The ~~ombudsman~~
3 Office shall represent the interests of Vermont patients and Vermont
4 consumers of health insurance and may suggest policies, procedures, or rules
5 to the ~~board~~ Board in order to protect patients' and consumers' interests.

6 Sec. 35c. 18 V.S.A. § 9377(e) is amended to read:

7 (e) The ~~board~~ Board or designee shall convene a broad-based group of
8 stakeholders, including health care professionals who provide health services,
9 health insurers, professional organizations, community and nonprofit groups,
10 consumers, businesses, school districts, the ~~state health care ombudsman~~
11 Office of the Health Care Advocate, and state and local governments, to advise
12 the ~~board~~ Board in developing and implementing the pilot projects and to
13 advise the Green Mountain Care ~~board~~ Board in setting overall policy goals.

14 Sec. 35d. 18 V.S.A. § 9410(a)(2) is amended to read:

15 (2)(A) The program authorized by this section shall include a consumer
16 health care price and quality information system designed to make available to
17 consumers transparent health care price information, quality information, and
18 such other information as the ~~commissioner~~ Commissioner determines is
19 necessary to empower individuals, including uninsured individuals, to make
20 economically sound and medically appropriate decisions.

1 an interested party in such proceedings upon filing a notice of intervention
2 with the ~~board~~ Board.

3 Sec. 35f. 18 V.S.A. § 9445(b) is amended to read:

4 (b) In addition to all other sanctions, if any person offers or develops any
5 new health care project without first having been issued a certificate of need or
6 certificate of exemption ~~therefore~~ for the project, or violates any other
7 provision of this subchapter or any lawful rule ~~or regulation promulgated~~
8 ~~thereunder~~ adopted pursuant to this subchapter, the ~~board~~ Board, the
9 ~~commissioner~~ Commissioner, the ~~state health care ombudsman~~ Office of the
10 Health Care Advocate, the ~~state long term care ombudsman~~ State Long-Term
11 Care Ombudsman, and health care providers and consumers located in the ~~state~~
12 State shall have standing to maintain a civil action in the ~~superior court~~
13 Superior Court of the county ~~wherein in which~~ such alleged violation has
14 occurred, or ~~wherein in which~~ such person may be found, to enjoin, restrain, or
15 prevent such violation. Upon written request by the ~~board~~ Board, it shall be
16 the duty of the ~~attorney general of the state~~ Vermont Attorney General to
17 furnish appropriate legal services and to prosecute an action for injunctive
18 relief to an appropriate conclusion, which shall not be reimbursed under
19 subdivision (a)(2) of this ~~subsection~~ section.

1 Sec. 35g. 33 V.S.A. § 1805 is amended to read:

2 § 1805. DUTIES AND RESPONSIBILITIES

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

6 * * *

7 (16) Referring consumers to the ~~office of health care ombudsman~~ Office
8 of the Health Care Advocate for assistance with grievances, appeals, and other
9 issues involving the Vermont ~~health benefit exchange~~ Health Benefit
10 Exchange.

11 * * *

12 Sec. 35h. 33 V.S.A. § 1807(b) is amended to read:

13 (b) Navigators shall have the following duties:

14 * * *

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

19 * * *

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

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

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

20 (2) The ~~commissioner of finance and management~~ Commissioner of
21 Finance and Management may anticipate receipts to the ~~division of health care~~

1 ~~administration regulatory and supervision fund~~ Health Care Administration
2 Regulatory and Supervision Fund and issue warrants based thereon.

3 * * * Health Resource Allocation Plan * * *

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

5 § 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION
6 PLAN

7 (a) No later than January 1, 2005, the ~~secretary of human services~~ Secretary
8 of Human Services or designee, in consultation with the ~~commissioner~~ Chair
9 of the Green Mountain Care Board and health care professionals and after
10 receipt of public comment, shall adopt a ~~state health plan~~ State Health Plan that
11 sets forth the health goals and values for the ~~state~~ State. The ~~secretary~~
12 Secretary may amend the ~~plan~~ Plan as the ~~secretary~~ Secretary deems necessary
13 and appropriate. The ~~plan~~ Plan shall include health promotion, health
14 protection, nutrition, and disease prevention priorities for the ~~state~~ State,
15 identify available human resources as well as human resources needed for
16 achieving the ~~state's~~ State's health goals and the planning required to meet
17 those needs, and identify geographic parts of the ~~state~~ State needing
18 investments of additional resources in order to improve the health of the
19 population. The ~~plan~~ Plan shall contain sufficient detail to guide development
20 of the ~~state health resource allocation plan~~ State Health Resource Allocation
21 Plan. Copies of the ~~plan~~ Plan shall be submitted to members of the ~~senate and~~

1 ~~house committees on health and welfare~~ Senate and House Committees on
2 Health and Welfare no later than January 15, 2005.

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

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

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

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

20 (C) Consistent with the principles set forth in subdivision (A) of this
21 subdivision (1), recommendations for the appropriate supply and distribution

1 of resources, programs, and services identified in subdivision (B) of this
2 subdivision (1), options for implementing such recommendations and
3 mechanisms which will encourage the appropriate integration of these services
4 on a local or regional basis. To arrive at such recommendations, the
5 ~~commissioner~~ Green Mountain Care Board shall consider at least the following
6 factors:

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

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

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

12 (iv) the needs of uninsured and underinsured populations;

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

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

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

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

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

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

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

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

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

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

20 (3) The ~~commissioner~~ Board, with the ~~advisory committee~~ Green
21 Mountain Care Board General Advisory Committee, shall conduct at least five

1 public hearings, in different regions of the state, on the ~~plan~~ Plan as proposed
2 and shall give interested persons an opportunity to submit their views orally
3 and in writing. To the extent possible, the ~~commissioner~~ Board shall arrange
4 for hearings to be broadcast on interactive television. Not less than 30 days
5 prior to any such hearing, the ~~commissioner~~ Board shall publish in the manner
6 prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place
7 and period during which to direct written comments to the ~~commissioner~~
8 Board. In addition, the ~~commissioner~~ Board may create and maintain a
9 website to allow members of the public to submit comments electronically and
10 review comments submitted by others.

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

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

19 (6) The ~~plan~~ Plan or any revised ~~plan~~ Plan proposed by the
20 ~~commissioner~~ Board shall be the ~~health resource allocation plan~~ Health
21 Resource Allocation Plan for the ~~state~~ State after it is approved by the ~~governor~~

1 Governor or upon passage of three months from the date the ~~governor~~
2 Governor receives the ~~plan~~ proposed Plan, whichever occurs first, unless the
3 ~~governor~~ Governor disapproves the ~~plan~~ proposed Plan, in whole or in part. If
4 the ~~governor~~ Governor disapproves, he or she shall specify the sections of the
5 ~~plan~~ proposed Plan which are objectionable and the changes necessary to meet
6 the objections. The sections of the ~~plan~~ proposed Plan not disapproved shall
7 become part of the ~~health resource allocation plan~~ Health Resource Allocation
8 Plan.

9 * * * Allocation of Expenses * * *

10 Sec. 37a. 18 V.S.A. § 9374(h) is amended to read:

11 (h)(1) ~~Expenses~~ Except as otherwise provided in subdivision (2) of this
12 subsection, expenses incurred to obtain information, analyze expenditures,
13 review hospital budgets, and for any other contracts authorized by the ~~board~~
14 Board shall be borne as follows:

15 (A) 40 percent by the ~~state~~ State from state monies;

16 (B) 15 percent by the hospitals;

17 (C) 15 percent by nonprofit hospital and medical service corporations
18 licensed under 8 V.S.A. chapter 123 or 125;

19 (D) 15 percent by health insurance companies licensed under
20 8 V.S.A. chapter 101; and

1 (E) 15 percent by health maintenance organizations licensed under
2 8 V.S.A. chapter 139.

3 (2) The Board may determine the scope of the incurred expenses to be
4 allocated pursuant to the formula set forth in subdivision (1) of this subsection
5 if, in the Board's discretion, the expenses to be allocated are in the best
6 interests of the regulated entities and of the State.

7 (3) Expenses under subdivision (1) of this subsection shall be billed to
8 persons licensed under Title 8 based on premiums paid for health care
9 coverage, which for the purposes of this section shall include major medical,
10 comprehensive medical, hospital or surgical coverage, and comprehensive
11 health care services plans, but shall not include long-term care or limited
12 benefits, disability, credit or stop loss, or excess loss insurance coverage.

13 Sec. 37b. 18 V.S.A. § 9415 is amended to read:

14 § 9415. ALLOCATION OF EXPENSES

15 (a) ~~Expenses~~ Except as otherwise provided in subsection (b) of this section,
16 expenses incurred to obtain information and to analyze expenditures, review
17 hospital budgets, and for any other related contracts authorized by the
18 ~~commissioner~~ Commissioner shall be borne as follows:

19 (1) 40 percent by the ~~state~~ State from state monies;₂

20 (2) 15 percent by the hospitals;₂

1 (3) 15 percent by nonprofit hospital and medical service corporations
2 licensed under 8 V.S.A. chapter 123 or 125;

3 (4) 15 percent by health insurance companies licensed under 8 V.S.A.
4 chapter 101; and

5 (5) 15 percent by health maintenance organizations licensed under
6 8 V.S.A. chapter 139.

7 (b) The Commissioner may determine the scope of the incurred expenses to
8 be allocated pursuant to the formula set forth in subsection (a) of this section if,
9 in the Commissioner’s discretion, the expenses to be allocated are in the best
10 interests of the regulated entities and of the State.

11 (c) Expenses under subsection (a) of this section shall be billed to persons
12 licensed under Title 8 based on premiums paid for health care coverage, which
13 for the purposes of this section include major medical, comprehensive medical,
14 hospital or surgical coverage, and any comprehensive health care services plan,
15 but ~~does~~ shall not include long-term care, limited benefits, disability, credit or
16 stop loss or excess loss insurance coverage

17 Sec. 37c. BILL-BACK REPORT

18 (a) Annually on or before September 15, the Green Mountain Care Board
19 and the Department of Financial Regulation shall report to the House
20 Committee on Health Care, the Senate Committees on Health and Welfare and
21 on Finance, and the House and Senate Committees on Appropriations the total

1 amount of all expenses eligible for allocation pursuant to 18 V.S.A. §§ 9374(h)
2 and 9415 during the preceding state fiscal year and the total amount actually
3 billed back to the regulated entities during the same period.

4 (b) The Board and the Department shall also present the information
5 required by subsection (a) of this section to the Joint Fiscal Committee
6 annually at its September meeting.

7 Sec. 37d. HEALTH CARE ADVOCATE; BILL BACK

8 (a) Through June 30, 2016, financial support for the Office of the Health
9 Care Advocate established pursuant to 18 V.S.A. chapter 229 for services
10 related to the Green Mountain Care Board's and Department of Financial
11 Regulation's regulatory and supervisory duties shall be considered expenses
12 incurred by the Board or the Department under 18 V.S.A. §§ 9374(h) and 9415
13 and shall be an acceptable use of the funds realized pursuant those sections.

14 (b) For fiscal year 2014, the Green Mountain Care Board and the
15 Department of Financial Regulation may allocate up to \$300,000.00 of
16 expenses pursuant to the authority granted by subsection (a) of this section.

17 (c) On or before February 1, 2014, the Director of Health Care Reform in
18 the Agency of Administration shall present to the House Committees on Health
19 Care, on Ways and Means, and on Appropriations and the Senate Committees
20 on Health and Welfare, on Finance, and on Appropriations sustainable funding
21 options for the Office of the Health Care Advocate, including sustainable

1 options based on sources other than the allocation of expenses described in
2 subsection (a) of this section.

3 * * * Hospital Community Reports * * *

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

5 § 9405b. HOSPITAL COMMUNITY REPORTS

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

11 * * *

12 (b) On or before January 1, 2005, and annually thereafter beginning on
13 June 1, 2006, the board of directors or other governing body of each hospital
14 licensed under chapter 43 of this title shall publish on its website, making
15 paper copies available upon request, its community report in a uniform format
16 approved by the ~~commissioner~~, Commissioner of Health and in accordance
17 with the standards and procedures adopted by rule under this section, ~~and shall~~
18 ~~hold one or more public hearings to permit community members to comment~~
19 ~~on the report. Notice of meetings shall be by publication, consistent with~~
20 ~~1 V.S.A. § 174.~~ Hospitals located outside this ~~state~~ State which serve a
21 significant number of Vermont residents, as determined by the ~~commissioner~~

1 Commissioner of Health, shall be invited to participate in the community
2 report process established by this subsection.

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

8 Sec. 39. EXTENSION FOR PUBLICATION OF 2013 HOSPITAL
9 COMMUNITY REPORTS

10 Notwithstanding the June 1 publication date specified in 18 V.S.A.
11 § 9405b(b), hospitals shall publish their 2013 hospital community reports on or
12 before October 1, 2013. Following publication of the hospital reports, the
13 Department of Financial Regulation shall publish hospital comparison
14 information as required under 18 V.S.A. § 9405b(c).

15 * * * VHCURES * * *

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

17 § 9410. HEALTH CARE DATABASE

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

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

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

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

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

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

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

13 (2)(A) The program authorized by this section shall include a consumer
14 health care price and quality information system designed to make available to
15 consumers transparent health care price information, quality information, and
16 such other information as the ~~commissioner~~ Board determines is necessary to
17 empower individuals, including uninsured individuals, to make economically
18 sound and medically appropriate decisions.

19 (B) ~~The commissioner shall convene a working group composed of~~
20 ~~the commissioner of mental health, the commissioner of Vermont health~~
21 ~~access, health care consumers, the office of the health care ombudsman,~~

1 ~~employers and other payers, health care providers and facilities, the Vermont~~
2 ~~program for quality in health care, health insurers, and any other individual or~~
3 ~~group appointed by the commissioner to advise the commissioner on the~~
4 ~~development and implementation of the consumer health care price and quality~~
5 ~~information system.~~

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

11 ~~(D)~~(C) The ~~commissioner~~ Board shall adopt such rules as are
12 necessary to carry out the purposes of this subdivision. The ~~commissioner's~~
13 Board's rules may permit the gradual implementation of the consumer health
14 care price and quality information system over time, beginning with health
15 care price and quality information that the ~~commissioner~~ Board determines is
16 most needed by consumers or that can be most practically provided to the
17 consumer in an understandable manner. The rules shall permit health insurers
18 to use security measures designed to allow subscribers access to price and
19 other information without disclosing trade secrets to individuals and entities
20 who are not subscribers. The ~~regulations~~ rules shall avoid unnecessary
21 duplication of efforts relating to price and quality reporting by health insurers,

1 health care providers, health care facilities, and others, including activities
2 undertaken by hospitals pursuant to their community report obligations under
3 section 9405b of this title.

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

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

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

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

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

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

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

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

7 (g) Any person who knowingly fails to comply with the requirements of
8 this section or rules adopted pursuant to this section shall be subject to an
9 administrative penalty of not more than \$1,000.00 per violation. The
10 ~~commissioner~~ Board may impose an administrative penalty of not more than
11 \$10,000.00 each for those violations the ~~commissioner~~ Board finds were
12 willful. In addition, any person who knowingly fails to comply with the
13 confidentiality requirements of this section or confidentiality rules adopted
14 pursuant to this section and uses, sells, or transfers the data or information for
15 commercial advantage, pecuniary gain, personal gain, or malicious harm shall
16 be subject to an administrative penalty of not more than \$50,000.00 per
17 violation. The powers vested in the ~~commissioner~~ Board by this subsection
18 shall be in addition to any other powers to enforce any penalties, fines, or
19 forfeitures authorized by law.

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

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

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

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

12 (2) The collection, storage, and release of health care data and
13 statistical information that is subject to the federal requirements of the Health
14 Insurance Portability and Accountability Act (“HIPAA”) shall be governed
15 exclusively by the ~~rules~~ regulations adopted thereunder in 45 ~~CFR~~ C.F.R. Parts
16 160 and 164.

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

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

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

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

20 (C) Consistent with the dictates of HIPAA, and subject to such terms
21 and conditions as the ~~commissioner~~ Board may prescribe by ~~regulation~~ rule,

1 the Vermont ~~program for quality in health care~~ Program for Quality in Health
2 Care shall have access to the unified health care database for use in improving
3 the quality of health care services in Vermont. In using the database, the
4 Vermont ~~program for quality in health care~~ Program for Quality in Health Care
5 shall agree to abide by the rules and procedures established by the
6 ~~commissioner~~ Board for access to the data. The ~~commissioner's~~ Board's rules
7 may limit access to the database to limited-use sets of data as necessary to
8 carry out the purposes of this section.

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

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

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

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

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

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

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

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

1 ~~(A)~~(B) the total number of denials of service at the preauthorization
2 level appealed to the health insurer at the first-level grievance and, of those, the
3 total number overturned;

4 ~~(B)~~(C) the total number of denials of service at the preauthorization
5 level appealed to the health insurer at any second-level grievance and, of those,
6 the total number overturned;

7 ~~(C)~~(D) the total number of denials of service at the preauthorization
8 level for which external review was sought and, of those, the total number
9 overturned;

10 Sec. 40c. DENIED CLAIMS; DEPARTMENT OF VERMONT HEALTH
11 ACCESS

12 On or before February 1, 2014, the Department of Vermont Health Access
13 shall present data to the House Committee on Health Care and the Senate
14 Committee on Health and Welfare on claims denied by the Department. To
15 the extent practicable, the Department shall base its presentation on the data
16 required by the standardized form created by the Department of Financial
17 Regulation for use by health insurers under 18 V.S.A. § 9414a(c).

18 * * * Cost-Shift Reporting * * *

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

20 (d) Annually, on or before January 15, the ~~board~~ Board shall submit a
21 report of its activities for the preceding ~~state fiscal~~ calendar year to the ~~house~~

1 ~~committee on health care and the senate committee on health and welfare~~
2 House Committee on Health Care and the Senate Committee on Health and
3 Welfare.

4 (1) The report shall include:

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

7 (B) any new developments with respect to health information
8 technology;

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

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

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

15 (F) an update regarding implementation of any prior authorization
16 pilot programs under section 9377a of this title;

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

21 (H) any recommendations for modifications to Vermont statutes; and

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

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

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

6 Sec. 117b. MEDICAID COST SHIFT REPORTING

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

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

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

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

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

21 (e) ~~The first \$250,000.00 resulting from declines in caseload and utilization~~

1 ~~related to hospital costs, as determined by the commissioner of social welfare,~~
2 ~~from the funds allocated within the Medicaid program appropriation for~~
3 ~~hospital costs in fiscal year 2001 shall be reserved for cost shift reduction for~~
4 ~~hospitals.~~

5 Sec. 42a. EXCHANGE IMPACT REPORT

6 On or before March 15, 2015 and every three years thereafter, the Agency
7 of Administration shall report to the House Committee on Health Care and the
8 Senate Committees on Health and Welfare and on Finance regarding the
9 impact of the Vermont Health Benefit Exchange and the federal individual
10 responsibility requirement on:

11 (1) the number of uninsured and underinsured Vermonters;

12 (2) the amount of uncompensated care and bad debt in Vermont; and

13 (3) the cost shift.

14 * * * Workforce Planning Data * * *

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

16 § 1353. POWERS AND DUTIES OF THE BOARD

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

18 * * *

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

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

4 (1) Financial institutions, credit unions, licensed lenders, mortgage
5 brokers, insurance companies, insurance agents, broker-dealers, investment
6 advisors, and other similar persons subject to the provisions of this title and
7 9 V.S.A. chapters 59, 61, and 150.

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

13 * * * Miscellaneous Provisions * * *

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

15 (h) To the extent required to avoid federal antitrust violations, the
16 Department of Vermont Health Access shall facilitate and supervise the
17 participation of health care professionals and health care facilities in the
18 planning and implementation of payment reform in the Medicaid and SCHIP
19 programs. The Department shall ensure that the process and implementation
20 include sufficient state supervision over these entities to comply with federal
21 antitrust provisions and shall refer to the Attorney General for appropriate

1 action the activities of any individual or entity that the Department determines,
2 after notice and an opportunity to be heard, violate state or federal antitrust
3 laws without a countervailing benefit of improving patient care, improving
4 access to health care, increasing efficiency, or reducing costs by modifying
5 payment methods.

6 Sec. 46a. STUDY OF FEES FOR COPIES OF ELECTRONIC MEDICAL
7 RECORDS

8 The Green Mountain Care Board shall study the costs and fees associated
9 with providing copies, pursuant to 18 V.S.A. § 9419, of medical records
10 maintained and provided to patients in a paperless format. The Department
11 shall consult with interested stakeholders, including the Vermont Association
12 of Hospitals and Health Systems and the Vermont Association for Justice, and
13 shall review related laws and policies in other states. On or before January 15,
14 2014, the Board shall report the results of its study to the House Committees
15 on Health Care and on Human Services and the Senate Committee on Health
16 and Welfare.

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

18 § 1901b. PHARMACY PROGRAM ENROLLMENT

19 (a) ~~The department of Vermont health access~~ Department of Vermont
20 Health Access and the ~~department for children and families~~ Department for
21 Children and Families shall monitor actual caseloads, revenue, and

1 expenditures; anticipated caseloads, revenue, and expenditures; and actual
2 and anticipated savings from implementation of the preferred drug list,
3 supplemental rebates, and other cost containment activities in each state
4 pharmaceutical assistance program, including VPharm and VermontRx. The
5 departments When applicable, the Departments shall allocate supplemental
6 rebate savings to each program proportionate to expenditures in each program.
7 ~~During the second week of each month, the department of Vermont health~~
8 ~~access shall report such actual and anticipated caseload, revenue, expenditure,~~
9 ~~and savings information to the joint fiscal committee and to the health care~~
10 ~~oversight committee.~~

11 (b)(1) ~~If at any time expenditures for VPharm and VermontRx are~~
12 ~~anticipated to exceed the aggregate amount of state funds expressly~~
13 ~~appropriated for such state pharmaceutical assistance programs during any~~
14 ~~fiscal year, the department of Vermont health access shall recommend to the~~
15 ~~joint fiscal committee and notify the health care oversight committee of a plan~~
16 ~~to cease new enrollments in VermontRx for individuals with incomes over~~
17 ~~225 percent of the federal poverty level.~~

18 (2) ~~If at any time expenditures for VPharm and VermontRx are~~
19 ~~anticipated to exceed the aggregate amount of state funds expressly~~
20 ~~appropriated for such state pharmaceutical assistance programs during any~~
21 ~~fiscal year, even with the cessation of new enrollments as provided for in~~

1 ~~subdivision (1) of this subsection, the department of Vermont health access~~
2 ~~shall recommend to the joint fiscal committee and notify the health health care~~
3 ~~oversight committee of a plan to cease new enrollments in the VermontRx for~~
4 ~~individuals with incomes more than 175 percent and less than 225 percent of~~
5 ~~the federal poverty level.~~

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

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

17 ~~(e)(1) If at any time after enrollment ceases under subsection (b) of this~~
18 ~~section expenditures for VermontRx, including expenditures attributable to~~
19 ~~renewed enrollment, are anticipated, by reason of increased federal financial~~
20 ~~participation or any other reason, to be equal to or less than the aggregate~~
21 ~~amount of state funds expressly appropriated for such state pharmaceutical~~

1 ~~assistance programs during any fiscal year, the department of Vermont health~~
2 ~~access shall recommend to the joint fiscal committee and notify the health care~~
3 ~~oversight committee of a plan to renew enrollment in VermontRx, with priority~~
4 ~~given to individuals with incomes more than 175 percent and less than~~
5 ~~225 percent, if adequate funds are anticipated to be available for each program~~
6 ~~for the remainder of the fiscal year.~~

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

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

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

18 ~~(1) “State “state pharmaceutical assistance program” means any health~~
19 ~~assistance programs administered by the agency of human services Agency of~~
20 ~~Human Services providing prescription drug coverage, including the Medicaid~~
21 ~~program, the Vermont health access plan, VPharm, VermontRx, the state~~

1 ~~children's health insurance program~~ State Children's Health Insurance
2 Program, the state State of Vermont AIDS ~~medication assistance program~~
3 Medication Assistance Program, the General Assistance program, the
4 ~~pharmacy discount plan program~~ Pharmacy Discount Plan Program, and any
5 other health assistance programs administered by the agency Agency providing
6 prescription drug coverage.

7 (2) ~~“VHAP” or “Vermont health access plan” means the programs of~~
8 ~~health care assistance authorized by federal waivers under Section 1115 of the~~
9 ~~Social Security Act, by No. 14 of the Acts of 1995, and by further acts of the~~
10 ~~General Assembly.~~

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

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

19 (5) ~~“VScript Expanded” means the state funded program of~~
20 ~~pharmaceutical assistance for elderly and disabled Vermonters with income~~

1 ~~over 175 and less than or equal to 225 percent of FPL, and administered under~~
2 ~~subchapter 4 of chapter 19 of this title.~~

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

4 Sec. 2c. EXCHANGE OPTIONS

5 In approving benefit packages for the Vermont health benefit exchange
6 pursuant to 18 V.S.A. ~~§ 9375(b)(7)~~ § 9375(b)(9), the Green Mountain Care
7 ~~board~~ Board shall approve a full range of cost-sharing structures for each level
8 of actuarial value. To the extent permitted under federal law, the ~~board~~ Board
9 shall also allow health insurers to establish rewards, premium discounts, split
10 benefit designs, rebates, or otherwise waive or modify applicable co-payments,
11 deductibles, or other cost-sharing amounts in return for adherence by an
12 insured to programs of health promotion and disease prevention pursuant to
13 33 V.S.A. § 1811(f)(2)(B).

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

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

17 Sec. 49a. 16 V.S.A. § 3851 is amended to read:

18 § 3851. DEFINITIONS

19 * * *

20 (c) “Eligible institution” means any:

21 * * *

1 (5) any:

2 * * *

3 (D) nonprofit assisted living facility, nonprofit continuing care
4 retirement facility, nonprofit residential care facility or similar nonprofit
5 facility for the continuing care of the elderly or the infirm, provided that such
6 facility is owned by or under common ownership with an otherwise eligible
7 institution, and in the case of facilities to be financed for an eligible institution
8 provided by this subdivision (5) of this subsection, for which the ~~department of~~
9 ~~financial regulation~~ Green Mountain Care Board, if required, has issued a
10 certificate of need.

11 * * *

12 Sec. 49b. 18 V.S.A. § 9351(d) is amended to read:

13 (d) The health information technology plan shall serve as the framework
14 within which the ~~commissioner of financial regulation~~ Green Mountain Care
15 Board reviews certificate of need applications for information technology
16 under section 9440b of this title. In addition, the ~~commissioner of information~~
17 ~~and innovation~~ Commissioner of Information and Innovation shall use the
18 health information technology plan as the basis for independent review of state
19 information technology procurements.

1 Sec. 49c. 33 V.S.A. § 6304(c) is amended to read:

2 (c) Designations for new home health agencies shall be established
3 pursuant to certificates of need approved by the ~~commissioner of financial~~
4 ~~regulation~~ Green Mountain Care Board. Thereafter, designations shall be
5 subject to the provisions of this subchapter.

6 * * * Transfer of Positions * * *

7 Sec. 50. TRANSFER OF POSITIONS

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

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

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

1 (standardized claims and edits), 33–34a (health information exchange), 35
2 (hospital energy efficiency), 39 (publication extension for 2013 hospital
3 reports), 40 (VHCURES), 43 and 44 (workforce planning), 46 (DVHA
4 antitrust provision), 48 (Exchange options), 49 (correction to payment reform
5 pilot repeal), 50 (transfer of positions), 51 (emergency rules), and 52 (repeals)
6 of this act and this section shall take effect on passage.

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

10 (c) Secs. 4 (newborn coverage), 5 (grace period for premium payment),
11 6–27 (Catamount and VHAP), 35a–35h (Office of the Health Care Advocate),
12 and 47 (pharmacy program enrollment) shall take effect on January 1, 2014.

13 (d) Secs. 31 (Healthy Vermonters) and 32 (VPharm) shall take effect on
14 January 1, 2014, except that the Department of Vermont Health Access may
15 continue to calculate household income under the rules of the Vermont Health
16 Access Plan after that date if the system for calculating modified adjusted
17 gross income for the Healthy Vermonters and VPharm programs is not
18 operational by that date, but no later than December 31, 2014.

19 (e) Secs. 5c–5n (rate review) of this act shall take effect on January 1, 2014
20 and shall apply to all insurers filing rates and forms for major medical
21 insurance plans on and after January 1, 2014, except that the Green Mountain

1 Care Board and the Department of Financial Regulation may amend their rules
2 and take such other actions before that date as are necessary to ensure that the
3 revised rate review process will be operational on January 1, 2014.

4 (f) Sec. 42a (Exchange impact report) shall take effect on July 1, 2014.

5 (g) Sec. 3(e)–(g) (8 V.S.A. § 4089i(e)–(g); step therapy) shall take effect on
6 September 1, 2013 and shall apply to all health insurers on and after
7 September 1, 2013 on such date as a health insurer offers, issues, or renews a
8 health insurance policy, but in no event later than September 1, 2014.

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