
Referred to Committee on

Date:
Subject: Health; health care reform; publicly financed health care; Green Mountain Care

Statement of purpose of bill as introduced: This bill proposes to implement Green Mountain Care, a publicly financed health care program for all Vermont residents, over time, starting with primary care in the first year, adding preventive dental and vision care in the second year, and incorporating additional health care services in later years. It would establish the Universal Health Care Advisory Group at the Green Mountain Care Board to provide recommendations to the General Assembly regarding the sequencing of and financing for the health care services to be added in the third through tenth years of Green Mountain Care’s implementation. The bill would also express legislative intent regarding funding sources for Green Mountain Care’s first and second years and would prohibit health insurance plans and rates from reflecting duplication of the coverage provided by Green Mountain Care.

An act relating to incremental implementation of Green Mountain Care

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

Sec. 1. PURPOSE

The purpose of this act is to initiate the incremental implementation of Green Mountain Care by starting to provide comprehensive, affordable, high-quality, publicly financed health care for all Vermonters in accordance with the
principles established in 2011 Acts and Resolves No. 48. The act gradually
expands the benefits available through Green Mountain Care over 10 years,
beginning with publicly financed primary care in the first year, adding
preventive dental and vision care in the second year, and adding the remaining
health care services according to a schedule recommended by the Green
Mountain Care Board’s Universal Health Care Advisory Group. It is the intent
of the General Assembly that, by the tenth year, the Green Mountain Care
benefit package should be at least as comprehensive as the benefit package
contemplated for the program in 2011 Acts and Resolves No. 48.

Sec. 2. 33 V.S.A. chapter 18, subchapter 2 is amended to read:

Subchapter 2. Green Mountain Care

* * *

§ 1822. IMPLEMENTATION; WAIVER

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

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

(2) Enactment of a law establishing the financing for Green Mountain
Care. [Repealed.]

(3) Approval by the Green Mountain Care Board of the initial Green
Mountain Care benefit package pursuant to 18 V.S.A. § 9375. [Repealed.]
(4) Enactment of the appropriations for the initial first year of Green Mountain Care benefit package proposed by the Green Mountain Care Board pursuant to 18 V.S.A. § 9375 based on the first-year benefits set forth in subdivision 1825(a)(1) of this chapter.

(5) A determination by the Green Mountain Care Board, as the result of a detailed and transparent analysis, that each of the following conditions will be met:

   (A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.

   (B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont’s economy. This determination shall include an analysis of the impact of implementation on economic growth.

   (C) The financing for Green Mountain Care is sustainable. In this analysis, the Board shall consider at least a five-year revenue forecast using the consensus process established in 32 V.S.A. § 305a, projections of federal and other funds available to support Green Mountain Care, and estimated expenses for Green Mountain Care for an equivalent time period.

   (D) Administrative expenses in Vermont’s health care system for which data are available will be reduced below 2011 levels, adjusted for inflation and other factors as necessary to reflect the present value of 2011 dollars at the time of the analysis.
(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont’s per-capita health care spending without reducing access to necessary care or resulting in excessive wait times for services.

(F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

[Repealed.]

(b) As soon as allowed under federal law, the Secretary of Administration shall seek a waiver under Section 1332 of the Affordable Care Act to:

(A) allow the State to suspend operation of modify the benefit package for the qualified health plans offered through the Vermont Health Benefit Exchange as appropriate to reflect the expansion of coverage through Green Mountain Care; and to

(B) enable Vermont to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the Affordable Care Act to the extent that reductions in premiums and out-of-pocket costs are attributable to the availability of coverage for certain health care services through Green Mountain Care.
(2) The Secretary may seek a waiver from other provisions of the Affordable Care Act as necessary to ensure the operation of Green Mountain Care.

(c) The Green Mountain Care Board’s analysis prepared pursuant to subdivision (a)(5) of this section shall be made available to the General Assembly and the public and shall include:

(1) a complete fiscal projection of revenues and expenses, as described in subdivision (a)(5) of this section, including reserves, if recommended, and other costs in addition to the cost of services, over at least a five-year period for a public-private universal health care system providing benefits with an actuarial value of 80 percent or greater;

(2) the financing plans provided to the General Assembly in January 2013 pursuant to 2011 Acts and Resolves No. 48, Sec. 9;

(3) an analysis of how implementing Green Mountain Care will further the principles of health care reform expressed in 18 V.S.A. § 9371 beyond the reforms established through the Blueprint for Health; and

(4) a comparison of best practices for reducing health care costs in self-funded plans, if available. [Repealed.]

* * *

VT LEG #351888 v.2
§ 1825. HEALTH BENEFITS

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

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

(3) The Green Mountain Care Board shall consider whether to impose cost-sharing requirements; if so, whether to make the cost-sharing requirements income-sensitized; and the impact of any cost-sharing requirements on an individual’s ability to access care. The Board shall consider waiving any cost-sharing requirement for evidence-based primary and preventive care; for palliative care; and for chronic care for individuals participating in chronic care management and, where circumstances warrant, for individuals with chronic conditions who are not participating in a chronic care management program.

(4)(A) The Green Mountain Care Board established in 18 V.S.A. chapter 220 shall consider whether to include dental, vision, and hearing benefits in the Green Mountain Care benefit package.
(B) The Green Mountain Care Board shall consider whether to
include long-term care benefits in the Green Mountain Care benefit package.

(1) In the first year of its implementation, the Green Mountain Care
benefit package shall consist of:

(A) all primary care services, including outpatient mental health
services and services for treatment of substance use disorder;

(B) all testing necessary for the diagnosis of communicable diseases;

and

(C) all vaccines recommended by the Centers for Disease Control
and Prevention.

(2) There shall be no co-payment, coinsurance, deductible, or other cost-
sharing requirement for the services listed in subdivision (1) of this subsection
at any time.

(b)(1) In the second year of its implementation, the Green Mountain Care
benefit package shall consist of the benefits set forth in subsection (a) of this
section, as well as:

(A) all prophylactic dental services, including two cleaning visits and
dental exams per year, fluoride treatment as prescribed by a dentist, and annual
dental x-rays; and

(B) one vision exam per year, as well as screening for glaucoma and
macular disease, if indicated.
(2) There shall be no co-payment, coinsurance, deductible, or other cost-sharing requirement for the services listed in subdivision (1) of this subsection at any time.

(c)(1) The Green Mountain Care benefit package for years three through 10 shall consist of the benefits set forth in subsections (a) and (b) of this section, with additional services to be added by the General Assembly based on recommendations from the Green Mountain Care Board’s Universal Health Care Advisory Group, which shall prioritize the addition of the following:

(A) all prenatal and maternal care;

(B) all neonatal care;

(C) all standard diagnostic screenings at recommended intervals, including mammography, colonoscopy, blood glucose, blood cholesterol, bone density, and hearing testing;

(D) all medically necessary dental services, including dentures;

(E) all emergency services, including ambulance and emergency medical technician services;

(F) all physical therapy services prescribed by a health care professional;

(G) all durable medical equipment and prostheses prescribed by a health care professional:
(H) specialty care and outpatient treatment, including outpatient surgery and oncology services;

(I) home health and hospice care prescribed by a health care professional; and

(J) hospital inpatient care.

(2) The Green Mountain Care Board’s Universal Health Care Advisory Group shall also recommend to the General Assembly whether and to what extent the Green Mountain Care benefit package should include prescription drugs, rehabilitation services in a skilled nursing facility, and long-term care in a skilled nursing facility.

(3) The Green Mountain Care Board’s Universal Health Care Advisory Group may consider recommending to the General Assembly reasonable co-payment, but not coinsurance or deductible, requirements for services included in the Green Mountain Care benefit package for years three through 10.

(4) It is the intent of the General Assembly that, by the tenth year of Green Mountain Care, the Green Mountain Care benefit package should be at least as comprehensive as the benefit package contemplated for the program in 2011 Acts and Resolves No. 48.

(5)(d) Green Mountain Care shall not limit coverage of preexisting conditions.
(e) The Green Mountain Care Board shall approve the benefit package annually based on the provisions of subsections (a) through (c) of this section and present it to the General Assembly as part of its recommendations for the Green Mountain Care budget.

(b)(f)(1)(A) For individuals eligible for Medicaid or CHIP, the benefits for each year shall include all benefits included in the Green Mountain Care benefit package for that year to the extent those benefits exceed the benefits available to the individual through Medicaid or CHIP, as applicable. If the Agency successfully obtains Medicaid and CHIP waivers under subdivision 1827(g)(1) of this chapter, the benefit package shall include the benefits required by federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

(B) Upon implementation of Green Mountain Care, the benefit package for individuals eligible for Medicaid or CHIP shall also include any optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services covered under the State plan for CHIP as provided in 42 U.S.C. § 1397cc for which these individuals are eligible on January 1, 2014. Beginning with the second year of Green Mountain Care and going forward, the Green Mountain Care Board may, consistent with federal law, modify these optional benefits, as long as at all times the benefit package for these individuals contains at least the benefits described in subdivision (A) of this subdivision (b)(1).
(2) For children eligible for benefits paid for with Medicaid funds, the benefit package provided following receipt of Medicaid and CHIP waivers under subdivision 1827(g)(1) of this chapter shall include early and periodic screening, diagnosis, and treatment services as defined under federal law.

(3) For individuals eligible for Medicare, the benefits for each year shall include all benefits included in the Green Mountain Care benefit package for that year to the extent those benefits exceed the benefits available to the individual through Medicare. If the Agency successfully obtains a Medicare waiver under subdivision 1827(g)(2) of this chapter, the benefit package shall include the benefits provided to these individuals under federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

(4) For an individual eligible for health care coverage through the U.S. Department of Veterans Affairs, TRICARE, or the Federal Employees Health Benefits Program, the benefit package shall include all benefits included in the Green Mountain Care benefit package for that year to the extent those benefits exceed the benefits available to the individual through the applicable federal program.

(5) The Green Mountain Care benefits for individuals eligible for the health care programs described in subdivisions (1)–(4) of this subsection shall include coverage of any co-payment, coinsurance, and deductible amounts.
attributable to health care services that would have been covered without cost-sharing under Green Mountain Care at the time the individual received the services. If the services would have included a cost-sharing requirement under Green Mountain Care at the time the individual received the services, Green Mountain Care shall cover any applicable cost-sharing amount to the extent it exceeds the cost-sharing amount for those services under Green Mountain Care.

* * *

§ 1827. ADMINISTRATION; ENROLLMENT

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

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

(3) When considering contract bids pursuant to this subsection, the Agency shall consider the interests of the State relating to the economy, the
location of the entity, and the need to maintain and create jobs in Vermont.

The Agency may utilize an econometric model to evaluate the net costs of each contract bid.

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

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

(d) Except for cost-sharing as permitted by the General Assembly for services included in the Green Mountain Care benefit package for years three through ten, Vermonters shall not be billed any additional amount for health services covered by Green Mountain Care.

(e) The Agency shall issue to each Vermont resident an electronic benefit card that enables the individual named on the card to receive services covered by Green Mountain Care. The Agency shall update annually the database of covered services that the card enables the cardholder to receive through Green Mountain Care to align with the expansion of the Green Mountain Care benefit package pursuant to section 1825 of this chapter.

(f) Green Mountain Care shall be the payer of last resort with respect to any health service that may be covered in whole or in part by any other health benefit plan, including Medicaid, CHIP, Medicare, private health insurance,
retiree health benefits, or federal health benefit plans offered by the military or
to federal employees.

(g)(1) The Agency may seek a waiver under Section 1115 of the Social
Security Act to include Medicaid and under Section 2107(e)(2)(A) of the
Social Security Act to include CHIP in Green Mountain Care. If the Agency is
unsuccessful in obtaining one or both of these waivers, Green Mountain Care
shall be the secondary payer with respect to any health service that may be
covered in whole or in part by Title XIX of the Social Security Act (Medicaid)
or Title XXI of the Social Security Act (CHIP), as applicable.

(2) The Agency may seek a waiver from the Centers for Medicare and
Medicaid Services to include Medicare in Green Mountain Care. If the
Agency is unsuccessful in obtaining a Medicare waiver, Green Mountain Care
shall be the secondary payer with respect to any health service that may be
covered in whole or in part by Title XVIII (Medicare) of the Social Security
Act.

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

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

(j)(1) The Agency shall make available the necessary information, forms, access to eligibility or enrollment systems, and billing procedures to health care professionals to ensure immediate enrollment for individuals in Green Mountain Care at the point of service or treatment.

(2) Health care professionals shall submit claims to the Agency electronically for covered services delivered to Vermont residents.

(3)(A) To the extent health care professionals are reimbursed on a fee-for-service basis for services covered by Green Mountain Care, the Agency shall establish a single, standard reimbursement rate for each covered service, regardless of the type of health care professional delivering the care. The standard reimbursement rate shall be based on a percentage of the Medicare rate for the service, to the extent applicable.

(B) The Green Mountain Care Board may recommend to the General Assembly payment mechanisms other than fee-for-service for services covered by Green Mountain Care.

(k) An individual aggrieved by an adverse decision of the Agency or plan administrator may appeal to the Human Services Board as provided in 3 V.S.A. § 3090.
The Agency, in collaboration with the Department of Financial Regulation, shall monitor the extent to which residents of other states move to Vermont for the purpose of receiving health services and the impact, positive or negative, of any such migration on Vermont’s health care system and on the State’s economy, and make appropriate recommendations to the General Assembly based on its findings.

* * *

Sec. 3. 18 V.S.A. § 9384 is added to read:

§ 9384. UNIVERSAL HEALTH CARE ADVISORY GROUP

(a) Creation. There is created the Universal Health Care Advisory Group to advise the Green Mountain Care Board and the General Assembly regarding the implementation and financing of Green Mountain Care.

(b) Membership. The Advisory Group shall be composed of the following members:

(1) the Chair of the Green Mountain Care Board or designee;

(2) the Commissioner of Health or designee;

(3) the Commissioner of Vermont Health Access or designee;

(4) the Commissioner of Taxes or designee;

(5) the Chief Health Care Advocate in the Office of the Health Care Advocate or designee;

(6) the Chair of the House Committee on Ways and Means;
(7) the Chair of the Senate Committee on Finance;

(8) one member of the public who represents agriculture or small business and comes from a community characterized by a higher rate of social vulnerability, appointed by the Governor;

(9) one member of the public who is a primary care provider, appointed by the Speaker of the House; and

(10) one member of the public who is a patient advocate and comes from a community that is underserved with respect to health care access, appointed by the President Pro Tempore of the Senate.

(c) Powers and duties; report. The Advisory Group shall report annually to the General Assembly on or before January 15 regarding:

(1) the Advisory Group’s recommendations for the sequencing of publicly funded health care services to be added to the Green Mountain Care benefit package in years three through 10 of the program pursuant to 33 V.S.A. § 1825(c)(1);

(2) the Advisory Group’s recommendations with respect to whether and to what extent the Green Mountain Care benefit package should include prescription drugs, rehabilitation services in a skilled nursing facility, and long-term care in a skilled nursing facility;

(3) the Advisory Group’s recommendations with respect to whether Green Mountain Care should include reasonable co-payment requirements for
services included in the Green Mountain Care benefit package for years three through 10 and, if so, for which services and in what amounts;

(4) the Advisory Group’s recommendations for the financing of Green Mountain Care for years three through 10 of the program and beyond; and

(5) the frequency with which the Advisory Group believes it should meet in the years following the first year of the Advisory Group’s existence and its projected funding needs for payment of per diem compensation and reimbursement of expenses in accordance with subsection (f) of this section for the ensuing year.

(d) Assistance. The Advisory Group shall have the administrative, technical, and legal assistance of the Green Mountain Care Board.

(e) Meetings.

(1) The Chair of the Green Mountain Care Board shall call the first meeting of the Advisory Group to occur on or before September 1, 2021.

(2) The Chief Health Care Advocate or designee shall be the Chair of the Advisory Group.

(3) A majority of the membership shall constitute a quorum.

(4) The Advisory Group shall meet at least monthly during its first year and shall recommend to the General Assembly the frequency with which the Advisory Group believes it should meet in the following years.

(f) Compensation and reimbursement.
(1) For attendance at meetings during adjournment of the General Assembly, a legislative member of the Advisory Group serving in his or her capacity as a legislator shall be entitled to per diem compensation and reimbursement of expenses pursuant to 2 V.S.A. § 23 for not more than 12 meetings in the first year of the Advisory Group’s existence and as approved by the General Assembly for the following years. These payments shall be made from monies appropriated to the General Assembly.

(2) The public members of the Advisory Group appointed pursuant to subdivisions (b)(8)–(10) of this section shall be entitled to per diem compensation and reimbursement of expenses as permitted under 32 V.S.A. § 1010 for not more than 12 meetings in the first year of the Advisory Group’s existence and as approved by the General Assembly for the following years. These payments shall be made from monies appropriated to the Green Mountain Care Board.

Sec. 4. GREEN MOUNTAIN CARE; FINANCING; INTENT

It is the intent of the General Assembly that Green Mountain Care shall be financed as follows:

(1) for the first year of Green Mountain Care’s implementation, by a combination of a public premium and the revenue generated by a payroll tax, a self-employment tax, and the existing tax on cigarettes and tobacco products or tobacco settlement funds, or both;
(2) for the second year of Green Mountain Care’s implementation, by a combination of the revenue from a tax on sugar-sweetened beverages and monies from the General Fund; and

(3) for years three through 10 and beyond, as determined by the General Assembly following receipt of the recommendations from the Green Mountain Care Board’s Universal Health Care Advisory Group in accordance with 18 V.S.A. § 9384.

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

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, a health maintenance organization, or a managed care organization and not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this State, nor shall any endorsement, rider, or application that becomes a part of any such policy be used, until a copy of the form and of the rules for the classification of risks has been filed with the Department of Financial Regulation and a copy of the premium rates has been filed with the Green Mountain Care Board; and the Green Mountain Care Board has issued a decision approving, modifying, or disapproving the proposed rate.

* * *
(3) The Board shall determine whether a rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, does not reflect duplication of the coverage provided by Green Mountain Care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State. In making this determination, the Board shall consider the analysis and opinion provided by the Department of Financial Regulation pursuant to subdivision (2)(B) of this subsection.

* * *

(h)(1) The authority of the Board under this section shall apply only to the rate review process for policies for major medical insurance coverage and shall not apply to the policy forms for major medical insurance coverage or to the rate and policy form review process for policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, student health insurance coverage, Medicare supplemental coverage, or other limited benefit coverage; to short-term, limited-duration health insurance coverage; or to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred. Premium rates and rules for the classification of risk for Medicare supplemental insurance policies shall be governed by sections 4062b and 4080e of this title.
(2) The policy forms for major medical insurance coverage, as well as the policy forms, premium rates, and rules for the classification of risk for the other lines of insurance described in subdivision (1) of this subsection shall be reviewed and approved or disapproved by the Commissioner. In making his or her determination, the Commissioner shall consider whether a policy form, premium rate, or rule is affordable, does not duplicate coverage provided by Green Mountain Care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this State; and, for a policy form for major medical insurance coverage, whether it ensures equal access to appropriate mental health care in a manner equivalent to other aspects of health care as part of an integrated, holistic system of care. The Commissioner shall make his or her determination within 30 days after the date the insurer filed the policy form, premium rate, or rule with the Department. At the expiration of the 30-day period, the form, premium rate, or rule shall be deemed approved unless prior to then it has been affirmatively approved or disapproved by the Commissioner or found to be incomplete. The Commissioner shall notify an insurer in writing if the insurer files any form, premium rate, or rule containing a provision that does not meet the standards expressed in this subsection. In such notice, the Commissioner shall state that a hearing will be granted within 20 days upon the insurer’s written request.

* * *

VT LEG #351888 v.2
Sec. 6. IMPLEMENTATION; INTENT

It is the intent of the General Assembly that the first year of Green Mountain Care’s implementation begin on January 1, 2023.

Sec. 7. EFFECTIVE DATE

This act shall take effect on July 1, 2021.