

1 S.88

2 Introduced by Senators Flanagan, McCormack, Ashe, Ayer, Campbell,

3 Choate, Cummings, Giard, Hartwell, Kittell, Lyons,

4 MacDonald, Shumlin, Starr and White

5 Referred to Committee on Health and Welfare

6 Date: February 17, 2009

7 Subject: Health care; universal access; reform; department organization

8 Statement of purpose: This bill proposes to establish the goal of universal
9 access to essential health care services in Vermont through a publicly financed,
10 integrated, regional health care delivery system; provide mechanisms for cost
11 containment in the system; and provide a framework, schedule, and process to
12 achieve that goal.

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

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

16 ~~Sec. 1. FINDINGS~~

17 ~~The general assembly finds that:~~

18 ~~(1) Vermont's health care infrastructure and services are public goods~~

19 ~~that are essential to the well-being of every Vermonter, and yet the~~

1 ~~infrastructure and services, including hospitals and other care systems, are~~
2 financially threatened.

3 (A) The financial danger to Vermont's nonprofit hospitals is
4 evidenced by extremely narrow operating margins, rising costs, and increasing
5 levels of uncompensated care.

6 (B) Hospital budgets are challenged by uneven and uncertain
7 reimbursements received from a multitude of payers and by the escalating
8 costs associated with insurance administration and bill collection.

9 (C) Competition between hospitals for a market share has forced
10 hospitals to make decisions purely on the basis of financial concerns, rather
11 than on the basis of community needs.

12 (D) The closing or for-profit conversion of any of Vermont's
13 hospitals would severely impact Vermonters' access to quality health care
14 services.

15 (E) Primary care and preventive services in Vermont have become
16 more difficult to sustain because reimbursement rates favor advanced and
17 specialty care over primary care.

18 (F) Fewer medical students are choosing to practice primary care,
19 and many Vermont primary care physicians are nearing retirement.

1 ~~(C) Insurance administration and bill collection have become~~
2 ~~increasing burdens for primary care physicians, detracting from clinical~~
3 ~~practice.~~

4 ~~(H) Increasing numbers of uninsured patients pose high-stakes ethical~~
5 ~~dilemmas for physicians and other health professionals making treatment~~
6 ~~decisions.~~

7 ~~(I) Prevention, which can save lives as well as money, is~~
8 ~~short-changed as primary care options are diminished.~~

9 ~~(2) Health care costs are rising at an unsustainable rate, causing~~
10 ~~hardships to individuals, families, businesses, taxpayers, and public~~
11 ~~institutions, and uncontrolled costs are threatening to paralyze the economy of~~
12 ~~the state of Vermont.~~

13 ~~(A) In 2008, total Vermont health care spending was projected to be~~
14 ~~\$4.58 billion.~~

15 ~~(B) Health care costs have risen an average of 9–10 percent per year~~
16 ~~over the past 30–40 years, with the rate rising to 12–13 percent in more recent~~
17 ~~years. These figures are well above the Consumer Price Index and, moreover,~~
18 ~~exceed by far the state's capacity to pay for health care costs as measured~~
19 ~~against the state's gross state product and personal income. For example,~~
20 ~~between 2001 and 2006, health care spending in Vermont grew at an average~~
21 ~~annual rate of eight percent, while personal income grew at four percent and~~

1 ~~the gross state product grew at three percent. Between 2001 and 2006, health~~
2 ~~care spending increased approximately 48 percent, from \$2.5 billion to \$3.7~~
3 ~~billion, while over the same period, personal income rose approximately 20~~
4 ~~percent and the gross state product rose approximately 16 percent.~~

5 (C) The department of banking, insurance, securities, and health care
6 administration projects that health care spending for Vermont residents will
7 exceed \$5 billion by 2010.

8 (D) Over one-half of bankruptcies nationally are associated with high
9 medical expenses. In approximately three-quarters of health-related
10 bankruptcies, the patient had insurance.

11 (E) In 2006, the state of Vermont spent \$6,321.00 per capita on
12 health care, more than any nation in the Organization for Economic
13 Cooperation and Development—except the United States itself—when
14 measured as a proportion of gross domestic product.

15 (F) Vermont's health care spending was 16 percent of the gross state
16 product in 2006.

17 (G) The cost of health care has a strong negative impact on the ability
18 of Vermont businesses and employers to compete in national and international
19 markets.

20 (3) The current financing of health care is complex, fragmented, and
21 inequitable.

1 ~~(A) The current financing of health care is accomplished through an~~
2 ~~inefficient and uncoordinated patchwork of public programs, private sector~~
3 ~~employer-sponsored self-insurance, commercial insurance, and individual~~
4 ~~payers.~~

5 ~~(B) In general, costs fall disproportionately on those with serious~~
6 ~~health conditions, on those with moderate and lower incomes, and on those~~
7 ~~who pay for care out-of-pocket because they have no health insurance.~~

8 ~~(C) The current financing of health care in Vermont creates~~
9 ~~incentives and disincentives within the system that often contradict the~~
10 ~~standards of best medical practice.~~

11 ~~(D) The fragmented financing of health care results in a lack of~~
12 ~~coordination and accountability among health care professionals, payers, and~~
13 ~~patients at both the regional and statewide levels. The ability of the system to~~
14 ~~provide the highest quality of care to the greatest number of people and to~~
15 ~~respond to rapid changes in technology and medical advances is compromised.~~

16 ~~(4) For a growing number of Vermonters, health care is unaffordable~~
17 ~~and therefore not available without incurring serious debt.~~

18 ~~(A) Over 60,000 Vermonters have no health insurance. As a result,~~
19 ~~these citizens often do not receive care in the most timely and effective~~
20 ~~manner.~~

1 ~~(B) Lack of insurance is associated with an increased rate of illness~~
2 ~~and a shorter life expectancy.~~

3 ~~(C) Premium cost increases have contributed to the growing rate of~~
4 ~~underinsurance, with more and more Vermonters purchasing high-deductible~~
5 ~~and less comprehensive plans.~~

6 ~~(D) The disparities in coverage result in an unreasonable rationing of~~
7 ~~available health care services.~~

8 ~~(E) The costs of health services provided to individuals who are~~
9 ~~unable to pay are shifted onto others. Those who bear the burden of this cost~~
10 ~~shift have an increasingly difficult time affording their own health care costs,~~
11 ~~including premiums.~~

12 ~~(5) Although the quality of health care services in Vermont is generally~~
13 ~~very good, there is a need to improve quality, efficiency, and safety.~~

14 ~~(A) Nationwide, there are an unacceptable number of adverse events~~
15 ~~attributable to medical errors, according to an Institute of Medicine report.~~
16 ~~Vermont is not immune to this problem.~~

17 ~~(B) Disease and injury prevention, health promotion, and health~~
18 ~~protection continue to be overlooked as investments in public health.~~

19 Sec. 2. 3 V.S.A. § 212(23) is added to read:

20 ~~(23) The department of health care administration.~~

1 ~~Sec. 3. 18 V.S.A. chapter 8 is added to read:~~

2 CHAPTER 8. HEALTH CARE SERVICES AND ADMINISTRATION

3 Subchapter 1. General Provisions

4 § 401. GUIDELINES FOR HEALTH CARE REFORM

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

7 (1) The health care infrastructure, including hospitals, primary care, and
8 other services, must be preserved so that Vermonters continue to have care
9 available to them within their own communities.

10 (2) A system for eliminating unnecessary expenditures and containing
11 costs must be implemented so that health care spending does not bankrupt the
12 Vermont economy.

13 (3) The financing of health care in Vermont must be sufficient,
14 equitable, fair, and sustainable, and such financing is best obtained when
15 broad-based taxes replace insurance premiums and out-of-pocket payments.

16 (4) Universal access to health care is a public good, and therefore it is
17 the policy of the state of Vermont to ensure universal access to and coverage
18 for essential health care services for all Vermonters.

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

~~§ 402. GOALS OF HEALTH CARE REFORM~~

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

~~(1) Vermont's nonprofit community hospital system will be preserved through a system of negotiated payments that are drawn from public revenues and which are based on annual global budgets.~~

~~(2) Vermont's primary care providers will be adequately compensated from public revenues through a uniform payment system that eliminates multiple insurers and reduces administrative burdens on providers.~~

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

~~(A) are integrated with each other;~~

~~(B) focus on meeting community health needs;~~

~~(C) match service capacity to community needs;~~

~~(D) coordinate and integrate care across the health care continuum;~~

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

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

~~(G) improve continuously the quality of care provided.~~

1 ~~(4) To ensure financial sustainability of Vermont's health care system,~~
2 the state is committed to slowing the rate of growth of health care costs to
3 seven percent or less by the year 2014.

4 (5) Health care costs will be controlled by:

5 (A) a reduction in the number of payers of health care services and,
6 therefore, the simplification of reimbursement mechanisms throughout the
7 health care system;

8 (B) paying hospitals on the basis of annually negotiated global
9 budgets;

10 (C) the elimination of administrative costs associated with private
11 insurance and bill collection;

12 (D) the collective purchase of pharmaceuticals and other supplies
13 through the establishment of a state drug formulary;

14 (E) the alignment of health care professional reimbursement with
15 best practices and outcomes rather than utilization;

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

18 (G) reductions in the prevalence of defensive medicine along with the
19 prudent and efficient utilization of medical technology;

20 (H) encouraging the appropriate distribution of primary care services
21 throughout the state; and

1 ~~(1) removing competitive pressure between hospitals and other~~
2 ~~facilities.~~

3 (6) To ensure fair financing of Vermont's health care system, all
4 services covered by a state-sponsored benefits package will be financed
5 primarily from broad-based taxes.

6 (7) To alleviate the historical dependence of health care access on
7 employment, employers will be relieved of the burden of purchasing private
8 health insurance for their employees. Instead, employers will be required to
9 contribute a fair share of taxes toward the health care needs of the general
10 population.

11 (8) All Vermont residents, subject to reasonable residency requirements,
12 will be covered under a publicly sponsored benefits package, regardless of
13 their age, employment, economic status, or their town of residency, even if
14 they require health care while outside Vermont.

15 (9) All essential health services will be covered under the publicly
16 sponsored benefits package. A process will be developed to define essential
17 health services, taking into consideration scientific evidence, available funds,
18 and the values and priorities of Vermonters. Coverage will follow the
19 individual from birth to death and be responsive and seamless through
20 employment and life changes.

1 ~~(10) Vermonters' health outcomes and key indicators of public health~~
2 ~~will show continuous improvement across all segments of the population.~~

3 ~~(11) The number of adverse events from medical errors will be reduced.~~

4 ~~(12) Disease and injury prevention, health promotion, and health~~
5 ~~protection will be incorporated into a publicly sponsored health care system.~~

6 § 403. DEFINITIONS

7 As used in this chapter:

8 (1) "Board" means the Vermont health care board established by section
9 407 of this title to develop policy, approve reimbursement rates, hear appeals,
10 and perform other quasi-judicial functions relating to the administration and
11 implementation of VermontCare under this chapter.

12 (2) "Department" means the department of health care administration
13 established by section 404 of this title to administer the publicly sponsored
14 health care benefits package established under this chapter.

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

18 (4) "Health service" means any medically necessary treatment or
19 procedure to maintain, diagnose, or treat an individual's physical or mental
20 condition, including services provided pursuant to a physician's order and
21 services to assist in activities of daily living.

1 ~~(5) "Hospital" shall have the same meaning as in section 1902 of this~~
2 ~~title and may include a hospital located outside Vermont.~~

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

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

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

15 ~~(9) "VermontCare" means the package of essential health services~~
16 ~~established pursuant to this chapter.~~

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

Subchapter 2. Governance

§ 404. DEPARTMENT OF HEALTH CARE ADMINISTRATION

(a) On July 1, 2009, the department of health care administration is created and shall have the powers and duties established by this chapter. The department is the successor to and continuation of the division of health care administration of the department of banking, insurance, securities, and health care administration under chapter 221 of this title; the office of Vermont health access under section 3088 of Title 3; and the division of rate setting under chapter 9 of Title 33; and shall continue the duties of those departments as established in chapter 107 of Title 8, chapter 221 of this title, and chapters 9 and 19 of Title 33.

(b) The department shall be under the direction and supervision of a commissioner who shall be appointed by the governor with the advice and consent of the senate and shall serve at the pleasure of the governor.

(c) The department shall carry out its duties in such a way as to further the public good and shall follow the guidelines and goals established under this chapter.

(d) A health care quality unit is established in the commissioner's office and is responsible for establishing policy and procedures to improve, promote, and ensure quality of care and patient safety. The unit shall provide policy advice and oversight to the department to ensure that the department's

1 ~~functions are carried out in such a way as to promote quality and safety. The~~
2 unit shall also collaborate with government and private entities and
3 organizations which are engaged in efforts to improve quality of care.

4 § 405. AUTHORITY OF THE COMMISSIONER

5 (a) The commissioner shall be responsible to the governor and shall plan,
6 coordinate, and direct the functions vested in the department. The
7 commissioner shall prepare and submit to the governor an annual budget and
8 shall prepare and submit to the governor and the general assembly in
9 November of each year a report concerning the operations of the department
10 for the preceding state fiscal year and the future goals and objectives of the
11 department.

12 (b) The commissioner shall establish such divisions as are necessary to
13 carry out the duties of the department under this chapter and may establish
14 advisory panels as necessary to further the goals of this chapter. The
15 commissioner may employ professional and support staff necessary to carry
16 out the functions of the department and may employ consultants and contract
17 with individuals and entities for the provision of services.

18 (c) The commissioner may, subject to the provisions of section 5 of
19 Title 32, apply for and accept gifts, grants, or contributions from any person
20 for purposes consistent with this chapter.

21 (d) The commissioner shall meet regularly with representatives of the

1 ~~community health boards established in section 408 of this title, professional~~
2 ~~organizations, consumer groups, and other statewide organizations in order to~~
3 ~~ensure that there is public input into the implementation and ongoing~~
4 ~~administration of the provisions of this chapter.~~

5 ~~(e) The commissioner shall consult and collaborate with the secretary of~~
6 ~~human services and the commissioner of education to ensure the effective and~~
7 ~~efficient operation of the provisions of this chapter.~~

8 ~~(f) The commissioner may delegate the powers and assign the duties~~
9 ~~transferred from other departments, offices, and divisions to the department of~~
10 ~~health care administration in such a manner as the commissioner deems~~
11 ~~appropriate.~~

12 ~~(g) The commissioner may adopt rules pursuant to chapter 25 of Title 3 to~~
13 ~~implement VermontCare as established by this chapter.~~

14 ~~(h) Subject to the approval of the general assembly, the commissioner may~~
15 ~~apply for any waivers of federal law or regulation necessary to carry out the~~
16 ~~provisions of this chapter.~~

17 § 406. DUTIES OF THE DEPARTMENT

18 In addition to the duties transferred pursuant to subsection 404(a) of this
19 title, the department of health care administration shall:

20 (1) As directed by the health care board, implement a system of payment
21 methodologies and amounts for hospitals and health care professionals under

1 ~~this chapter.~~

2 (2) Implement the cost reduction targets established under subsection
3 410(c) of this title.

4 (3) Conduct planning and analysis, including designing and
5 implementing procedures to evaluate, measure, and report to the governor and
6 general assembly whether the guidelines under section 401 of this title and the
7 goals under section 402 of this title are being met.

8 (4) Establish and maintain a database with information needed to carry
9 out the commissioner's duties and obligations.

10 (5) Administer any spending for VermontCare established under this
11 chapter, which may include any billing or collection functions necessary to
12 implement this chapter.

13 (6) Establish a Vermont drug formulary that will negotiate discounts
14 from manufacturers and establish uniform standards for prescription drug
15 utilization under VermontCare.

16 § 407. HEALTH CARE BOARD

17 (a) On July 1, 2009, a Vermont health care board is created and shall have
18 the powers and duties established by this chapter. The board shall receive
19 administrative support from the department. The board shall consist of one
20 member appointed by the governor, one member appointed by the speaker of
21 the house of representatives, and one member appointed by the president pro

1 ~~tempore of the senate. The initial term of the member appointed by the~~
2 ~~governor shall be three years, the initial term of the member appointed by the~~
3 ~~speaker of the house shall be two years, and the initial term of the member~~
4 ~~appointed by the president pro tempore of the senate shall be one year.~~
5 ~~Thereafter, each term shall be for three years. Members shall be removed only~~
6 ~~for cause. The member appointed by the governor shall be the chair. All~~
7 ~~members shall be part-time state employees. All members shall be exempt~~
8 ~~from the state classified system. A person in the employ of or holding any~~
9 ~~official relation to any health care provider subject to the supervision of the~~
10 ~~board, or engaged in the management of such health care provider, or owning~~
11 ~~stock, bonds, or other securities thereof, or who is, in any manner, connected~~
12 ~~with the operation of such health care provider shall not be a member of the~~
13 ~~board; nor shall any person holding the office of member personally or in~~
14 ~~connection with a partner or agent render professional health care services or~~
15 ~~make or perform any business contract with any health care provider subject to~~
16 ~~the board's supervision if such service or contract relates to the business of the~~
17 ~~health care provider, except contracts made as an individual or family in the~~
18 ~~regular course of obtaining health care services.~~

19 (b) The board shall:

20 (1) Develop the package of essential health services to be covered under
21 VermontCare pursuant to section 409 of this title. The board shall ensure the

1 ~~package of essential health services will provide a choice of services and of~~
2 ~~health care professionals, contain costs over time, and improve the quality of~~
3 ~~care and health outcomes. In developing the package of essential health~~
4 ~~services, the board shall:~~

5 ~~(A) engage in a public process designed to respond to Vermonters'~~
6 ~~health care values and priorities;~~

7 ~~(B) consider the current range of health services received by~~
8 ~~Vermonters through public and private benefit packages;~~

9 ~~(C) consider credible evidence-based scientific research and~~
10 ~~comments by health care professionals both nationally and internationally~~
11 ~~concerning clinical efficacy and risk;~~

12 ~~(D) consider health care ethics;~~

13 ~~(E) consider the cost-effectiveness of health services and technology;~~

14 ~~(F) consider revenues anticipated to be available to finance~~
15 ~~VermontCare;~~

16 ~~(G) consider the state health plan and the health resource allocation~~
17 ~~plan established under section 9405 of this title; and~~

18 ~~(H) consider any Vermont-specific initiatives.~~

19 ~~(2) Establish a system of payment methodologies and amounts for~~
20 ~~hospitals and health care professionals under this chapter.~~

21 ~~(c) On or before February 1, 2011, the board shall propose to the general~~

1 ~~assembly the package of essential health services to be covered under~~

2 VermontCare, to begin July 1, 2013.

3 (d) The board shall have the authority provided, and its proceedings shall
4 be governed by provisions of the Administrative Procedure Act relating to
5 contested cases in chapter 25 of Title 3.

6 (e) Beginning July 1, 2011, the board shall have jurisdiction to:

7 (1) hear contested cases for aggrieved parties of an adverse decision
8 under chapter 19 of Title 33 and under this chapter;

9 (2) hear consumer complaints relating to health services;

10 (3) approve or amend reimbursement rates and methodologies
11 established under this chapter, including global hospital budgets under section
12 414 of this title; and

13 (4) approve or amend certificate of need proposals under subchapter 5 of
14 chapter 221 of this title, the unified health care budget under section 9406 of
15 this title, and hospital budget reviews under subchapter 7 of chapter 221 of this
16 title.

17 § 408. INTEGRATED SYSTEMS OF CARE; COMMUNITY HEALTH

18 BOARDS

19 (a) The delivery of health care in Vermont shall be integrated in order to
20 provide a coordinated continuum of services to the citizens of Vermont and to
21 improve health outcomes. Communities will integrate their health care

1 ~~systems by organizing existing health care professionals, health care~~
2 ~~institutions, and community members into a community health board that will~~
3 ~~act to assess, prioritize, and define community health needs.~~

4 ~~(b) Based on a plan adopted by the general assembly, there shall be~~
5 ~~established a community health board in each region of the state. There shall~~
6 ~~be no fewer than three regions. The community health boards shall be~~
7 ~~implemented no later than January 1, 2011.~~

8 ~~(c) Each community health board shall have the following duties: solicit~~
9 ~~public input; conduct a community needs assessment for incorporation into the~~
10 ~~health resources allocation plan; plan for community health needs based on the~~
11 ~~community needs assessment; develop budget recommendations and resource~~
12 ~~allocations for the region; and provide oversight and evaluation regarding the~~
13 ~~delivery of care in its region.~~

14 Subchapter 3. VermontCare

15 § 409. VERMONTCARE; IMPLEMENTATION DATES

16 ~~(a) The department of health care administration shall implement~~
17 ~~VermontCare to provide Vermont residents coverage for hospital services no~~
18 ~~later than July 1, 2011 and coverage for primary and preventive health services~~
19 ~~no later than July 1, 2012.~~

1 ~~(b) No later than July 1, 2013, VermontCare shall include all other essential~~
2 health services in addition to primary care, preventive care, and hospital
3 services to Vermont residents.

4 § 410. BUDGET FOR PACKAGE OF HEALTH SERVICES

5 (a) After approval of the package of health services by the general
6 assembly pursuant to subsection 407(c) of this title, the department shall
7 develop a budget for the package based on the payment methodologies under
8 section 411 of this title, negotiated payment amounts under section 412 of this
9 title, and the cost containment targets under subsection (c) of this section.

10 (b) For each state fiscal year, beginning with state fiscal year 2012, the
11 department shall propose its budget for the package of health services to the
12 general assembly on or before January 15 of each year, including
13 recommended expenditures during the next succeeding state fiscal year broken
14 down by health care sector and region, and anticipated revenues available to
15 support such expenditures.

16 (c) To further the goals established in section 402 of this title, the
17 department shall develop and issue a cost containment target for each health
18 care sector. The cost containment target shall be considered when negotiating
19 payment amounts under section 412 of this title.

§ 411. PAYMENT METHODOLOGIES FOR HEALTH CARE

PROFESSIONALS AND HOSPITALS

(a) Under the direction of the board, by February 1, 2010, the department shall determine by rule pursuant to chapter 25 of Title 3 the type of payment method to be used for each health care sector which provides health services under VermontCare. The payment methods shall be in alignment with the goals of this chapter and shall encourage cost-containment, provision of high quality, evidence-based health services in an integrated setting, patient self-management, and healthy lifestyles. In developing the payment methods, the board shall consult with health care professionals prior to the department filing draft rules for comment.

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

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

(2) capitated payments;

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

1 ~~(4) fee supplements if necessary to encourage specialized health care~~
2 professionals to offer a specific, necessary health service which is not available
3 in a specific geographic region; and

4 (5) fee for service.

5 § 412. PAYMENT AMOUNTS

6 (a) The intent of this section is to ensure reasonable payments to health
7 care professionals and to eliminate the shift of costs between the payers of
8 health services by ensuring that the amount paid to health care professionals
9 under VermontCare is sufficient.

10 (b) The department shall negotiate with hospitals, health care professionals,
11 and groups of health care professionals to establish payment amounts for
12 health services provided by VermontCare. The amounts shall be sufficient to
13 provide reasonable access to health services, provide sufficient uniform
14 payment to health care professionals, and encourage the financial stability of
15 health care professionals. In determining the payment amounts, the board shall
16 consider:

17 (1) the advice and recommendations of the board;

18 (2) the actual cost of the health service;

19 (3) expected revenues;

20 (4) cost containment targets; and

21 (5) shared costs between affiliated health care professionals.

1 ~~(c) The department shall negotiate with each hospital to establish a global~~
2 ~~hospital payment for health services covered by VermontCare and provided by~~
3 ~~the hospital. The department shall consider the global hospital budget under~~
4 ~~section 414 of this title and other information necessary to the determination of~~
5 ~~the appropriate payment, including all revenue received from other sources.~~
6 ~~The global hospital payment shall be reflected as a specific line item in the~~
7 ~~department's annual budget submitted to the general assembly.~~

8 (d) The department shall negotiate a contract including payment methods
9 and amounts with any out-of-state hospital that regularly treats a sufficient
10 volume of Vermont residents to provide health services under VermontCare.
11 The department may also contract with out-of-state hospitals for the provision
12 of specialized health services under VermontCare that are not available locally
13 to Vermonters.

14 (e) The department shall pay the amount charged for a medically necessary
15 health service for which the individual received a referral or for an emergency
16 health service customarily covered by VermontCare received in an out-of-state
17 hospital with which the department has not established a contract. The
18 department shall develop a reference pricing system for nonemergency health
19 services usually covered by VermontCare which are received in an out-of-state
20 hospital with which the department has not contracted.

1 ~~(f) To facilitate negotiation of payment amounts under this section, the~~
2 ~~commissioner may approve the creation of one or more health care~~
3 ~~professional bargaining groups, consisting of health care professionals who~~
4 ~~choose to participate. The commissioner shall adopt by rule criteria for~~
5 ~~forming and approving bargaining groups, and criteria and procedures for~~
6 ~~negotiations authorized by this section. In authorizing the activities provided~~
7 ~~for in this section, the general assembly intends to displace state and federal~~
8 ~~antitrust laws by granting state action immunity for actions that might~~
9 ~~otherwise be considered to be in violation of state or federal antitrust laws.~~

10 § 413. VERMONTCARE TRUST FUND

11 (a) The VermontCare trust fund is hereby established in the state treasury
12 for the purpose of establishing a special fund to be the single source to finance
13 health care coverage for beneficiaries of VermontCare as established under this
14 subchapter.

15 (b) Into the fund shall be deposited:

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

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

20 (c) The fund shall be administered pursuant to subchapter 5 of chapter 7 of
21 Title 32, except that interest earned on the fund and any remaining balance

1 ~~shall be retained in the fund. The department of health care administration~~
2 ~~shall maintain records indicating the amount of money in the fund at any time.~~

3 ~~(d) All monies received by or generated to the fund shall be used only for~~
4 ~~the administration and delivery of health care covered through the~~
5 ~~VermontCare program administered by the department of health care~~
6 ~~administration under this subchapter.~~

7 ~~(e) To the extent permitted under federal law and any Medicaid waiver,~~
8 ~~including the Global Commitment for Health Medicaid Section 1115 waiver,~~
9 ~~the monies received by or generated to the fund shall be matched by federal~~
10 ~~funds.~~

11 § 414. GLOBAL HOSPITAL BUDGETS

12 ~~(a) For each hospital fiscal year, beginning with hospital fiscal year 2012,~~
13 ~~the department shall develop a global hospital budget for each hospital located~~
14 ~~in Vermont. When developing the global hospital budget, the department shall~~
15 ~~consider the health resource allocation plan under section 9405 of this title and~~
16 ~~the unified health care budget under section 9406 of this title, as applicable to~~
17 ~~hospitals, the hospital budget review under section 9456 of this title, the global~~
18 ~~hospital payments under subsection 412(c) of this title, and all other revenue~~
19 ~~received by hospitals. The global hospital budget shall be submitted to the~~
20 ~~board for approval with sufficient time for the board to approve the budget no~~
21 ~~later than September 1 prior to the hospital fiscal year.~~

1 ~~(b) For hospital fiscal year 2012 and thereafter, the global hospital budget~~
2 developed under subsection (a) of this section shall serve as a spending cap
3 within which hospital costs are controlled, resources directed, and quality and
4 access assured. The global hospital budget shall limit the total annual growth
5 of hospital costs to the Consumer Price Index plus three percent. Prior to
6 hospital fiscal year 2012, the growth rate of the Consumer Price Index plus
7 three percent shall serve as a target amount. The department shall ensure that
8 hospital budget reviews and certificates of need are consistent with the global
9 hospital budget.

10 (c) The department shall adopt rules specifying the circumstances under
11 which a hospital may seek amendment of its budget after approval by the
12 board. An amendment to a hospital's budget shall be reviewed by the
13 department before submission to the board for approval.

14 (d) The department may adopt rules for the development of a voluntary
15 three-year global hospital budget process to facilitate long-term planning and
16 to moderate variation in utilization. The rules shall include a process for
17 annual budget adjustment within the three-year period.

18 (e) A hospital or health care professional aggrieved by an adverse decision
19 of the department may appeal to the board.

§ 415. ADMINISTRATION; ENROLLMENT

(a) The department shall administer VermontCare or, under an open bidding process, solicit and receive bids from insurance carriers or third-party administrators for administration.

(b) Nothing in this chapter shall require an individual to enroll in VermontCare. Notwithstanding this provision, an individual who qualifies for enrollment and who seeks services covered by VermontCare shall be automatically enrolled.

(c) Nothing in this chapter shall require an individual covered by health insurance to terminate that insurance. Notwithstanding this provision, after July 1, 2013, private insurance companies shall hereby be prohibited from selling health insurance policies in Vermont that cover services already covered by VermontCare.

(d) An individual may elect to maintain supplemental health insurance if the individual so chooses, provided that after July 1, 2013, the supplemental insurance covers only services that are not already covered by VermontCare.

(e) Vermonters shall not be billed any additional amount for health services covered by VermontCare.

(f) The assistance provided under this chapter shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XVIII of the Social Security Act (Medicare) or by any other health

1 ~~benefit plan funded solely with federal funds, such as federal health benefit~~
2 ~~plans offered by the Veterans' Administration or to federal employees.~~

3 ~~(g) The department shall ensure that VermontCare complies with the~~
4 ~~provisions of Title XIX of the Social Security Act (Medicaid) unless the~~
5 ~~department, after approval of the general assembly, seeks and receives a~~
6 ~~federal waiver.~~

7 ~~(h) Any prescription drug coverage offered by VermontCare required by~~
8 ~~this chapter shall be consistent with the standards and procedures applicable to~~
9 ~~the pharmacy best practices and cost control program established by sections~~
10 ~~1996 and 1998 of Title 33 and the state drug formulary.~~

11 ~~(i) The department or plan administrator shall make available the necessary~~
12 ~~information, forms, and billing procedures to health care professionals to~~
13 ~~ensure payment for health services covered under VermontCare.~~

14 ~~(j) An individual aggrieved by an adverse decision of the department or~~
15 ~~plan administrator may appeal to the board.~~

16 Sec. 4. TRANSFER OF POSITIONS

17 ~~(a) Effective October 1, 2009 and consistent with the provisions of this act,~~
18 ~~the secretary of administration shall transfer to the department of health care~~
19 ~~administration and place under the supervision of the department's~~
20 ~~commissioner:~~

1 ~~(1) All employees, contracts, consultants, and positions of the office of~~
2 ~~Vermont health access under section 3088 of Title 3 and the remaining~~
3 ~~balances of all appropriation amounts for personal services and operating~~
4 ~~expenses.~~

5 ~~(2) All employees, contracts, consultants, and positions of the division~~
6 ~~of rate setting under chapter 9 of Title 33 and the remaining balances of all~~
7 ~~appropriation amounts for personal services and operating expenses.~~

8 ~~(3) All employees, contracts, consultants, and positions of the division~~
9 ~~of health care administration pursuant to chapter 221 of Title 18 and the~~
10 ~~remaining balances of all appropriation amounts for personal services and~~
11 ~~operating expenses.~~

12 ~~(b) On or before November 1, 2009, the secretary of administration, in~~
13 ~~consultation with the commissioner of health care administration, shall provide~~
14 ~~a detailed report to the joint fiscal committee of all the transfers made under~~
15 ~~this section.~~

16 Sec. 5. STATUTORY REVISION AND RECODIFICATION

17 ~~The legislative council shall revise the Vermont Statutes Annotated as~~
18 ~~necessary to reflect the purposes of this act, including recodification of the~~
19 ~~provisions in chapter 107 of Title 8, chapters 9 and 19 of Title 33, and chapter~~
20 ~~221 of Title 18, and the renaming throughout the statutes of the department of~~

1 ~~banking, insurance, securities, and health care administration as the department~~
2 ~~of banking, insurance, and securities.~~

3 Sec. 6. APPROPRIATION; POSITIONS

4 ~~(a) Fiscal year 2009. The amount of \$60,000.00 is appropriated from the~~
5 ~~general fund to the secretary of administration in fiscal year 2009 for the health~~
6 ~~care board established in section 407 of Title 18 by Sec. 2 of this act.~~

7 ~~(b) Fiscal year 2010. The amount of \$120,000.00 is appropriated from the~~
8 ~~general fund to the department of health care administration in fiscal year 2010~~
9 ~~for the purposes of establishing the department of health care administration.~~

10 ~~Beginning in fiscal year 2010, there are established in the department two new~~
11 ~~exempt positions: one commissioner of the department of health care~~
12 ~~administration and one staff assistant. These positions shall be transferred and~~
13 ~~converted from existing vacant positions in the executive branch of state~~
14 ~~government.~~

15 ~~(c) The department of health care administration is authorized to seek~~
16 ~~matching funds to assist with carrying out the purposes of this act. In addition,~~
17 ~~it may accept any and all donations, gifts, and grants of money, equipment,~~
18 ~~supplies, materials, and services from the federal or any local government, or~~
19 ~~any agency thereof and from any person, firm, or corporation for any of its~~
20 ~~purposes and functions under this act and may receive and use the same subject~~

1 ~~to the terms, conditions, and regulations governing such donations, gifts, and~~
2 ~~grants.~~

3 Sec. 7. REPEAL

4 (a) Section 9403 of Title 18 (division of health care administration of the
5 department of banking, insurance, securities, and health care administration),
6 section 3088 of Title 3 (the office of Vermont health access), and section 902
7 of Title 33 (the division of rate setting) are repealed October 1, 2009, and the
8 divisions and offices are transferred to the department of health care
9 administration established in this act.

10 (b) Section 4080f of Title 8 (Catamount Health) is repealed on July 1, 2011
11 with respect to hospital services, on July 1, 2012 with respect to primary and
12 preventive care services, and on July 1, 2013 with respect to all other services
13 covered by VermontCare.

14 (c) Section 4080c of Title 8 (health insurance safety net) is repealed on
15 July 1, 2013.

16 (d) Chapter 25 of Title 21 (employers' health care premium contribution) is
17 repealed on July 1, 2013.

18 (e) Section 1986 of Title 33 (Catamount fund) is repealed on July 1, 2013
19 and any monies remaining in the fund shall be transferred to the general fund.

20 Sec. 8. EFFECTIVE DATES AND TRANSITION

21 (a) This act shall take effect upon passage.

1 ~~(b) The commissioner of the department of health care administration shall~~
2 ~~be appointed within 60 days after passage.~~

3 ~~(c) Unless explicitly repealed by this act, current law and regulation are~~
4 ~~intended to remain effective and operational, and these functions shall remain~~
5 ~~with the agency, department, or division designated by law or its successor in~~
6 ~~interest.~~

Sec. 1. FINDINGS

The general assembly finds that:

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

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

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

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

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

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

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

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

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

~~level or that the annual deductible for the health insurance plan exceeded five percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums. Most Vermonters are a job loss away from being uninsured.~~

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

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

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

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

~~* * * HEALTH CARE SYSTEM DESIGN * * *~~

~~Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM~~

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

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

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

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

~~(4) Vermont's health delivery system must model continuous~~

~~improvement of health care quality and safety and, therefore, the system must be accountable in access, cost, quality, and reliability.~~

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

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

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

~~Sec. 3. GOALS OF HEALTH CARE REFORM~~

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

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

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

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

~~(A) are coordinated;~~

~~(B) focus on meeting community health needs;~~

~~(C) match service capacity to community needs;~~

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

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

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

~~(G) contain costs.~~

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

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

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

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

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

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

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

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

~~(G) increasing price and quality transparency.~~

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

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

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

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

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

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

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

~~§ 901. CREATION OF COMMISSION~~

~~(a) There is established a commission on health care reform. The commission, under the direction of co-chairs who shall be appointed by the speaker of the house and president pro tempore of the senate, shall monitor~~

~~health care reform initiatives and recommend to the general assembly actions needed to attain health care reform.~~

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

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

~~***~~

~~Sec. 5. APPOINTMENT; COMMISSION ON HEALTH CARE REFORM~~

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

~~Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN~~

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

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

~~(3) Each design option shall include sufficient detail to allow the~~

~~governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.~~

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

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

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

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

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

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

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

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

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

~~(2) coordinated local delivery systems;~~

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

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

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

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

~~(1) A payment system for health services.~~

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

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

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

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

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

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

~~(ii) enrollment processes.~~

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

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

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

~~(i) amendments necessary to current law on the unified health~~

~~care budget, including consideration of cost containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.~~

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

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

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

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

~~(II) capitated payments;~~

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

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

~~(V) diagnosis-related groups;~~

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

~~(VIII) fee for service.~~

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

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

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

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

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

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

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

~~(D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the~~

~~option may include a fee assessed on insurers combined with a global budget to streamline administration of health services.~~

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

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

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

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

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

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

~~(B) a proposal to the Centers on Medicare and Medicaid Services to~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(E) impacts on the state's economy;~~

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

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

Sec. 7. GRANT FUNDING

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

Sec. 7a. HOSPITAL BUDGETS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~Sec. 7d. REPEAL~~

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

~~Sec. 7e. INSURANCE REGULATION; INTENT~~

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

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

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

~~by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.~~

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

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

~~Sec. 8. APPROPRIATION~~

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

~~Sec. 9. EFFECTIVE DATES~~

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

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

~~*** HEALTH CARE REFORM PROVISIONS ***~~

~~Sec. 1. FINDINGS~~

~~The general assembly finds that:~~

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

~~(2) The cost of health care in Vermont is estimated to increase by \$1 billion, from \$4.9 billion in 2010 to \$5.9 billion, by 2012.~~

~~(3) Vermont's per-capita health care expenditures are estimated to be \$9,463.00 in 2012, compared to \$7,414.00 per capita in 2008.~~

~~(4) The average annual increase in Vermont per-capita health care expenditures from 2009 to 2012 is expected to be 6.3 percent. National per-capita health care spending is projected to grow at an average annual rate of 4.8 percent during the same period.~~

~~(5) From 2004 to 2008, Vermont's per-capita health care expenditures grew at an average annual rate of eight percent compared to five percent for the United States.~~

~~(6) At the national level, health care expenses are estimated at 18 percent of GDP and are estimated to rise to 34 percent by 2040.~~

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

(8) Of the approximately 47,000 Vermonters who remain uninsured, more than one-half qualify for state health care programs, and nearly 40 percent of those who qualify do so at an income level which requires no premium.

(9) Many Vermonters do not access health care because of unaffordable insurance premiums, deductibles, co-payments, and coinsurance.

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

(11) At a time when high health care costs are negatively affecting families, employers, nonprofit organizations, and government at the local, state, and federal levels, Vermont is making positive progress toward health care reform.

(12) An additional 30,000 Vermonters are currently covered under state health care programs than were covered in 2007, including approximately 12,000 Vermonters who receive coverage through Catamount Health.

(13) Vermont's health care reform efforts to date have included the Blueprint for Health, a vision, plan, and statewide partnership that strives to strengthen the primary care health care delivery and payment systems and create new community resources to keep Vermonters healthy. Expanding the Blueprint for Health statewide may result in a significant systemwide savings in the future.

(14) Health information technology, a system designed to promote patient education, patient privacy, and licensed health care practitioner best practices through the shared use of electronic health information by health care facilities, health care professionals, public and private payers, and patients, has already had a positive impact on health care in this state and should continue to improve quality of care in the future.

(15) Indicators show Vermont's utilization rates and spending are significantly lower than those of the vast majority of other states. However, significant variation in both utilization and spending are observed within Vermont which provides for substantial opportunity for quality improvements and savings.

(16) Other Vermont health care reform efforts that have proven beneficial to thousands of Vermonters include Dr. Dynasaur, VHAP, Catamount Health, and the department of health's wellness and prevention initiatives.

(17) Testimony received by the senate committee on health and welfare and the house committee on health care makes it clear that the current best efforts described in subdivisions (12), (13), (14), (15), and (16) of this section will not, on their own, provide health care coverage for all Vermonters or sufficiently reduce escalating health care costs.

(18) Only continued structural reform will provide all Vermonters with access to affordable, high quality health care.

(19) Federal health care reform efforts will provide Vermont with many opportunities to grow and a framework by which to strengthen a universal and affordable health care system.

(20) To supplement federal reform and maximize opportunities for this state, Vermont must provide additional state health care reform initiatives.

* * * HEALTH CARE SYSTEM DESIGN * * *

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

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

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

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

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

(4) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.

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

(6) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be evaluated for improvement in access, quality, and reliability and for a reduction in cost.

(7) A system for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and reducing care that does not improve health outcomes, must be implemented for the health of the Vermont economy.

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

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

Sec. 3. GOALS OF HEALTH CARE REFORM

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

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

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

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

(A) are coordinated;

(B) focus on meeting community health needs;

(C) match service capacity to community needs;

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

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

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

(G) contain costs.

(4) To ensure financial sustainability of Vermont's health care system, the state is committed to slowing the rate of growth of total health care costs, preferably to reducing health care costs below today's amounts, and to raising revenues that are sufficient to support the state's financial obligations for health care on an ongoing basis.

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

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

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

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

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

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

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

(G) increasing price and quality transparency.

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

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

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

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

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

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

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

§ 901. CREATION OF COMMISSION

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

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

(2) The two nonvoting members with experience in health care shall not:

(A) be in the employ of or holding any official relation to any health care provider or insurer or be engaged in the management of a health care provider or insurer;

(B) own stock, bonds, or other securities of a health care provider or insurer, unless the stock, bond, or other security is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the member chooses the stock, bond, or security;

(C) in any manner, be connected with the operation of a health care provider or insurer; or

(D) render professional health care services or make or perform any business contract with any health care provider or insurer if such service or contract relates to the business of the health care provider or insurer, except contracts made as an individual or family in the regular course of obtaining health care services.

* * *

Sec. 5. APPOINTMENT; COMMISSION ON HEALTH CARE REFORM

Within 15 days of enactment, the speaker of the house and the president pro tempore of the senate shall appoint the new members of the joint legislative commission on health care reform as specified in Sec. 4 of this act. All other

current members, including those appointed by the governor and the legislative members, shall continue to serve their existing terms.

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

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

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

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

(B) One option shall design a public health benefit option administered by state government, which allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans.

(C) A third and any additional options shall be designed by the consultant, in consultation with the commission, taking into consideration the principles in Sec. 2 of this act, the goals in Sec. 3, and the parameters described in this section.

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

(b)(1) No later than 45 days after enactment, the commission shall propose to the joint fiscal committee a recommendation, including the requested amount, for one or more outside consultants who have demonstrated experience in designing health care systems that have expanded coverage and

contained costs to provide the expertise necessary to do the analysis and design required by this act. Within seven days of the commission's proposal, the joint fiscal committee shall meet and may accept, reject, or modify the commission's proposal.

(2) The commission shall serve as a resource for the consultant by providing information and feedback to the consultant upon request, by recommending additional resources, and by receiving periodic progress reports by the consultant as needed. In order to maintain the independence of the consultant, the commission shall not direct the consultant's recommendations or proposal.

(c) In creating the designs, the consultant shall review and consider the following fundamental elements:

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

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

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

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

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

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

(2) coordinated regional delivery systems;

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

(4) financing and estimated costs, including federal financings; and

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

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

(1) A payment system for health services.

(A)(i) Packages of health services. In order to allow the general assembly a choice among varied packages of health services in each design option, the consultant shall provide at least two packages of health services providing for the integration of physical and mental health as further described in subdivision (A)(ii) of this subdivision (1) as part of each design option.

(ii)(I) Each design option shall include one package of health services which includes access to and coverage for primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health and substance abuse services.

(II) For each design option, the consultant shall consider including at least one additional package of health services, which includes the services described in subdivision (A)(ii)(I) of this subdivision (1) and coverage for supplemental health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services.

(iii)(I) For each proposed package of health services, the consultant shall consider including a cost-sharing proposal that may provide a waiver of any deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.

(II) For each proposed package of health services, the consultant shall consider including a proposal that has no cost-sharing. If this proposal is included, the consultant shall provide the cost differential between subdivision (A)(iii)(I) of this subdivision (1) and this subdivision (II).

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

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

(ii) enrollment processes.

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

utilization reviews.

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

(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. Payment methods for mental health services shall be consistent with mental health parity. The consultant shall consider:

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

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

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

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

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

(II) capitated payments;

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

(IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is

not available in a specific geographic region;

(V) diagnosis-related groups;

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

(VII) fee for service.

(v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should be in an amount which provides reasonable access to health services, provides sufficient uniform payment to health care professionals, and assists to create financial stability of health care professionals. Payment amounts shall be consistent with mental health parity. The consultant shall consider the following processes:

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

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

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

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

(V) Developing a reference pricing system for nonemergency

health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract.

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

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

(2) Coordinated regional health systems. The consultant shall propose in each design a coordinated regional health system, which ensures that the delivery of health services to the citizens of Vermont is coordinated in order to improve health outcomes, improve the efficiency of the health system, and improve patients' experience of health services. The consultant shall review and analyze Vermont's existing efforts to reform the delivery of health care, including the Blueprint for Health described in chapter 13 of Title 18, and consider whether to build on or improve current reform efforts. In designing coordinated regional health systems, the consultant shall consider:

(A) how to ensure that health professionals, hospitals, health care facilities, and home- and community-based service providers offer health services in a coordinated manner designed to optimize health services at a lower cost, to reduce redundancies in the health system as a whole, and to improve quality;

(B) the creation of regional mechanisms to solicit public input for the regional health system; conduct a community needs assessment for incorporation into the health resources allocation plan; and plan for community health needs based on the community needs assessment; and

(C) the development of a regional entity, organization, or another mechanism to manage health services for that region's population, which may include making budget recommendations and resource allocations for the region; providing oversight and evaluation regarding the delivery of care in its region; developing payment methodologies and incentive payments; or other functions necessary to manage the region's health system.

(3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation

plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

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

(A) an estimate of the total costs of each design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured; any estimated costs necessary to build a new system; and any estimated savings from implementing a single system.

(B) financing proposals for sustainable revenue, including by maximizing federal revenues, or reductions from existing health care programs, services, state agencies, or other sources necessary for funding the cost of the new system.

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

(D) a proposal to participate in a federal insurance exchange established by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 in order to maximize federal funds and, if applicable, a waiver from these provisions when available.

(5) A method to address compliance of the proposed design option or options with federal law if necessary, including the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options.

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

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

(3) The commission or its consultant may engage with interested parties,

such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont.

(g) In the proposal and implementation plan provided to the general assembly and the governor as provided for in subsection (a) of this section, the consultant shall include:

(1) A recommendation for key indicators to measure and evaluate the design option chosen by the general assembly.

(2) An analysis of each design option, including:

(A) the financing and cost estimates outlined in subdivision (e)(4) of this section;

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

(C) the expected net fiscal impact, including tax implications, on individuals and on businesses from the modifications to the health care system proposed in the design;

(D) impacts on the state's economy;

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

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

(3) A comparative analysis of the coverage, benefits, payments, health care delivery, and other features in each design option with Vermont's current health care system and health care reform efforts, the new federal insurance exchange, insurance regulatory provisions, and other provisions in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 . The comparative analysis should be in a format to allow the general assembly to compare easily each design option with the current system and efforts. If appropriate, the analysis shall include a comparison of financial or other changes in Medicaid and Medicaid-funded programs in a format currently used by the department of Vermont health access in order to compare the estimates for the design option to the most current actual expenditures available.

(4) A recommendation for which of the design options best meets the principles and goals outlined in Secs. 2 and 3 of this act in an affordable, timely, and efficient manner. The recommendation section of the proposal shall not be finalized until after the receipt of public input as provided for in subdivision (a)(1)(B) of this section.

(h) After receipt of the proposal and implementation plan pursuant to subdivision (g)(2) of this section, the general assembly shall solicit input from interested members of the public and engage in a full and open public review and hearing process on the proposal and implementation plan.

Sec. 7. GRANT FUNDING

The staff director of the joint legislative commission on health care reform shall apply for grant funding, if available, for the design and implementation analysis provided for in Sec. 6 of this act. Any amounts received in grant funds shall first be used to offset any state funds that are appropriated or allocated in this act or in other acts related to the requirements of Sec. 6. Any grant funds received in excess of the appropriated amount may be used for the analysis.

***** HEALTH CARE REFORM – MISCELLANEOUS *****

Sec. 8. 18 V.S.A. § 9401 is amended to read:

§ 9401. POLICY

(a) It is the policy of the state of Vermont that health care is a public good for all Vermonters and to ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

Sec. 9. 8 V.S.A. § 4062c is amended to read:

§ 4062c. COMPLIANCE WITH FEDERAL LAW

Except as otherwise provided in this title, health insurers, hospital or medical service corporations, and health maintenance organizations that issue, sell, renew, or offer health insurance coverage in Vermont shall comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (42 U.S.C., Chapter 6A, Subchapter XXV), and the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152. The commissioner shall enforce such requirements pursuant to his or her authority under this title.

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

(a) From the effective date of this act through July 1, 2011, the commissioner of health shall undertake such planning steps and other actions

as are necessary to secure grants and other beneficial opportunities for Vermont provided by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

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

* * * HEALTH CARE DELIVERY SYSTEM PROVISIONS * * *

Sec. 11. INTENT

It is the intent of the general assembly to reform the health care delivery system in order to manage total costs of the system, improve health outcomes for Vermonters, and provide a positive health care experience for patients and providers. In order to achieve this goal and to ensure the success of health care reform, it is essential to pursue innovative approaches to a single system of health care delivery that integrates health care at a community level and contains costs through community-based payment reform. It is also the intent of the general assembly to ensure sufficient state involvement and action in designing and implementing payment reform pilot projects in order to comply with federal anti-trust provisions by replacing competition between payers and others with state regulation and supervision.

Sec. 12. BLUEPRINT FOR HEALTH; COMMITTEES

It is the intent of the general assembly to codify and recognize the existing expansion design and evaluation committee and payer implementation work group and to codify the current consensus-building process provided for by these committees in order to develop payment reform models in the Blueprint for Health. The director of the Blueprint may continue the current composition of the committees and need not reappoint members as a result of this act.

Sec. 13. 18 V.S.A. chapter 13 is amended to read:

CHAPTER 13. CHRONIC CARE INFRASTRUCTURE AND PREVENTION MEASURES

§ 701. DEFINITIONS

For the purposes of this chapter:

(1) "Blueprint for Health" or "Blueprint" means the state's ~~plan for chronic care infrastructure, prevention of chronic conditions, and chronic care~~

~~management program, and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.~~

(2) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, hyperlipidemia, and chronic pain.

(3) “Chronic care information system” means the electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.

(4) “Chronic care management” means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for ~~the physician and patient relationship~~ licensed health care practitioners and their patients, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

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

(6) ~~“Health risk assessment” means screening by a health care professional for the purpose of assessing an individual’s health, including tests or physical examinations and a survey or other tool used to gather information about an individual’s health, medical history, and health risk factors during a health screening.~~ “Health benefit plan” shall have the same meaning as in 8 V.S.A. § 4088h.

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

(8) "Hospital" shall have the same meaning as in section 9456 of this title.

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

~~(a)(1) As used in this section, "health insurer" shall have the same meaning as in section 9402 of this title.~~

~~(b) The department of Vermont health access shall be responsible for the Blueprint for Health.~~

~~(2) The director of the Blueprint, in collaboration with the commissioner of health and the commissioner of Vermont health access, shall oversee the development and implementation of the Blueprint for Health, including ~~the~~ five-year a strategic plan describing the initiatives and implementation time lines and strategies. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration.~~

~~(e)(b)(1)(A) The ~~secretary~~ commissioner of Vermont health access shall establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall consist of no fewer than 10 individuals, including the commissioner of health; the commissioner of mental health; a representative from the department of banking, insurance, securities, and health care administration; a representative from the office of Vermont health access; a representative from the Vermont medical society; a representative from the Vermont nurse practitioners association; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine ~~profession~~ professions; a primary care professional serving low income or uninsured Vermonters; a representative of the Vermont assembly of home health agencies who has clinical experience; a representative from a self-insured employer who offers a health benefit plan to its employees; and a representative of the state employees' health plan, who shall be designated by the director of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan. In addition, the director of the commission on health care reform shall be a nonvoting member of the executive committee.~~

~~(2)(B) The executive committee shall engage a broad range of health care professionals who provide health services as defined under ~~section~~ 8 V.S.A. § 4080f of Title 18, health insurance plans insurers, professional organizations, community and nonprofit groups, consumers, businesses, school~~

districts, and state and local government in developing and implementing a five-year strategic plan.

(2)(A) The director shall convene an expansion design and evaluation committee, which shall meet no fewer than six times annually, to recommend a design plan, including modifications over time, for the statewide implementation of the Blueprint for Health and to recommend appropriate methods to evaluate the Blueprint. This committee shall be composed of the members of the executive committee, representatives of participating health insurers, representatives of participating medical homes and community health teams, the deputy commissioner of health care reform, a representative of the Bi-State Primary Care Association, a representative of the University of Vermont College of Medicine's Office of Primary Care, a representative of the Vermont information technology leaders, and consumer representatives. The committee shall comply with open meeting and public record requirements in chapter 5 of Title 1.

(B) The director shall also convene a payer implementation work group, which shall meet no fewer than six times annually, to design the medical home and community health team enhanced payments, including modifications over time, and to make recommendations to the expansion design and evaluation committee described in subdivision (A) of this subdivision (2). The work group shall include representatives of the participating health insurers, representatives of participating medical homes and community health teams, and the commissioner of Vermont health access or designee. The work group shall comply with open meeting and public record requirements in chapter 5 of Title 1.

(d)(c) The Blueprint shall be developed and implemented to further the following principles:

(1) the primary care provider should serve a central role in the coordination of care and shall be compensated appropriately for this effort;

(2) use of information technology should be maximized;

(3) local service providers should be used and supported, whenever possible;

(4) transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to the Blueprint model of health care delivery and payment;

(5) implementation of the Blueprint in communities across the state should be accompanied by payment to providers sufficient to support care management activities consistent with the Blueprint, recognizing that interim

or temporary payment measures may be necessary during early and transitional phases of implementation; and

(6) interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior, the physical and social environment, and health care policies and systems.

(d) The Blueprint for Health shall include the following initiatives:

(1) Technical assistance as provided for in section 703 of this title to implement:

(A) a patient-centered medical home;

(B) community health teams; and

(C) a model for uniform payment for health services by health insurers, Medicaid, Medicare if available, and other entities that encourage the use of the medical home and the community health teams.

(2) Collaboration with Vermont information technology leaders established in section 9352 of this title to assist health care professionals and providers to create a statewide infrastructure of health information technology in order to expand the use of electronic medical records through a health information exchange and a centralized clinical registry on the Internet.

(3) In consultation with employers, consumers, health insurers, and health care providers, the development, maintenance, and promotion of evidence-based, nationally recommended guidelines for greater commonality, consistency, and coordination among health insurers in care management programs and systems.

(4) The adoption and maintenance of clinical quality and performance measures for each of the chronic conditions included in Medicaid's care management program established in 33 V.S.A. § 1903a. These conditions include asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.

(5) The adoption and maintenance of clinical quality and performance measures, aligned with but not limited to existing outcome measures within the agency of human services, to be reported by health care professionals, providers, or health insurers and used to assess and evaluate the impact of the Blueprint for health and cost outcomes. In accordance with a schedule established by the Blueprint executive committee, all clinical quality and performance measures shall be reviewed for consistency with those used by the Medicare program and updated, if appropriate.

(6) The adoption and maintenance of clinical quality and performance measures for pain management, palliative care, and hospice care.

(7) The use of surveys to measure satisfaction levels of patients, health care professionals, and health care providers participating in the Blueprint.

~~(e)(1) The strategic plan shall include:~~

~~(A) a description of the Vermont Blueprint for Health model, which includes general, standard elements established in section 1903a of Title 33, patient self management, community initiatives, and health system and information technology reform, to be used uniformly statewide by private insurers, third party administrators, and public programs;~~

~~(B) a description of prevention programs and how these programs are integrated into communities, with chronic care management, and the Blueprint for Health model;~~

~~(C) a plan to develop and implement reimbursement systems aligned with the goal of managing the care for individuals with or at risk for conditions in order to improve outcomes and the quality of care;~~

~~(D) the involvement of public and private groups, health care professionals, insurers, third party administrators, associations, and firms to facilitate and assure the sustainability of a new system of care;~~

~~(E) the involvement of community and consumer groups to facilitate and assure the sustainability of health services supporting healthy behaviors and good patient self management for the prevention and management of chronic conditions;~~

~~(F) alignment of any information technology needs with other health care information technology initiatives;~~

~~(G) the use and development of outcome measures and reporting requirements, aligned with existing outcome measures within the agency of human services, to assess and evaluate the system of chronic care;~~

~~(H) target timelines for inclusion of specific chronic conditions in the chronic care infrastructure and for statewide implementation of the Blueprint for Health;~~

~~(I) identification of resource needs for implementing and sustaining the Blueprint for Health and strategies to meet the needs; and~~

~~(J) a strategy for ensuring statewide participation no later than January 1, 2011 by health insurers, third party administrators, health care professionals, hospitals and other professionals, and consumers in the chronic care management plan, including common outcome measures, best practices~~

~~and protocols, data reporting requirements, payment methodologies, and other standards. In addition, the strategy should ensure that all communities statewide will have implemented at least one component of the Blueprint by January 1, 2009.~~

~~(2) The strategic plan developed under subsection (a) of this section shall be reviewed biennially and amended as necessary to reflect changes in priorities. Amendments to the plan shall be included in the report established under subsection (i) of this section section 709 of this title.~~

~~(f) The director of the Blueprint shall facilitate timely progress in adoption and implementation of clinical quality and performance measures as indicated by the following benchmarks:~~

~~(1) by July 1, 2007, clinical quality and performance measures are adopted for each of the chronic conditions included in the Medicaid Chronic Care Management Program. These conditions include, but are not limited to, asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.~~

~~(2) at least one set of clinical quality and performance measures will be added each year and a uniform set of clinical quality and performance measures for all chronic conditions to be addressed by the Blueprint will be available for use by health insurers and health care providers by January 1, 2010.~~

~~(3) in accordance with a schedule established by the Blueprint executive committee, all clinical quality and performance measures shall be reviewed for consistency with those used by the Medicare program and updated, if appropriate.~~

~~(g) The director of the Blueprint shall facilitate timely progress in coordination of chronic care management as indicated by the following benchmarks:~~

~~(1) by October 1, 2007, risk stratification strategies shall be used to identify individuals with or at risk for chronic disease and to assist in the determination of the severity of the chronic disease or risk thereof, as well as the appropriate type and level of care management services needed to manage those chronic conditions.~~

~~(2) by January 1, 2009, guidelines for promoting greater commonality, consistency, and coordination across health insurers in care management programs and systems shall be developed in consultation with employers, consumers, health insurers, and health care providers.~~

~~(3) beginning July 1, 2009, and each year thereafter, health insurers, in collaboration with health care providers, shall report to the secretary on~~

~~evaluation of their disease management programs and the progress made toward aligning their care management program initiatives with the Blueprint guidelines.~~

~~(h)(1) No later than January 1, 2009, the director shall, in consultation with employers, consumers, health insurers, and health care providers, complete a comprehensive analysis of sustainable payment mechanisms. No later than January 1, 2009, the director shall report to the health care reform commission and other stakeholders his or her recommendations for sustainable payment mechanisms and related changes needed to support achievement of Blueprint goals for health care improvement, including the essential elements of high quality chronic care, such as care coordination, effective use of health care information by physicians and other health care providers and patients, and patient self management education and skill development.~~

~~(2) By January 1, 2009, and each year thereafter, health insurers will participate in a coordinated effort to determine satisfaction levels of physicians and other health care providers participating in the Blueprint care management initiatives, and will report on these satisfaction levels to the director and in the report established under subsection (i) this section.~~

~~(i) The director shall report annually, no later than January 1, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year, and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight committee, and the commission on health care reform. The report shall include the number of participating insurers, health care professionals and patients; the progress for achieving statewide participation in the chronic care management plan, including the measures established under subsection (e) of this section; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in subsections (g) and (h) of this section; and other information as requested by the committees. The surveys shall be developed in collaboration with the executive committee established under subsection (e) of this section.~~

~~(j) It is the intent of the general assembly that health insurers shall participate in the Blueprint for Health no later than January 1, 2009 and shall engage health care providers in the transition to full participation in the Blueprint.~~

§ 703. HEALTH PREVENTION; CHRONIC CARE MANAGEMENT

(a) The director shall develop a model for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management through an integrated system, including a patient-centered medical home and a community health team; and uniform payment for health services by health insurers, Medicaid, Medicare if available, and other entities that encourage the use of the medical home and the community health teams.

(b) When appropriate, the model may include the integration of social services provided by the agency of human services or may include coordination with a team at the agency of human services to ensure the individual's comprehensive care plan is consistent with the agency's case management plan for that individual or family.

(c) In order to maximize the participation of federal health care programs and to maximize federal funds available, the model for care coordination and management may meet the criteria for medical home, community health team, or other related demonstration projects established by the U.S. Department of Health and Human Services and the criteria of any other federal program providing funds for establishing medical homes, community health teams, or associated payment reform.

(d) The model for care coordination and management shall include the following components:

(1) A process for identifying individuals with or at risk for chronic disease and to assist in the determination of the risk for or severity of a chronic disease, as well as the appropriate type and level of care management services needed to manage those chronic conditions.

(2) Evidence-based clinical practice guidelines, which shall be aligned with the clinical quality and performance measures provided for in section 702 of this title.

(3) Models for the collaboration of health care professionals in providing care, including through a community health team.

(4) Education for patients on how to manage conditions or diseases, including prevention of disease; programs to modify a patient's behavior; and a method of ensuring compliance of the patient with the recommended behavioral change.

(5) Education for patients on health care decision-making, including education related to advance directives, palliative care, and hospice care.

(6) Measurement and evaluation of the process and health outcomes of patients.

(7) A method for all health care professionals treating the same patient on a routine basis to report and share information about that patient.

(8) Requirements that participating health care professionals and providers have the capacity to implement health information technology that meets the requirements of 42 U.S.C. § 300jj in order to facilitate coordination among members of the community health team, health care professionals, and primary care practices; and, where applicable, to report information on quality measures to the director of the Blueprint.

(9) A sustainable, scalable, and adaptable financial model reforming primary care payment methods through medical homes supported by community health teams that lead to a reduction in avoidable emergency room visits and hospitalizations and a shift of health insurer expenditures from disease management contracts to financial support for local community health teams in order to promote health, prevent disease, and manage care in order to increase positive health outcomes and reduce costs over time.

(e) The director of the Blueprint shall provide technical assistance and training to health care professionals, health care providers, health insurers, and others participating in the Blueprint.

§ 704. MEDICAL HOME

Consistent with federal law to ensure federal financial participation, a health care professional providing a patient's medical home shall:

(1) provide comprehensive prevention and disease screening for his or her patients and managing his or her patients' chronic conditions by coordinating care;

(2) enable patients to have access to personal health information through a secure medium, such as through the Internet, consistent with federal health information technology standards;

(3) use a uniform assessment tool provided by the Blueprint in assessing a patient's health;

(4) collaborate with the community health teams, including by developing and implementing a comprehensive plan for participating patients;

(5) ensure access to a patient's medical records by the community health team members in a manner compliant with the Health Insurance Portability and Accountability Act, 12 V.S.A. § 1612, 18 V.S.A. §§ 1852, 7103, 9332, and 9351, and 21 V.S.A. § 516; and

(6) meet regularly with the community health team to ensure integration of a participating patient's care.

§ 705. COMMUNITY HEALTH TEAMS

(a) Consistent with federal law to ensure federal financial participation, the community health team shall consist of health care professionals from multiple disciplines, including obstetrics and gynecology, pharmacy, nutrition and diet, social work, behavioral and mental health, chiropractic, other complementary and alternative medical practice licensed by the state, home health care, public health, and long-term care.

(b) The director shall assist communities to identify the service areas in which the teams work, which may include a hospital service area or other geographic area.

(c) Health care professionals participating in a community health team shall:

(1) Collaborate with other health care professionals and with existing state agencies and community-based organizations in order to coordinate disease prevention, manage chronic disease, coordinate social services if appropriate, and provide an appropriate transition of patients between health care professionals or providers. Priority may be given to patients willing to participate in prevention activities or patients with chronic diseases or conditions identified by the director of the Blueprint.

(2) Support a health care professional or practice which operates as a medical home, including by:

(A) assisting in the development and implementation of a comprehensive care plan for a patient that integrates clinical services with prevention and health promotion services available in the community and with relevant services provided by the agency of human services. Priority may be given to patients willing to participate in prevention activities or patients with chronic diseases or conditions identified by the director of the Blueprint;

(B) providing a method for health care professionals, patients, caregivers, and authorized representatives to assist in the design and oversight of the comprehensive care plan for the patient;

(C) coordinating access to high-quality, cost-effective, culturally appropriate, and patient- and family-centered health care and social services, including preventive services, activities which promote health, appropriate specialty care, inpatient services, medication management services provided by a pharmacist, and appropriate complementary and alternative (CAM) services;

(D) providing support for treatment planning, monitoring the patient's health outcomes and resource use, sharing information, assisting patients in making treatment decisions, avoiding duplication of services, and engaging in other approaches intended to improve the quality and value of health services;

(E) assisting in the collection and reporting of data in order to evaluate the Blueprint model on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(F) providing a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of health information technology or other means as determined by the director of the Blueprint.

(3) Provide care management and support when a patient moves to a new setting for care, including by:

(A) providing on-site visits from a member of the community health team, assisting with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospital, nursing home, or other institution setting;

(B) generally assisting health care professionals, patients, caregivers, and authorized representatives in discharge planning, including by assuring that postdischarge care plans include medication management as appropriate;

(C) referring patients as appropriate for mental and behavioral health services;

(D) ensuring that when a patient becomes an adult, his or her health care needs are provided for; and

(E) serving as a liaison to community prevention and treatment programs.

§ 706. HEALTH INSURER PARTICIPATION

(a) As provided for in 8 V.S.A. § 4088h, health insurance plans shall be consistent with the Blueprint for Health as determined by the commissioner of banking, insurance, securities, and health care administration.

(b) No later than January 1, 2011, health insurers shall participate in the Blueprint for Health as a condition of doing business in this state as provided for in this section and in 8 V.S.A. § 4088h. Under 8 V.S.A. § 4088h, the commissioner of banking, insurance, securities, and health care administration may exclude or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited benefit coverage in the

Blueprint for Health. Health insurers shall be exempt from participation if the insurer only offers benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(c)(1) The Blueprint payment reform methodologies shall include per-person per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating the community health teams. Per-person per-month payments to practices shall be based on the official National Committee for Quality Assurance's Physician Practice Connections – Patient Centered Medical Home (NCOA PPC-PCMH) score and shall be in addition to their normal fee-for-service or other payments.

(2) Consistent with the recommendation of the Blueprint expansion design and evaluation committee, the director of the Blueprint may implement changes to the payment amounts or to the payment reform methodologies described in subdivision (1) of this subsection, including by providing for enhanced payment to health care professional practices which operate as a medical home, payment toward the shared costs for community health teams, or other payment methodologies required by the Centers for Medicare and Medicaid Services (CMS) for participation by Medicaid or Medicare.

(3) Health insurers shall modify payment methodologies and amounts to health care professionals and providers as required for the establishment of the model described in sections 703 through 705 of this title and this section, including any requirements specified by the Centers for Medicare and Medicaid Services (CMS) in approving federal participation in the model to ensure consistency of payment methods in the model.

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

(d) An insurer may appeal a decision of the director to require a particular payment methodology or payment amount to the commissioner of Vermont health access, who shall provide a hearing in accordance with chapter 25 of Title 3. An insurer aggrieved by the decision of the commissioner may appeal to the superior court for the Washington district within 30 days after the commissioner issues his or her decision.

§ 707. PARTICIPATION BY HEALTH CARE PROFESSIONALS AND HOSPITALS

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

(b) The director of health care reform or designee shall ensure hospitals have access to state and federal resources to support connectivity to the state's health information exchange network.

(c) The director of the Blueprint shall engage health care professionals and providers to encourage participation in the Blueprint, including by providing information and assistance.

§ 708. CERTIFICATION OF HOSPITALS

(a) The director of health care reform or designee shall establish a process for annually certifying that a hospital meets the participation requirements established under section 707 of this title. Once a hospital is fully connected to the state's health information exchange, the director of health care reform or designee shall waive further certification. The director may require a hospital to resume certification if the criteria for connectivity change, if the hospital loses connectivity to the state's health information exchange, or for another reason which results in the hospital's not meeting the participation requirement in section 707 of this title. The certification process, including the appeal process, shall be completed prior to the hospital budget review required under section 9456 of this title.

(b) Once the hospital has been certified or certification has been waived, the director of health care reform or designee shall provide the hospital with documentation to include in its annual budget review as required by section 9456 of this title.

(c) A denial of certification by the director of health care reform or designee may be appealed to the commissioner of Vermont health access, who shall provide a hearing in accordance with chapter 25 of Title 3. A hospital aggrieved by the decision of the commissioner may appeal to the superior court for the district in which the hospital is located within 30 days after the commissioner issues his or her decision.

§ 709. ANNUAL REPORT

(a) The director of the Blueprint shall report annually, no later than January 15, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight committee, and the joint legislative commission on health care reform.

(b) The report required by subsection (a) of this section shall include the number of participating insurers, health care professionals, and patients; the progress made in achieving statewide participation in the chronic care management plan, including the measures established under this subchapter; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress made toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in this subchapter; and other information as requested by the committees.

Sec. 14. PAYMENT REFORM; PILOTS

(a)(1) The department of Vermont health access shall be responsible for developing pilot projects to test payment reform methodologies as provided under this section. The director of payment reform shall oversee the development, implementation, and evaluation of the payment reform pilot projects. Whenever health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration. The terms used in this section shall have the same meanings as in chapter 13 of Title 18.

(2) The director of payment reform shall convene a broad-based group of stakeholders, including health care professionals who provide health services as defined under 8 V.S.A. § 4080f, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local government to advise the director in developing and implementing the pilot projects.

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

(A) payment reform pilot projects should be organized around primary care professionals and be structured to serve the population using the primary care professionals;

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

(C) health care providers and professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care;

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

(E) the design and implementation of the payment reform pilot projects should be aligned with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform;

(F) the global budget should include a broad, comprehensive set of services, including prescription drugs, diagnostic services, services received in a hospital, and services from a licensed health care practitioner;

(G) with input from long-term care providers, the global budget may also include home health services, and long-term care services if feasible;

(H) financial performance of an integrated community of care should be measured instead of the financial viability of a single institution.

(4)(A) No later than February 1, 2011, the director of payment reform shall provide a strategic plan for the pilot projects to the house committee on health care and the senate committee on health and welfare. The strategic plan shall provide:

(i) A description of the proposed payment reform pilot projects, including a description of the possible organizational model or models for health care providers or professionals to coordinate patient care, a detailed design of the financial model or models, and an estimate of savings to the health care system from cost reductions due to reduced administration, from a reduction in health care inflation, or from other sources.

(ii) An ongoing program evaluation and improvement protocol.

(iii) An implementation time line for pilot projects, with the first project to become operational no later than January 1, 2012, and with two or more additional pilot projects to become operational no later than July 1, 2012.

(B) The director shall not implement the pilot projects until the strategic plan has been approved or modified by the general assembly.

(b) Health insurer participation.

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

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

(C) After the pilot projects are implemented, health insurers shall have the same appeal rights provided for in 18 V.S.A. § 706 for participation in the Blueprint for Health.

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

(c) To the extent required to avoid federal anti-trust violations, the commissioner of banking, insurance, securities, and health care administration shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The department shall ensure that the process and implementation includes sufficient state supervision over these entities to comply with federal anti-trust provisions.

(d) The commissioner of Vermont health access or designee shall apply for grant funding, if available, for the design and implementation of the pilot projects described in this act. Any amounts received in grant funds shall first

be used to offset any state funds that are appropriated or allocated in this act or in other acts related to the pilot projects described in this section. Any grant funds received in excess of the appropriated amount may be used for the design and implementation of the pilot projects.

(e) If the pilot projects are approved by the general assembly, the director of payment reform shall report annually by January 15 beginning in 2012 on the status of implementation of the pilot projects for the prior calendar year, including any analysis or evaluation of the effectiveness of the pilot projects, and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight committee, and the commission on health care reform.

Sec. 15. 8 V.S.A. § 4088h is amended to read:

§ 4088h. HEALTH INSURANCE AND THE BLUEPRINT FOR HEALTH

(a)(1) A health insurance plan shall be offered, issued, and administered consistent with the blueprint for health established in chapter 13 of Title 18, as determined by the commissioner.

~~(b)(2)~~ As used in this section, “health insurance plan” means any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined in ~~section 18 V.S.A. § 9402 of Title 18~~. The term shall include the health benefit plan offered by the state of Vermont to its employees and any health benefit plan offered by any agency or instrumentality of the state to its employees. The term shall not include benefit plans providing coverage for specific disease or other limited benefit coverage unless so directed by the commissioner.

(b) Health insurers as defined in 18 V.S.A. § 701 shall participate in the Blueprint for Health as specified in 18 V.S.A. § 706. In consultation with the director of the Blueprint for Health and the director of health care reform, the commissioner may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage. A health insurer shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured’s assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

Sec. 16. 18 V.S.A. § 9456(a) is amended to read:

(a) The commissioner shall conduct reviews of each hospital’s proposed budget based on the information provided pursuant to this subchapter, and in

accordance with a schedule established by the commissioner. The commissioner shall require the submission of documentation certifying that the hospital is participating in the Blueprint for Health if required by section 708 of this title.

Sec. 17. FEDERAL HEALTH CARE REFORM; DEMONSTRATION PROGRAMS

(a)(1) Medicare waivers. Upon establishment by the secretary of the U.S. Department of Health and Human Services (HHS) of an advanced practice primary care medical home demonstration program or a community health team demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, the secretary of human services may apply to the secretary of HHS to enable Vermont to include Medicare as a participant in the Blueprint for Health as described in chapter 13 of Title 18.

(2) Upon establishment by the secretary of HHS of a shared savings program pursuant to Sec. 3022 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, the secretary of human services may apply to the secretary of HHS to enable Vermont to participate in the program by establishing payment reform pilot projects as provided for by Sec. 14 of this act.

(b)(1) Medicaid waivers. The intent of this section is to provide the secretary of human services with the authority to pursue Medicaid participation in the Blueprint for Health through any existing or new waiver.

(2) Upon establishment by the secretary of HHS of a health home demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, the secretary of human services may apply to the secretary of HHS to include Medicaid as a participant in the Blueprint for Health as described in chapter 13 of Title 18. In the alternative, under Section 1115 of the Social Security Act, the secretary of human services may apply for an amendment to an existing Section 1115 waiver or may include in the renegotiation of the Global Commitment for Health Section 1115 waiver a request to include Medicaid as a participant in the Blueprint for Health as described in chapter 13 of Title 18.

Sec. 18. [DELETED]

Sec. 19. BLUEPRINT FOR HEALTH; EXPANSION

The commissioner of Vermont health access shall expand the Blueprint for Health as described in chapter 13 of Title 18 to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013, to primary care practices statewide whose owners wish to participate.

* * * IMMEDIATE COST-CONTAINMENT PROVISIONS * * *

Sec. 20. HOSPITAL BUDGETS

(a)(1) The commissioner of banking, insurance, securities, and health care administration shall implement this section consistent with the goals identified in Sec. 50 of No. 61 of the Acts of 2009, 18 V.S.A. § 9456 and the goals of systemic health care reform, containing costs, solvency for efficient and effective hospitals, and promoting fairness and equity in health care financing. The authority provided in this section shall be in addition to the commissioner's authority under subchapter 7 of chapter 221 of Title 8 (hospital budget reviews).

(2) Except as provided for in subdivision (3) of this subsection, the commissioner of banking, insurance, securities, and health care administration shall target hospital budgets consistent with the following:

(A) For fiscal years 2011 and 2012, the commissioner shall aim to minimize rate increases for each hospital in an effort to balance the goals outlined in this section and shall ensure that the systemwide increase shall be lower than the prior year's increase.

(B)(i) For fiscal year 2011, the total systemwide net patient revenue increase for all hospitals reviewed by the commissioner shall not exceed 4.5 percent.

(ii) For fiscal year 2012, the total systemwide net patient revenue increase for all hospitals reviewed by the commissioner shall not exceed 4.0 percent.

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

(B) In calculating the hospital budgets as provided for in subdivision (2) of this subsection and if necessary to achieve the goals identified in this section, the commissioner may exempt hospital revenue and expenses

associated with health care reform, hospital expenses related to electronic medical records or other information technology, hospital expenses related to acquiring or starting new physician practices, and other expenses, such as all or a portion of the provider tax. The expenditures shall be specifically reported, supported with sufficient documentation as required by the commissioner, and may only be exempt if approved by the commissioner.

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

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

Sec. 21. 18 V.S.A. § 9440(b)(1) is amended to read:

(b)(1) The application shall be in such form and contain such information as the commissioner establishes. In addition, the commissioner may require of an applicant any or all of the following information that the commissioner deems necessary:

* * *

(I) additional information as needed by the commissioner, including information from affiliated corporations or other persons in the control of or controlled by the applicant.

Sec. 22. 18 V.S.A. § 9456(g) is amended to read:

(g) The commissioner may request, and a hospital shall provide, information determined by the commissioner to be necessary to determine whether the hospital is operating within a budget established under this section. For purposes of this subsection, subsection (h) of this section, and subdivision 9454(a)(7) of this title, the commissioner's authority shall extend to an affiliated corporation or other person in the control of or controlled by the hospital to the extent that such authority is necessary to carry out the purposes of this subsection, subsection (h) of this section, or subdivision 9454(a)(7) of this title. As used in this subsection, a rebuttable presumption of "control" is created if the entity, hospital, or other person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 20 percent or more of the voting securities or membership interest or other governing interest of the hospital or other controlled entity.

Sec. 23. 18 V.S.A. § 9456(h)(2) is amended to read:

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

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

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

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

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

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

Sec. 24. 18 V.S.A. § 9456(b) is amended to read:

(b) In conjunction with budget reviews, the commissioner shall:

(1) review utilization information;

(2) *consider the goals and recommendations of the health resource allocation plan;*

(3) *consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;*

(4) *consider any reports from professional review organizations;*

(5) *solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;*

(6) *meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;*

(7) *give public notice of the meetings with hospitals, and invite the public to attend and to comment on the proposed budgets;*

(8) *consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;*

(9) *require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals;*

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

Sec. 25. 18 V.S.A. § 9439(f) is amended to read:

~~(f) The commissioner shall establish, by rule, annual cycles for the review of applications for certificates under this subchapter, in addition to the review cycles for skilled nursing and intermediate care beds established under subsections (d) and (e) of this section. A review cycle may include in the same group some or all of the types of projects subject to certificate of need review. Such rules may exempt emergency applications, pursuant to subsection 9440(d) of this title. Unless an application meets the requirements of subsection 9440(e) of this title, the commissioner shall consider disapproving a certificate of need application for a hospital if a project was not identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan required under subdivision 9454(a)(6) of this title. The commissioner shall review all hospital four-year capital plans as part of the review under subdivision 9437(2)(B) of this title.~~

Sec. 26. INSURANCE REGULATION; INTENT

It is the intent of the general assembly that the commissioner of banking, insurance, securities, and health care administration use the existing insurance rate review and approval authority to control the costs of health insurance unrelated to the cost of medical care where consistent with other statutory obligations, such as ensuring solvency. Rate review and approval authority may include imposing limits on:

- (1) administrative costs as a percentage of the premium;
- (2) contributions to reserves;
- (3) producer commissions in specified markets;
- (4) medical trends;
- (5) pharmacy trends; and
- (6) such other areas as the commissioner deems appropriate.

Sec. 27. 8 V.S.A § 4080a(h)(2)(D) is added to read:

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

Sec. 28. 8 V.S.A § 4080b(h)(2)(D) is added to read:

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

Sec. 29. RULEMAKING; REPORTING OF INFORMATION

The commissioner of banking, insurance, securities, and health care administration shall adopt rules pursuant to chapter 25 of Title 3 requiring each health insurer licensed to do business in this state to report to the department of banking, insurance, securities, and health care administration at least annually information specific to its Vermont contracts, including

enrollment data, loss ratios, and such other information as the commissioner deems appropriate.

Sec. 30. 8 V.S.A. § 4089b(g) is amended to read:

(g) On or before July 15 of each year, health insurance companies doing business in Vermont, ~~and~~ whose individual share of the commercially-insured Vermont market, as measured by covered lives, comprises at least five percent of the commercially-insured Vermont market, shall file with the commissioner, in accordance with standards, procedures, and forms approved by the commissioner:

* * *

(2) The health insurance plan's revenue loss and expense ratio relating to the care and treatment of mental health conditions covered under the health insurance plan. The expense ratio report shall list amounts paid in claims for services and administrative costs separately. A managed care organization providing or administering coverage for treatment of mental health conditions on behalf of a health insurance plan shall comply with the minimum loss ratio requirements pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, applicable to the underlying health insurance plan with which the managed care organization has contracted to provide or administer such services. The health insurance plan shall also bear responsibility for ensuring the managed care organization's compliance with the minimum loss ratio requirement pursuant to this subdivision.

* * * HEALTH CARE WORKFORCE PROVISIONS * * *

Sec. 31. INTERIM STUDY OF VERMONT'S PRIMARY CARE WORKFORCE DEVELOPMENT

(a) Creation of committee. There is created a primary care workforce development committee to determine the additional capacity needed in the primary care delivery system if Vermont achieves the health care reform principles and purposes established in Secs. 1 and 2 of No. 191 of the Acts of the 2005 Adj. Sess. (2006) and to create a strategic plan for ensuring that the necessary workforce capacity is achieved in the primary care delivery system. The primary care workforce includes physicians, advanced practice nurses, and other health care professionals providing primary care as defined in 8 V.S.A. § 4080f.

(b) Membership. The primary care workforce development committee shall be composed of 18 members as follows:

(1) the commissioner of Vermont health access;

(2) the deputy commissioner of the division of health care administration or designee;

(3) the director of the Blueprint for Health;

(4) the commissioner of health or designee;

(5) a representative of the University of Vermont College of Medicine's Area Health Education Centers (AHEC) program;

(6) a representative of the University of Vermont College of Medicine's Office of Primary Care, a representative of the University of Vermont College of Nursing and Health Sciences, a representative of nursing programs at the Vermont State Colleges, and a representative from Norwich University's nursing programs;

(7) a representative of the Vermont Association of Naturopathic Physicians;

(8) a representative of Bi-State Primary Care Association;

(9) a representative of Vermont Nurse Practitioners Association;

(10) a representative of Physician Assistant Academy of Vermont;

(11) a representative of the Vermont Medical Society;

(12) a representative of the Vermont health care workforce development partners;

(13) a mental health or substance abuse treatment professional currently in practice, to be appointed by the commissioner of Vermont health access;

(14) a representative of the Vermont assembly of home health agencies;
and

(15) the commissioner of labor or designee.

(c) Powers and duties.

(1) The committee established in subsection (a) of this section shall study the primary care workforce development system in Vermont, including the following issues:

(A) the current capacity and capacity issues of the primary care workforce and delivery system in Vermont, including the number of primary care professionals, issues with geographic access to services, and unmet primary health care needs of Vermonters.

(B) the resources needed to ensure that the primary care workforce and the delivery system are able to provide sufficient access to services should

all or most Vermonters become insured, to provide sufficient access to services given demographic factors in the population and in the workforce, and to participate fully in health care reform initiatives, including participation in the Blueprint for Health and transition to electronic medical records; and

(C) how state government, universities and colleges, and others may develop the resources in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes.

(2) The committee shall create a detailed and targeted five-year strategic plan with specific action steps for attaining sufficient capacity in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes. By November 15, 2010, the department of Vermont health access in collaboration with AHEC and the department of health shall report to the joint legislative commission on health care reform, the house committee on health care, and the senate committee on health and welfare its findings, the strategic plan, and any recommendations for legislative action.

(3) For purposes of its study of these issues, the committee shall have administrative support from the department of Vermont health access. The commissioner of Vermont health access shall call the first meeting of the committee and shall jointly operate with the representative from AHEC to cochair of the committee.

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

Sec. 31a. 1 V.S.A. § 376 is added to read:

§ 376. HEALTH CARE CAREER AWARENESS MONTH

October of each year is designated as health care career awareness month.

* * * PRESCRIPTION DRUG PROVISIONS * * *

Sec. 32. 18 V.S.A. § 4631a is amended to read:

§ 4631a. GIFTS EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

(1) "Allowable expenditures" means:

(A) Payment to the sponsor of a significant educational, medical, scientific, or policy-making conference or seminar, provided:

(i) the payment is not made directly to a health care ~~provider~~ professional or pharmacist;

(ii) funding is used solely for bona fide educational purposes, except that the sponsor may, in the sponsor's discretion, apply some or all of the funding to provide meals and other food for all conference participants; and

(iii) all program content is objective, free from industry control, and does not promote specific products.

(B) Honoraria and payment of the expenses of a health care professional who serves on the faculty at a bona fide significant educational, medical, scientific, or policy-making conference or seminar, provided:

(i) there is an explicit contract with specific deliverables which are restricted to medical issues, not marketing activities; and

(ii) consistent with federal law, the content of the presentation, including slides and written materials, is determined by the health care professional.

(C) For a bona fide clinical trial:

(i) gross compensation for the Vermont location or locations involved;

(ii) direct salary support per principal investigator and other health care professionals per year; and

(iii) expenses paid on behalf of investigators or other health care professionals paid to review the clinical trial.

(D) For a research project that constitutes a systematic investigation, is designed to develop or contribute to general knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals working in the particular field of inquiry:

(i) gross compensation;

(ii) direct salary support per health care professional; and

(iii) expenses paid on behalf of each health care professional.

(E) Payment or reimbursement for the reasonable expenses, including travel and lodging-related expenses, necessary for technical training of individual health care professionals on the use of a medical device if the commitment to provide such expenses and the amounts or categories of reasonable expenses to be paid are described in a written agreement between the health care provider and the manufacturer.

(F) Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally

recognized discovery for which the health care provider holds an ownership right.

(G) The payment of the reasonable expenses of an individual related to the interview of the individual by a manufacturer of prescribed products in connection with a bona fide employment opportunity.

~~(G)~~(H) Other reasonable fees, payments, subsidies, or other economic benefits provided by a manufacturer of prescribed products at fair market value.

(2) “Bona fide clinical trial” means an FDA-reviewed clinical trial that constitutes “research” as that term is defined in 45 C.F.R. § 46.102 and reasonably can be considered to be of interest to scientists or health care professionals working in the particular field of inquiry.

(3) “Clinical trial” means any study assessing the safety or efficacy of prescribed products administered alone or in combination with other prescribed products or other therapies, or assessing the relative safety or efficacy of prescribed products in comparison with other prescribed products or other therapies.

(4) “Free clinic” means a health care facility operated by a nonprofit private entity that:

(A) in providing health care, does not accept reimbursement from any third-party payor, including reimbursement from any insurance policy, health plan, or federal or state health benefits program that is individually determined;

(B) in providing health care, either:

(i) does not impose charges on patients to whom service is provided; or

(ii) imposes charges on patients according to their ability to pay;

(C) may accept patients’ voluntary donations for health care service provision; and

(D) is licensed or certified to provide health services in accordance with Vermont law.

(5) “Gift” means:

(A) Anything of value provided to a health care provider for free; or

(B) ~~Any~~ Except as otherwise provided in subdivision (a)(1)(A)(ii) of this section, any payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless:

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

(ii) *the health care provider reimburses the cost at fair market value.*

(6) “Health benefit plan administrator” means the person or entity who sets formularies on behalf of an employer or health insurer.

(5)(7)(A) “Health care professional” means:

(i) *a person who is authorized by law to prescribe or to recommend prescribed products, who regularly practices in this state, and who either is licensed by this state to provide or is otherwise lawfully providing health care in this state; or*

(ii) *a partnership or corporation made up of the persons described in subdivision (i) of this subdivision (5)(7)(A); or*

(iii) *an officer, employee, agent, or contractor of a person described in subdivision (i) of this subdivision (5)(7)(A) who is acting in the course and scope of employment, of an agency, or of a contract related to or supportive of the provision of health care to individuals.*

(B) The term shall not include a person described in subdivision (A) of this subdivision (5)(7) who is employed solely by a manufacturer.

(6)(8) “Health care provider” means a health care professional, a hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to dispense or purchase for distribution prescribed products in this state. The term does not include a hospital foundation that is organized as a nonprofit entity separate from a hospital.

(7)(9) “Manufacturer” means a pharmaceutical, biological product, or medical device manufacturer or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repacking, distributing, or labeling of prescribed products. The term does not include a wholesale distributor of biological products, a retailer, or a pharmacist licensed under chapter 36 of Title 26.

(8)(10) “Marketing” shall include promotion, detailing, or any activity that is intended to be used or is used to influence sales or market share or to evaluate the effectiveness of a professional sales force.

(9)(11) “Pharmaceutical manufacturer” means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, whether directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis,

or any entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs. The term does not include a wholesale distributor of prescription drugs, a retailer, or a pharmacist licensed under chapter 36 of Title 26.

~~(H)(12)~~ “Prescribed product” means a drug or device as defined in section 201 of the federal Food, Drug and Cosmetic Act, 21 U.S.C. § 321, ~~or a compound drug or drugs, or a biological product as defined in section 351 of the Public Health Service Act, 42 U.S.C. § 262,~~ for human use.

(13) “Sample” means a unit of a prescription drug, biological product, or medical device that is not intended to be sold and is intended to promote the sale of the drug, product, or device. The term includes starter packs and coupons or other vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price.

~~(H)(14)~~ “Significant educational, scientific, or policy-making conference or seminar” means an educational, scientific, or policy-making conference or seminar that:

(A) is accredited by the Accreditation Council for Continuing Medical Education or a comparable organization or is presented by an approved sponsor of continuing education, provided that the sponsor is not a manufacturer of prescribed products; and

(B) offers continuing ~~medical~~ education credit, features multiple presenters on scientific research, or is authorized by the ~~sponsoring association~~ sponsor to recommend or make policy.

(b)(1) It is unlawful for any manufacturer of a prescribed product or any wholesale distributor of medical devices, or any agent thereof, to offer or give any gift to a health care provider.

(2) The prohibition set forth in subdivision (1) of this subsection shall not apply to any of the following:

(A) Samples of a prescribed product or reasonable quantities of an over-the-counter drug, nonprescription medical device, or item of nonprescription durable medical equipment provided to a health care provider for free distribution to patients.

(B) The loan of a medical device for a short-term trial period, not to exceed 90 days, to permit evaluation of a medical device by a health care provider or patient.

(C) The provision of reasonable quantities of medical device demonstration or evaluation units to a health care provider to assess the

appropriate use and function of the product and determine whether and when to use or recommend the product in the future.

(D) The provision, distribution, dissemination, or receipt of peer-reviewed academic, scientific, or clinical articles or journals and other items that serve a genuine educational function provided to a health care provider for the benefit of patients.

(E) Scholarship or other support for medical students, residents, and fellows to attend a significant educational, scientific, or policy-making conference or seminar of a national, regional, or specialty medical or other professional association if the recipient of the scholarship or other support is selected by the association.

(F) Rebates and discounts for prescribed products provided in the normal course of business.

(G) Labels approved by the federal Food and Drug Administration for prescribed products.

(H) The provision of free prescription drugs or over-the-counter drugs, medical devices, biological products, medical equipment or supplies, or financial donations to a free clinic.

(I) The provision of free prescription drugs to or on behalf of an individual through a prescription drug manufacturer's patient assistance program.

(J) Fellowship salary support provided to fellows through grants from manufacturers of prescribed products, provided:

(i) such grants are applied for by an academic institution or hospital;

(ii) the institution or hospital selects the recipient fellows;

(iii) the manufacturer imposes no further demands or limits on the institution's, hospital's, or fellow's use of the funds; and

(iv) fellowships are not named for a manufacturer and no individual recipient's fellowship is attributed to a particular manufacturer of prescribed products.

(K) The provision of coffee or other snacks or refreshments at a booth at a conference or seminar.

(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees and may impose on a manufacturer that violates this section a civil penalty of no more than

\$10,000.00 per violation. Each unlawful gift shall constitute a separate violation.

Sec. 33. 18 V.S.A. § 4632 is amended to read:

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

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

(A) any allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title to any health care provider, except:

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

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

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

(iv) samples of a prescription drug provided to a health care professional for free distribution to patients;

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

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

(B) any allowable expenditure or gift ~~permitted under subdivision 4631a(b)(2) of this title~~ to an academic institution, to a nonprofit hospital foundation, or to a professional, educational, or patient organization representing or serving health care providers or consumers, located in or providing services in Vermont, except:

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

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

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

~~(iv) samples of a prescription drug provided to a health care professional for free distribution to patients.~~

~~(2) Annually on July 1, each manufacturer of prescribed products also shall disclose to the office of the attorney general the name and address of the individual responsible for the manufacturer's compliance with the provisions of this section.~~

~~(3) Disclosure shall be made on a form and in a manner prescribed by the office of the attorney general and shall require manufacturers of prescribed products to report each allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title including:~~

~~(A) except as otherwise provided in subdivision (a)(2) of this section, the value, nature, and purpose of each allowable expenditure, and gift permitted under subdivision 4631a(b)(2) of this title according to specific categories identified by the office of the attorney general;~~

~~(B) the name of the recipient;~~

~~(C) the recipient's address;~~

~~(D) the recipient's institutional affiliation;~~

~~(E) prescribed product or products being marketed, if any; and~~

~~(F) the recipient's state board number.~~

~~(4) The office of the attorney general shall report annually on the disclosures made under this section to the general assembly and the governor on or before April 1. The report shall include:~~

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

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

~~(5) After issuance of the report required by subdivision (a)(5) of this section, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.~~

~~(6) The office of Vermont health access shall examine the data available from the office of the attorney general for relevant expenditures and determine whether and to what extent prescribing patterns by health care providers of prescribed products reimbursed by Medicaid, VHAP, Dr. Dynasaur, VermontRx, and VPharm may reflect manufacturer influence. The office may select the data most relevant to its analysis. The office shall report its analysis annually to the general assembly and the governor on or before October 1.~~

~~(b)(1) Annually on July 1, the office of the attorney general shall collect a \$500.00 fee from each manufacturer of prescribed products filing annual disclosures of expenditures greater than zero described in subsection (a) of this section.~~

~~(2) Fees collected under this section shall fund collection and analysis of information on activities related to the marketing of prescribed products under ~~sections~~ section 4631a of this title and 4632 of Title 18 this section. The fees shall be collected in a special fund assigned to the office.~~

~~(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer of prescribed products that fails to disclose as required by subsection (a) of this section a civil penalty of no more than \$10,000.00 per violation. Each unlawful failure to disclose shall constitute a separate violation.~~

~~(d) The terms used in this section shall have the same meanings as they do in section 4631a of this title.~~

Sec. 33. 18 V.S.A. § 4632 is amended to read:

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

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

(A) any allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title to any health care provider, except:

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

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

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

~~(iv) samples of a prescription drug or biological product provided to a health care professional for free distribution to patients interview expenses as described in subdivision 4631a(a)(1)(G) of this title; and~~

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

(B) any allowable expenditure or gift ~~permitted under subdivision 4631a(b)(2) of this title~~ to an academic institution, to a nonprofit hospital foundation, or to a professional, educational, or patient organization representing or serving health care providers or consumers located in or providing services in Vermont, except:

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

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

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

~~(iv) samples of a prescription drug provided to a health care professional for free distribution to patients.~~

(2)(A)(i) Subject to the provisions of subdivision (B) of this subdivision (a)(2) and to the extent allowed under federal law, annually on or before April 1 of each year beginning in 2012, each manufacturer of prescribed products shall disclose to the office of the attorney general all free samples of prescribed products provided to health care providers during the preceding calendar year, identifying for each sample the product, recipient, number of units, and dosage.

(ii) The office of the attorney general may contract with academic researchers to release to such researchers data relating to manufacturer distribution of free samples, subject to confidentiality provisions and without including the names or license numbers of individual recipients, for analysis and aggregated public reporting.

(iii) Any public reporting of manufacturer distribution of free samples shall not include information that allows for the identification of individual recipients of samples or connects individual recipients with the monetary value of the samples provided.

(B) Subdivision (A) of this subdivision (a)(2) shall not apply to samples of prescription drugs required to be reported under Sec. 6004 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, if as of January 1, 2011, the office of the attorney general has determined that the U.S. Department of Health and Human Services will collect and report state- and recipient-specific information regarding manufacturer distribution of free samples of such prescription drugs.

(2)(3) Annually on July 1, each manufacturer of prescribed products also shall disclose to the office of the attorney general the name and address of the individual responsible for the manufacturer's compliance with the provisions of this section.

(3)(4) Disclosure shall be made on a form and in a manner prescribed by the office of the attorney general and shall require manufacturers of prescribed products to report each allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title including:

(A) except as otherwise provided in subdivision (a)(2) of this section, the value, nature, and purpose of each allowable expenditure, and gift permitted under subdivision 4631a(b)(2) of this title according to specific categories identified by the office of the attorney general;

(B) the name of the recipient;

(C) the recipient's address;

(D) the recipient's institutional affiliation;

(E) prescribed product or products being marketed, if any; and

(F) the recipient's state board number.

~~(4)~~(5) The office of the attorney general shall report annually on the disclosures made under this section to the general assembly and the governor on or before April 1. The report shall include:

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

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

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

~~(6)~~(7) The office of Vermont health access shall examine the data available from the office of the attorney general for relevant expenditures and determine whether and to what extent prescribing patterns by health care providers of prescribed products reimbursed by Medicaid, VHAP, Dr. Dynasaur, VermontRx, and VPharm may reflect manufacturer influence. The office may select the data most relevant to its analysis. The office shall report its analysis annually to the general assembly and the governor on or before October 1.

(b)(1) Annually on July 1, the office of the attorney general shall collect a \$500.00 fee from each manufacturer of prescribed products filing annual disclosures of expenditures greater than zero described in subsection (a) of this section.

(2) Fees collected under this section shall fund collection and analysis of information on activities related to the marketing of prescribed products under ~~sections section~~ section 4631a ~~and 4632~~ of ~~Title 18~~ this title and under this section. The fees shall be collected in a special fund assigned to the office.

(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer of prescribed products that fails to disclose as required by subsection (a) of this section a civil penalty of no more than \$10,000.00 per violation. Each unlawful failure to disclose shall constitute a separate violation.

(d) The terms used in this section shall have the same meanings as they do in section 4631a of this title.

**** HEALTH INSURANCE COVERAGE PROVISIONS ****

Sec. 34. 8 V.S.A. chapter 107, subchapter 12 is added to read:

Subchapter 12. Coverage for Dental Procedures

§ 4100i. ANESTHESIA COVERAGE FOR CERTAIN DENTAL PROCEDURES

(a) A health insurance plan shall provide coverage for the hospital or ambulatory surgical center charges and administration of general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for dental procedures performed on a covered person who is:

(1) a child seven years of age or younger who is determined by a dentist licensed pursuant to chapter 13 of Title 26 to be unable to receive needed dental treatment in an outpatient setting, where the provider treating the patient certifies that due to the patient's age and the patient's condition or problem, hospitalization or general anesthesia in a hospital or ambulatory surgical center is required in order to perform significantly complex dental procedures safely and effectively;

(2) a child 12 years of age or younger with documented phobias or a documented mental illness, as determined by a physician licensed pursuant to chapter 23 of Title 26 or by a licensed mental health professional, whose dental needs are sufficiently complex and urgent that delaying or deferring treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; for whom a successful result cannot be expected from dental care provided under local anesthesia; and for whom a superior result can be expected from dental care provided under general anesthesia; or

(3) a person who has exceptional medical circumstances or a developmental disability, as determined by a physician licensed pursuant to chapter 23 of Title 26, which place the person at serious risk.

(b) A health insurance plan may require prior authorization for general anesthesia and associated hospital or ambulatory surgical center charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(c) A health insurance plan may restrict coverage for general anesthesia and associated hospital or ambulatory surgical center charges to dental care that is provided by:

(1) a fully accredited specialist in pediatric dentistry;

(2) a fully accredited specialist in oral and maxillofacial surgery; and

(3) a dentist to whom hospital privileges have been granted.

(d) The provisions of this section shall not be construed to require a health insurance plan to provide coverage for the dental procedure or other dental care for which general anesthesia is provided.

(e) The provisions of this section shall not be construed to prevent or require reimbursement by a health insurance plan for the provision of general anesthesia and associated facility charges to a dentist holding a general anesthesia endorsement issued by the Vermont board of dental examiners if the dentist has provided services pursuant to this section on an outpatient basis in his or her own office and the dentist is in compliance with the endorsement's terms and conditions.

(f) As used in this section:

(1) "Ambulatory surgical center" shall have the same meaning as in 18 V.S.A. § 9432.

(2) "Anesthesiologist" means a person who is licensed to practice medicine or osteopathy under chapter 23 or 33 of Title 26 and who either:

(A) has completed a residency in anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology or their predecessors or successors; or

(B) is credentialed by a hospital to practice anesthesiology and engages in the practice of anesthesiology at that hospital full-time.

(3) "Certified registered nurse anesthetist" means an advanced practice registered nurse licensed by the Vermont board of nursing to practice as a certified registered nurse anesthetist.

(4) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, but does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

(5) "Licensed mental health professional" means a licensed physician, psychologist, social worker, mental health counselor, or nurse with professional training, experience, and demonstrated competence in the treatment of mental illness.

Sec. 35. 8 V.S.A. chapter 107, subchapter 13 is added to read:

Subchapter 13. Tobacco Cessation

§ 4100j. COVERAGE FOR TOBACCO CESSATION PROGRAMS

(a) A health insurance plan shall provide coverage of at least one three-month supply per year of tobacco cessation medication, including over-the-counter medication, if prescribed by a licensed health care practitioner for an individual insured under the plan. A health insurance plan may require the individual to pay the plan's applicable prescription drug co-payment for the tobacco cessation medication.

(b) As used in this subchapter:

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

(2) "Tobacco cessation medication" means all therapies approved by the federal Food and Drug Administration for use in tobacco cessation.

* * * CATAMOUNT PROVISIONS * * *

Sec. 36. 2 V.S.A. § 903(b)(2) is amended to read:

(2) If the commission determines that the market is not cost-effective, the agency of administration shall issue a request for proposals for the administration only of Catamount Health as described in section 4080f of Title 8. A contract entered into under this subsection shall not include the assumption of risk. If Catamount Health is administered under this subsection, the agency shall purchase a stop-loss policy for an aggregate claims amount for Catamount Health as a method of managing the state's financial risk. The agency shall determine the amount of aggregate stop-loss reinsurance and may purchase additional types of reinsurance if prudent and cost-effective. The agency may include in the contract the chronic care management program established under section 1903a of Title 33.

Sec. 37. 8 V.S.A. § 4080f is amended to read:

§ 4080f. CATAMOUNT HEALTH

* * *

(c)(1) Catamount Health shall provide coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services. The benefits for Catamount Health shall be a preferred provider organization plan with:

* * *

(2) Catamount Health shall provide a chronic care management program that has criteria substantially similar to the chronic care management program established in section 1903a of Title 33 in accordance with the Blueprint for Health established under chapter 13 of Title 18 and shall share the data on enrollees, to the extent allowable under federal law, with the secretary of administration or designee in order to inform the health care reform initiatives under section 3V.S.A. § 2222a of Title 3.

* * *

(f)(1) Except as provided for in subdivision (2) of this subsection, the carrier shall pay a health care professional the lowest of the health care professional's contracted rate, the health care professional's billed charges, or the rate derived from the Medicare fee schedule, at an amount 10 percent greater than fee schedule amounts paid under the Medicare program in 2006. Payments based on Medicare methodologies under this subsection shall be indexed to the Medicare economic index developed annually by the Centers for Medicare and Medicaid Services. The commissioner may approve adjustments to the amounts paid under this section in accordance with a carrier's pay for performance, quality improvement program, or other payment methodologies in accordance with the ~~blueprint for health~~ Blueprint for Health established under chapter 13 of Title 18.

(2) Payments for hospital services shall be calculated using a hospital-specific cost-to-charge ratio approved by the commissioner, adjusted for each hospital to ensure payments at 110 percent of the hospital's actual cost for services. The commissioner may use individual hospital budgets established under section ~~18 V.S.A. § 9456 of Title 18~~ to determine approved ratios under this subdivision. Payments under this subdivision shall be indexed to changes in the Medicare payment rules, but shall not be lower than 102 percent of the hospital's actual cost for services. The commissioner may approve adjustments to the amounts paid under this section in accordance with a carrier's pay for performance, quality improvement program, or other payment methodologies in accordance with the ~~blueprint for health~~ Blueprint for Health established under chapter 13 of Title 18.

(3) Payments for chronic care and chronic care management shall meet the requirements in section ~~18 V.S.A. § 702 of Title 18 and section 1903a of Title 33.~~

* * *

** * * OBESITY PREVENTION * * **

Sec. 38. REPORT ON OBESITY PREVENTION INITIATIVE

No later than November 15, 2010, the attorney general shall report to the house committees on health care and on human services, the senate committee on health and welfare, and the commission on health care reform regarding the results of the attorney general's initiative on the prevention of obesity. Specifically, the report shall include:

- (1) a list of the stakeholders involved in the initiative;*
- (2) the actions the stakeholder group identified and developed related to obesity prevention;*
- (3) the stakeholder group's recommendations; and*
- (4) opportunities identified by the group to generate revenue and the group's recommendations on how such revenue should be applied.*

Sec. 38a. STATUTORY REVISION

18 V.S.A. §§ 4051–4071 shall be recodified as subchapter 1 (labeling for marketing and sale) of chapter 82 of Title 18.

Sec. 38b. 18 V.S.A. chapter 82, subchapter 2 is added to read:

Subchapter 2. Menu Labeling

§ 4086. MENUS AND MENU BOARDS

(a) Except as otherwise provided in 4091 of this title, in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name, regardless of the type of ownership of the locations and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subsection (b) of this section.

(b) Except as otherwise provided in section 4091 of this title, the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner:

(1) On a menu listing an item for sale:

(A) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

(B) a succinct statement concerning suggested daily caloric intake, as specified by federal regulation or, in the absence of an applicable federal

~~regulation, by the commissioner of health by rule, posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu.~~

~~(2) On a menu board, including a drive-through menu board:~~

~~(A) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and~~

~~(B) a succinct statement concerning suggested daily caloric intake, as specified by federal regulation or, in the absence of an applicable federal regulation, by the commissioner of health by rule, posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board.~~

~~(3)(A) In a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the following nutrition information:~~

~~(i) the total number of calories in each serving size or other unit of measure of the food that are:~~

~~(I) derived from any source; and~~

~~(I) derived from the total fat; and~~

~~(ii) the amount of each of the following nutrients: Total fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber, and total protein contained in each serving size or other unit of measure;~~

~~(B) To the extent that federal statutes or regulations require disclosure of different or additional nutrition information, a restaurant or similar retail establishment that follows the federal law shall be deemed to be in compliance with the requirements of this subdivision (3).~~

~~(4) On the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in subdivision (3) of this subsection.~~

~~§ 4087. SELF-SERVICE FOOD AND FOOD ON DISPLAY~~

~~Except as otherwise provided in section 4091 of this title, in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to~~

~~customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.~~

§ 4088. REASONABLE BASIS

~~For the purposes of this chapter, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in Section 101.10 of Title 21, Code of Federal Regulations, or any successor regulation, or in a related guidance of the United States Food and Drug Administration.~~

§ 4089. MENU VARIABILITY AND COMBINATION MEALS

~~Except as otherwise provided by federal law or regulation, the commissioner of health shall establish by rule, pursuant to chapter 25 of Title 3, standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the commissioner, including ranges, averages, or other methods.~~

§ 4090. ADDITIONAL INFORMATION

~~Except as otherwise provided by federal law or regulation, if the commissioner of health determines that a nutrient, other than a nutrient required under subdivision 4086(b)(3) of this title, should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the commissioner may require, by rule, disclosure of such nutrient in the written form required under subdivision 4086(b)(3).~~

§ 4091. NONAPPLICABILITY TO CERTAIN FOOD

~~Sections 4086 through 4090, inclusive, of this chapter shall not apply to:~~

~~(1) items that are not listed on a menu or menu board, such as condiments and other items placed on the table or counter for general use;~~

~~(2) daily specials, temporary menu items appearing on the menu for fewer than 60 days per calendar year, or custom orders;~~

~~(3) such other food that is part of a customary market test appearing on the menu for fewer than 90 days, under terms and conditions established by federal law or regulation, if applicable; if not applicable, then under terms and conditions established by the commissioner of health by rule; or~~

~~(4) alcoholic beverages.~~

~~§ 4092. VOLUNTARY PROVISION OF NUTRITION INFORMATION~~

~~(a) An authorized official of any restaurant or similar retail food establishment not subject to the requirements of this chapter may elect to be subject to such requirements by registering biannually the name and address of such restaurant or similar retail food establishment with the Secretary of the U.S. Department of Health and Human Services and the commissioner of health, as specified by the Secretary by regulation and the commissioner by rule.~~

~~(b) To the extent allowed by federal law, within 120 days following the effective date of this chapter, the commissioner of health shall engage in rulemaking pursuant to chapter 25 of Title 3 specifying the terms and conditions for implementation of subsection (a) of this section.~~

~~(c) Nothing in this section shall be construed to authorize the commissioner of health to require an application, review, or licensing process for any entity to register with the Secretary pursuant to subsection (a) of this section.~~

~~§ 4093. RULEMAKING~~

~~(a) To the extent permitted under federal law, within one year after the effective date of this chapter, the commissioner of health shall adopt rules pursuant to chapter 25 of Title 3 to carry out the purposes of this chapter.~~

~~(b) In adopting rules, the commissioner shall:~~

~~(1) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the commissioner shall determine;~~

~~(2) specify the format and manner of the nutrient content disclosure requirements under this chapter; and~~

~~(3) reasonably align the rules, to the extent practicable, with federal and other states' laws on menu labeling.~~

~~(c) No later than January 15, 2011, the commissioner shall report to the house committee on human services and the senate committee on health and welfare a report on the commissioner's progress toward adopting rules under this section.~~

~~§ 4094. DEFINITIONS~~

~~To the extent not inconsistent with federal law, as used in this chapter.~~

~~(1) "Menu" or "menu board" means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.~~

~~(2) "Restaurant" or "other similar retail food establishment" means an establishment from which food or beverage of the type for immediate consumption is sold, whether such food is consumed on the premises or not.~~

~~(A) "Restaurant" shall not include any school, hospital, nursing home, assisted living facility, or any restaurant-like facility operated by or in connection with a school, hospital, medical clinic, nursing home, or assisted living facility providing food for students, patients, visitors, and their families.~~

~~(B) "Restaurant" shall not include grocery stores, except for separately owned food facilities to which this section otherwise applies that are located in a grocery store. For purposes of this subdivision, "grocery store" means a store primarily engaged in the retail sale of canned food, dry goods, fresh fruits and vegetables, and fresh meats, fish, and poultry. The term "grocery store" includes convenience stores.~~

~~(C) "Restaurant" shall not include any fraternal organization or any organization whose members consist solely of veterans of the armed forces of the United States.~~

~~(3) "Standard menu item" means any item listed on a menu or menu board by a restaurant, but excluding alcoholic beverages.~~

~~§ 4095. ENFORCEMENT; LIABILITY; PENALTY~~

~~(a) The commissioner of health or duly authorized agents or employees who inspect restaurants and food establishments on behalf of the department of health shall be required to determine that the nutrition information required under this subchapter is listed on the menu or menu board, and that any additional required information is available for customers upon request. If, upon inspection, the required information is not clearly visible on a menu or menu board or the additional required information is not available upon request, the commissioner or inspector shall note such fact on the inspection report and cause a corresponding reduction in points from the restaurant's or other food establishment's rating score.~~

~~(b) Nothing in this section shall be construed to create or enhance any claim, right of action, or civil liability that did not previously exist under state or federal law or to limit any claim, right of action, or civil liability that otherwise exists under state or federal law.~~

~~(c) No private right of action shall arise from this subchapter. The sole enforcement authority for this subchapter shall be the state of Vermont.~~

§ 4096. RELATION TO OTHER LAWS

To the extent permitted by federal law, nothing in this chapter shall be construed to restrict the ability of cities or towns to impose labeling requirements in excess of those required by this chapter.

Sec. 38b. 18 V.S.A. chapter 82, subchapter 2 is added to read:

Subchapter 2. Menu Labeling

§ 4086. MENUS AND MENU BOARDS

(a) Restaurants and similar food establishments that are part of a chain with 20 or more locations doing business under the same name and offering for sale substantially the same menu items shall disclose on the menu and on the menu board:

(1) adjacent to the name of each standard menu item the number of calories contained in the item; and

(2) a succinct statement concerning suggested daily caloric intake.

(b) This section shall not apply to alcoholic beverages or to grocery stores except for separately owned food facilities to which this section otherwise applies that are located in a grocery store. For purposes of this section, grocery stores include convenience stores.

(c) If at any time subsection (a) or (b) of this section or both are preempted by federal law, then restaurants and similar food establishments that are part of a chain with 20 or more locations doing business under the same name and offering for sale substantially the same menu items shall comply with the menu labeling provisions of the applicable federal statutes and regulations.

(d) A violation of this section shall be deemed a violation of the Consumer Fraud Act, chapter 63 of Title 9, provided that no private right of action shall arise from the provisions of this section. The attorney general has the same authority to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as provided under subchapter 1 of chapter 63 of Title 9.

Sec. 38b. 18 V.S.A. chapter 82, subchapter 2 is added to read:

Subchapter 2. Menu Labeling

§ 4086. MENUS AND MENU BOARDS

(a) Restaurants and similar food establishments that are part of a chain with 20 or more locations doing business under the same name and offering for sale substantially the same menu items shall disclose on the menu and on the menu board:

(1) adjacent to the name of each standard menu item the number of calories contained in the item; and

(2) a succinct statement concerning suggested daily caloric intake.

(b) This section shall not apply to alcoholic beverages or to grocery stores except for separately owned food facilities to which this section otherwise applies that are located in a grocery store. For purposes of this section, grocery stores include convenience stores.

(c) If at any time subsection (a) or (b) of this section or both are preempted by federal law, then restaurants and similar food establishments that are part of a chain with 20 or more locations doing business under the same name and offering for sale substantially the same menu items shall comply with the menu labeling provisions of the applicable federal statutes and regulations.

(d) A violation of this section shall be deemed a violation of the Consumer Fraud Act, chapter 63 of Title 9, provided that no private right of action shall arise from the provisions of this section. The attorney general has the same authority to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as provided under subchapter 1 of chapter 63 of Title 9.

*** * * MISCELLANEOUS PROVISIONS * * ***

Sec. 39. POSITION

In fiscal year 2011, the department of Vermont health access may establish one new exempt position to create a director of payment reform in the division of health care reform to fulfill the requirements in Sec. 14 of this act. This position shall be transferred and converted from existing vacant positions in the executive branch of state government

Sec. 40. APPROPRIATIONS

(a) It is the intent of the general assembly to fund the payment reform pilot projects described in Sec. 14 of this act, including the position provided for in Sec. 39 of this act for a total of \$250,000.00 in a budget neutral manner through the reallocation of existing sources in the fiscal year 2011 appropriations act.

(b) In fiscal year 2011, \$250,000.00 in general funds is appropriated to the joint fiscal committee for hiring the consultant required under Sec. 6 of this act.

(c) In fiscal year 2011, \$50,000.00 of the amount appropriated in general funds in Sec. B.125 of H.789 of the Acts of the 2009 Adj. Sess. (2010) and allocated to the commission on health care reform for studies is transferred to the joint fiscal committee for hiring the consultant required in Sec. 6 of this

act.

Sec. 41. EFFECTIVE DATES

(a) This section and Secs. 1 (findings), 2 (principles), 3 (goals), 4 (health care reform commission membership), 5 (appointments), 6 (design options), 7 (grants), 8 (public good), 9 (federal health care reform; BISHCA), 10 (federal health care reform; AHS), 11 (intent), 17 (demonstration waivers), 20 through 24 (hospital budgets), 25 (CON prospective need), 29 (rules; insurers), 31 (primary care study), 32 and 33 (pharmaceutical expenditures), and 38 (obesity report) of this act shall take effect upon passage.

(b) Secs. 12 and 13 (Blueprint for Health), 14 (payment reform pilots), 15 (8 V.S.A. § 4088h), 16 (hospital certification), 19 (Blueprint Expansion), 26 through 28 (insurer rate review), 31a (health care career awareness month), 36 and 37 (citation corrections), 39 (position), and 40 (appropriations) of this act shall take effect on July 1, 2010.

(c) Sec. 30 (8 V.S.A. § 4089b; loss ratio) shall take effect on January 1, 2011 and shall apply to all health insurance plans on and after January 1, 2011, on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than January 1, 2012.

(d) Secs. 34 and 35 of this act shall take effect on October 1, 2010, and shall apply to all health insurance plans on and after October 1, 2010, on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than October 1, 2011.

(e) Secs. 38a (statutory revision) and 38b (menu labeling) of this act shall take effect on January 1, 2011.