

NO. 191. AN ACT RELATING TO HEALTH CARE AFFORDABILITY
FOR VERMONTERS.

(H.861)

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

Sec. 1. HEALTH CARE REFORM PRINCIPLES

The general assembly adopts the following guidelines, modeled after the Coalition 21 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 care services for all Vermonters.

(2) Health care coverage needs to be comprehensive and continuous.

(3) Vermont's health delivery system must model continuous improvement of health care quality and safety.

(4) The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.

(5) Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.

(6) Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Sec. 2. LEGISLATIVE PURPOSE AND INTENT

(a) It is the intent of the general assembly that all Vermonters receive affordable and appropriate health care at the appropriate time and that health care costs be contained over time. The general assembly finds that effective

first steps to achieving this purpose are the prevention and management of chronic conditions; coverage of the uninsured through Catamount Health, a comprehensive and affordable benefit plan with sliding-scale premiums; and providing minimum preventive services starting with immunizations for all Vermonters. The general assembly finds that chronic care management is one tool to contain health care costs and ensure that the costs of Vermont's health care system become sustainable.

(b) It is also the intent of the general assembly to ensure that any reduction in the "cost shift" to private insurance is returned to consumers by slowing the rate of growth in insurance premiums. This cost shift results when the costs of health services are inadequately paid for by public health care programs and when individuals are unable to pay for services. Raising Medicaid payment rates and reducing the number of uninsured will reduce this cost shift. In addition, standardizing the minimum criteria and reporting requirements for uncompensated care and bad debt write-offs by hospitals will more clearly identify and account for this cost shift.

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

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

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

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

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

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

(2) the Vermont health information technology project pursuant to section 9417 of Title 18.

(3) the multi-payer data collection project pursuant to section 9410 of Title 18.

(4) the common claims administration project pursuant to section 9408 of Title 18.

(5) the consumer price and quality information system pursuant to section 9410 of Title 18.

(6) any information technology work done by the quality assurance system pursuant to section 9416 of Title 18.

(7) the public health promotion programs of the agency of human

services.

(8) Medicaid, the Vermont health access plan, Dr. Dynasaur, premium assistance programs for employer-sponsored insurance, VPharm, and Vermont Rx, established in chapter 19 of Title 33, which are programs to provide health care coverage to elderly, disabled, and low to middle income Vermonters.

(9) Catamount Health, established in section 4080f of Title 8, which provides a comprehensive benefit plan with a sliding-scale premium based on income to uninsured Vermonters.

(10) the uniform hospital uncompensated care policies.

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

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

* * * Chronic Care Infrastructure and Prevention * * *

Sec. 4. BLUEPRINT FOR HEALTH

(a) The general assembly endorses the “blueprint for health” chronic condition prevention and chronic care management initiative as a foundation which it intends to strengthen by broadening its scope and coordinating the initiative with other public and private chronic care coordination and management programs.

(b) The charge and the strategic plan for the blueprint for health are codified in Sec. 5 of this act as chapter 13 of Title 18.

(c)(1) The department of health shall revise the current strategic plan for the blueprint for health and provide the revised plan to the commission on health care reform, the health access oversight committee, the house committee on health care, and the senate committee on health and welfare no later than October 1, 2006.

(2) The revised strategic plan shall provide that a model for the chronic care information system under the blueprint for health is fully designed no later than January 1, 2007.

(3) Due to the increase in funding and expected expanded capacity of the blueprint for health, the commissioner of health, in collaboration with the executive committee established under section 702 of Title 18, shall consider and include recommendations in the revised strategic plan for an implementation structure and time line. The considerations and recommendations shall include at minimum an assessment of the options for an

organizational structure and a recommendation as to which structure is most likely to achieve the statewide goals of the blueprint for health, to maintain an effective partnership between the public and private sectors, and to broaden the participation of stakeholders statewide. The commissioner of health shall submit a preliminary report on the implementation structure no later than June 15, 2006 to the commission on health care reform.

Sec. 5. 18 V.S.A. chapter 13 is added to read:

CHAPTER 13. CHRONIC CARE INFRASTRUCTURE

AND PREVENTION MEASURES

§ 701. DEFINITIONS

For the purposes of this chapter:

(1) “Blueprint for health” 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.

(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, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease,

cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

(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, 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.

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

(a) In coordination with the secretary of administration under section 2222a of Title 3, the commissioner of health shall be responsible for the development and implementation of the blueprint for health, including the five-year strategic plan.

(b)(1) The commissioner shall establish an executive committee to advise the commissioner 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 a representative from the department of banking, insurance, securities, and health care administration; the office of Vermont health access; the Vermont medical society; the Vermont program for quality in health care; 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; and a primary care professional serving low income or uninsured Vermonters.

(2) The executive committee shall engage a broad range of health care professionals who provide services as defined under section 4080f of Title 18, health insurance plans, professional organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local government in developing and implementing a five-year strategic plan.

(c)(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 to be included in the chronic care infrastructure and for statewide implementation of the blueprint for health;

(I) identification of resource needs for implementation 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, 2009 by 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.

(2) The strategic plan shall be reviewed biennially and amended as necessary to reflect changes in priorities. Amendments to the plan shall be reported to the general assembly in the report established under subsection (d) of this section.

(d)(1) The commissioner of health shall report annually on the status of implementation of the Vermont blueprint for health 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 (c) 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; and other information as requested by the committees. The surveys shall be developed in collaboration with the executive committee established under subsection (b) of this section.

(2) If statewide participation in the blueprint for health is not achieved by January 1, 2009, the commissioner shall evaluate the blueprint for health and recommend to the general assembly changes necessary to create alternative measures to ensure statewide participation by health insurers, third party administrators, and health care professionals.

Sec. 6. 33 V.S.A. § 1903a is added to read:

§ 1903a. CHRONIC CARE MANAGEMENT PROGRAM

(a) The secretary of administration or designee shall create a chronic care management program as provided for in this section, which shall be administered or provided by a private entity for individuals with one or more chronic conditions who are enrolled in Medicaid, the Vermont health access plan (VHAP), or Dr. Dynasaur. The program shall not include individuals who are also eligible for Medicare, who are enrolled in the Choices for Care Medicaid Section 1115 waiver or who are in an institute for mental disease as defined in 42 C.F.R. § 435.1009. The secretary may also exclude individuals who are eligible for or participating in the Medicaid care coordination program established through the office of Vermont health access.

(b) The secretary shall include a broad range of chronic conditions in the chronic care management program.

(c) The chronic care management program shall be designed to include:

(1) a method involving the health care professional in identifying eligible patients, including the use of the chronic care information system established in section 702 of Title 18, an enrollment process which provides incentives and strategies for maximum patient participation, and a standard statewide health risk assessment for each individual;

(2) the process for coordinating care among health care professionals;

(3) the methods of increasing communications among health care professionals and patients, including patient education, self-management, and follow-up plans;

(4) the educational, wellness, and clinical management protocols and tools used by the care management organization, including management guideline materials for health care professionals to assist in patient-specific recommendations;

(5) process and outcome measures to provide performance feedback for health care professionals and information on the quality of care, including patient satisfaction and health status outcomes;

(6) payment methodologies to align reimbursements and create financial incentives and rewards for health care professionals to establish management systems for chronic conditions, to improve health outcomes, and to improve

the quality of care, including case management fees, pay for performance, payment for technical support and data entry associated with patient registries, the cost of staff coordination within a medical practice, and any reduction in a health care professional's productivity;

(7) payment to the care management organization which would put the care management organization's fee at risk if the management is not successful in reducing costs to the state;

(8) a requirement that the data on enrollees be shared, to the extent allowable under federal law, with the secretary in order to inform the health care reform initiatives under section 2222a of Title 3;

(9) a method for the care management organization to participate closely in the blueprint for health and other health care reform initiatives; and

(10) participation in the pharmacy best practices and cost-control program under subchapter 5 of chapter 19 of this title, including the multi-state purchasing pool and the statewide preferred drug list.

(d) The secretary shall issue a request for proposals for the program established under this section and shall review the request for proposals with the commission on health care reform prior to issuance. The issuance of the request for proposals is conditioned on the approval of the commission in order to ensure that the request meets the intent of this section, section 702 of Title 18, and chapter 19 of this title. Any contract under this section may allow the

entity to subcontract some services to other entities if it is cost-effective, efficient, or in the best interest of the individuals enrolled in the program.

(e) The secretary shall ensure that the chronic care management program is modified over time to comply with the Vermont blueprint for health strategic plan and to the extent feasible, collaborate in its initiatives.

Sec. 7. PREVENTION AND CHRONIC CARE MANAGEMENT; AGENCY
OF HUMAN SERVICES; IMPLEMENTATION PLAN

(a) No later than January 1, 2007, the agency of human services shall develop an implementation plan for prevention of chronic conditions and for chronic care management which at minimum meets the criteria and requirements of chapter 13 of Title 18 and section 1903a of Title 33. The agency's implementation plan shall be revised periodically to reflect changes to the Vermont blueprint for health strategic plan. In addition to the chronic care management provided under section 1903a of Title 33, the agency may provide additional care coordination services to appropriate individuals as specified in its strategic plan. The agency shall ensure that Medicaid, Medicaid waiver programs, and Dr. Dynasaur change the payment methodologies in order to align with the recommendation of the strategic plan developed under chapter 13 of Title 18 and the request for proposals under section 1903a of Title 33. The agency shall analyze and include a recommendation as to any waivers or waiver modifications needed to implement a chronic care management program.

(b) Where permitted under federal law, the agency shall require recertification or reapplication for Medicaid, the Vermont health access plan (VHAP), and Dr. Dynasaur no more often than once a year.

Sec. 8. PREVENTION AND CHRONIC CARE MANAGEMENT; STATE EMPLOYEES

The commissioner of human resources shall include in any request for proposals for the administration of the health benefit plans for state employees a request for a description of any chronic care management program provided by the entity and how the program aligns with the Vermont blueprint for health strategic plan developed under section 702 of Title 18. The commissioner shall also work with the secretary of administration or designee, and the Vermont state employees' association on how and when to align the state employees' health benefit plan with the goals and statewide standards developed by the Vermont blueprint for health in section 702 of Title 18.

* * * Medicaid Initiatives * * *

Sec. 9. MEDICAID REIMBURSEMENT

(a)(1) The office of Vermont health access shall adjust Medicaid and the Vermont health access plan reimbursement to reflect the following priorities in the following order:

(A) an increase in base rates for evaluation and management procedure codes to enhance payment to a level equivalent to the 2006 rates in the Medicare program;

(B) incentives and payment restructuring for health care professionals participating in the care coordination program;

(C) an increase in base rates for current procedural terminology (CPT) codes which are significantly lower than the 2006 Medicare reimbursement levels starting with the lowest first; and

(D) an increase in dental reimbursement by, first, restoring the reductions in adult dental rates which were effective February 1, 2006 and, second, by splitting the remaining amount approximately in half to increase rates for dental services and to increase the dental cap for adults in such a manner as to offset any loss in benefit level due to the rate increases.

(2) The Medicaid reimbursement rate increases in subdivision (1) of this subsection shall be effective on January 1, 2007 for fiscal year 2007 and July 1 for fiscal years 2008 through 2010.

(b) To the extent permitted by the appropriation in Sec. 107 of H.881 of the 2005 Adj. Sess. (2006), the office of Vermont health access shall increase Medicaid reimbursements to hospitals effective January 1, 2007. In fiscal year 2008 and thereafter, the office shall increase Medicaid reimbursement rates as provided for in this subsection annually on July 1 until the federal upper limit is reached.

(c) In fiscal years subsequent to 2007, it is the intent of the general assembly that Medicaid reimbursement increases to health care professionals and hospitals under Medicaid, the Vermont health access plan, and Dr.

Dynasaur should be tied to the standards and quality or performance measures developed under the Vermont blueprint for health strategic plan established in section 702 of Title 18. Prior to implementation, these standards shall be approved by the general assembly through the appropriations process.

(d) No later than October 31, 2006, the office shall report to the health access oversight committee with a plan for allocation of the appropriated amounts for fiscal year 2007 among the priorities established in subsection (a) of this section and among hospital reimbursements as provided for in subsection (b) of this section. Prior to the implementation of the reimbursement adjustments in this section, the health access oversight committee shall review and determine if the allocation among the priorities is equitable and reflects legislative intent.

Sec. 10. BLUEPRINT FOR HEALTH; REIMBURSEMENT

From the funds appropriated in Sec. 115a of H.881 of the 2005 Adj. Sess. (2006), the department of health shall provide incentive grants and stipends to physician practices participating in any pilot projects developed under the Vermont blueprint for health established in section 702 of Title 18.

Sec. 11. VHAP PREMIUM REDUCTIONS

Sec. 147(d) of No. 66 of the Acts of 2003, as amended by Sec. 129 of No. 122 of the Acts of the 2003 Adj. Sess. (2004) and Sec. 279 of No. 71 of the Acts of 2005, is further amended to read:

(d) VHAP, premium-based.

* * *

(2) The agency shall establish per individual premiums for the VHAP Uninsured program for the following brackets of income for the VHAP group as a percentage of federal poverty level (FPL):

(A) Income greater than 50 percent and less than or equal to 75 percent of FPL: ~~\$11.00~~ \$7.00 per month.

(B) Income greater than 75 percent and less than or equal to 100 percent of FPL: ~~\$39.00~~ \$25.00 per month.

(C) Income greater than 100 percent and less than or equal to 150 percent of FPL: ~~\$50.00~~ \$33.00 per month.

(D) Income greater than 150 percent and less than or equal to 185 percent of FPL: ~~\$75.00~~ \$49.00 per month.

Sec. 12. DR. DYNASAUR AND SCHIP PREMIUM REDUCTIONS

Sec. 147(f) of No. 66 of the Acts of 2003, as amended by Sec. 280 of No. 71 of the Acts of 2005, is amended to read:

(f) Dr. Dynasaur and SCHIP premium changes.

(1) The agency is authorized to amend the rules for individuals eligible for Dr. Dynasaur under the federal Medicaid and SCHIP programs to require beneficiary households to pay a monthly premium based on the following:

(A) for individuals living in households whose incomes are greater than 225 percent of FPL and less than or equal to 300 percent of FPL, and who have no other insurance coverage: ~~\$80.00~~ \$40.00 per household per month.

(B) for individuals living in households whose incomes are greater than 225 percent of FPL and less than or equal to 300 percent of FPL, and who have other insurance coverage: ~~\$40.00~~ \$20.00 per household per month.

(C) for individuals living in households whose incomes are greater than 185 percent of FPL and less than or equal to 225 percent of FPL: ~~\$30.00~~ \$15.00 per household per month.

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Sec. 13. 33 V.S.A. § 1974 is added to read:

§ 1974. EMPLOYER-SPONSORED INSURANCE; PREMIUM

ASSISTANCE

(a) No later than October 1, 2007, subject to approval by the Centers for Medicare and Medicaid Services, the agency of human services shall establish a premium assistance program to assist individuals eligible for or enrolled in the Vermont health access plan and uninsured individuals with incomes under 300 percent of the federal poverty guidelines and their dependents to purchase an approved employer-sponsored insurance plan if offered to those individuals by an employer. The agency shall determine whether to include children who are eligible for Medicaid or Dr. Dynasaur in the premium assistance program at their parent's option. The agency shall not mandate participation of children in employer-sponsored insurance.

(b) VHAP-eligible premium assistance.

(1) For individuals enrolled in or who apply for enrollment in the

Vermont health access plan on or after October 1, 2007 who have access to an approved employer-sponsored insurance plan, the premium assistance program shall provide:

(A) A subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual is obligated to make out-of-pocket expenditures for premiums and cost-sharing amounts which are substantially equivalent to or less than the premium and cost-sharing obligations on an annual basis under the Vermont health access plan.

(B) Supplemental benefit coverage equivalent to the benefits offered by the Vermont health access plan.

(2) In consultation with the department of banking, insurance, securities, and health care administration, the agency shall develop criteria for approving employer-sponsored health insurance plans to ensure the plans provide comprehensive and affordable health insurance when combined with the assistance under this section. At minimum, an approved employer-sponsored insurance plan shall conform to the following standards:

(A) The benefits covered by the plan must be substantially similar to the benefits covered under the certificates of coverage offered by the typical benefit plans issued by the four health insurers with the greatest number of covered lives in the small group and association market in this state.

(B) The plan shall include appropriate coverage of chronic conditions

in a manner consistent with statewide participation by health insurers in the Vermont blueprint for health, and in accordance with the standards established in section 702 of Title 18.

(3) The agency shall determine whether it is cost-effective to the state to enroll an individual in an approved employer-sponsored insurance plan with the premium assistance under this subsection as compared to enrolling the individual in the Vermont health access plan. If the agency determines that it is cost-effective, the individual shall be required to enroll in the approved employer-sponsored plan as a condition of continued assistance under this section or coverage under the Vermont health access plan, except that dependents who are children of eligible individuals shall not be required to enroll in the premium assistance program. Notwithstanding this requirement, an individual shall be provided benefits under the Vermont health access plan until the next open enrollment period offered by the employer or insurer.

(c) Uninsured individuals; premium assistance.

(1) For the purposes of this subsection:

(A) “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, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease,

cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

(B) “Uninsured” means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(i) the individual’s coverage ended because of:

(I) loss of employment;

(II) death of the principal insurance policyholder;

(III) divorce or dissolution of a civil union;

(IV) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(V) no longer qualifying for COBRA, VIPER, or other state continuation coverage; or

(ii) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

(C) “Vermont resident” means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act

or acts consistent with that intent.

(2) An individual is eligible for premium assistance under this subsection if the individual:

(A) is an uninsured Vermont resident;

(B) has income under 300 percent of the federal poverty level;

(C) has access to an approved employer-sponsored insurance plan;

and

(D) is 18 or over and is not claimed on a tax return as a dependent of a resident of another state.

(3) The premium assistance program under this subsection shall provide a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual, with greater amounts of financial assistance provided to eligible individuals with lower household income and lesser amounts of assistance provided to eligible individuals with higher household income. Until an approved employer-sponsored plan is required to meet the standard in subdivision (4)(B)(ii) of this subsection, the subsidy shall include premium assistance and assistance to cover all cost-sharing amounts for chronic care.

(4) In consultation with the department of banking, insurance, securities, and health care administration, the agency shall develop criteria for approving employer-sponsored health insurance plans to ensure the plans provide comprehensive and affordable health insurance when combined with the assistance under this section. At minimum, an approved employer-sponsored

insurance plan shall include:

(A) covered benefits to be substantially similar, as determined by the agency, to the benefits covered under Catamount Health; and

(B)(i) until January 1, 2009 or when statewide participation in the Vermont blueprint for health is achieved, appropriate coverage of chronic conditions in a manner consistent with statewide participation by health insurers in the Vermont blueprint for health, and in accordance with the standards established in section 702 of Title 18;

(ii) after statewide participation is achieved, coverage of chronic conditions substantially similar to Catamount Health.

(5) The agency shall determine whether it is cost-effective to the state to require the individual to purchase the approved employer-sponsored insurance plan with premium assistance under this subsection instead of Catamount Health established in section 4080f of Title 8 with assistance under subchapter 3a of chapter 19 of this title. If providing the individual with assistance to purchase Catamount Health is more cost-effective to the state than providing the individual with premium assistance to purchase the individual's approved employer-sponsored plan, the state shall provide the individual the option of purchasing Catamount Health with assistance for that product. An individual may purchase Catamount Health and receive Catamount Health assistance until the approved employer-sponsored plan has an open enrollment period, but the individual shall be required to enroll in the approved employer-sponsored plan

in order to continue to receive any assistance.

(d) Participation in an approved employer-sponsored insurance plan with premium assistance under this section or Catamount Health shall not disqualify an individual from the Vermont health access plan if an approved employer-sponsored insurance plan or Catamount Health is no longer available to that individual.

(e) If the emergency board determines that the funds appropriated for either of the premium assistance programs under this section are insufficient to meet the projected costs of enrolling new program participants into the appropriate program, the emergency board shall suspend new enrollment in that program or restrict enrollment to eligible lower income individuals. This subsection does not affect eligibility for the Vermont health access plan or purchase of Catamount Health.

(f) The agency of human services shall request federal approval for an amendment to the Global Commitment for Health Medicaid Section 1115 waiver for the premium assistance program authorized by this section.

(g)(1) Of the amount appropriated in H.881 of the 2005 Adj. Sess. (2006) for the employer-sponsored insurance premium assistance program established by this section, no more than \$250,000.00 may be expended for start-up and initial administrative expenses until the report as required by subdivision (2) of this subsection has been received and approved.

(2) No additional amounts appropriated in H.881 of the 2005 Adj. Sess. (2006) for the employer-sponsored premium assistance program may be made after November 15, 2006 without approval of a majority of the combined membership of the joint fiscal committee and the health access oversight committee at a joint meeting upon receipt of a report from the agency, which must include the following:

(A) a plan for the additional expenditures;

(B) a survey to determine whether and how many individuals currently enrolled in VHAP, including those eligible as caretakers, are potentially eligible for employer-sponsored premium assistance under this section;

(C) the sliding-scale premium and cost-sharing assistance amounts provided under the premium assistance program to individuals;

(D) a description and estimate of benefits offered by the Vermont health access plan that are likely to be provided as supplemental benefits for the employer-sponsored premium assistance program enrollees;

(E) a plan for covering dependent children through the premium assistance program; and

(F) the anticipated budgetary impact of an employer-sponsored insurance premium assistance program for fiscal year 2008, including savings attributable to enrolling current VHAP enrollees in the premium assistance

program established under this section, the start-up and administrative costs of the program, and the cost of providing the subsidy to these enrollees.

(h) The agency shall report monthly to the joint fiscal committee, the health access oversight committee, and the commission on health care reform with the number of individuals enrolled in the premium assistance program, the income levels of the individuals, a description of the range and types of employer-sponsored plans that have been approved, the percentage of premium and cost-sharing amounts paid by employers whose employees participate in the premium assistance program, and the net savings or cost of the program.

(i) The health access oversight committee shall monitor the development, implementation, and ongoing operation of the employer-sponsored premium assistance program under this section.

Sec. 14. AGENCY OF HUMAN SERVICES; SOLE SOURCE

Notwithstanding subsection 2222(g) of Title 3 and the requirements of the agency's bulletin 3.5 (Contracting Procedures), the agency of human services may negotiate contracts with a sole source for information technology or administrative services necessary for application simplification, surveys, outreach and enrollment assistance, reporting, and public notices and hearings if necessary to implement the employer-sponsored insurance premium assistance programs, the Catamount Health assistance program, or to ensure an individual's seamless transition between the agency's programs, employer-sponsored insurance premium assistance programs, and the Catamount Health

assistance program by October 1, 2007. The requirements of section 1903a of Title 33 are not waived by this section.

Sec. 15. 8 V.S.A. § 4080f is added to read:

§ 4080f. CATAMOUNT HEALTH

(a) As used in this section:

(1) “Carrier” means a registered small group carrier as defined in section 4080a of this title.

(2) “Catamount Health” means the plan for coverage of primary care, preventive care, chronic care, acute episodic care, and hospital services as established in this section to be provided through a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization subscriber contract which is offered or issued to an individual and which meets the requirements of this section.

(3) “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, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

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

(7) “Preventive care” means health services provided by health care professionals to identify and treat asymptomatic individuals who have developed risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

(8) “Primary care” means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by

problem origin, organ system, or diagnosis, and shall include prenatal care and the treatment of mental illness.

(9) “Uninsured” means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no private insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(A) the individual’s private insurance or employer-sponsored coverage ended because of:

(i) loss of employment;

(ii) death of the principal insurance policyholder;

(iii) divorce or dissolution of a civil union;

(iv) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(v) no longer qualifying for COBRA, VIPER, or other state continuation coverage; or

(B) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

(b) No person may sell, offer, or renew Catamount Health unless such person is a registered small group carrier and has filed a letter of intent pursuant to this section.

(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:

(A) a \$250.00 deductible for an individual and a \$500.00 deductible for a family for health services received in network, and a \$500.00 deductible for an individual and a \$1,000.00 deductible for a family for health services received out of network;

(B) 20 percent co-insurance, in and out of network;

(C) a \$10.00 office co-payment;

(D) prescription drug coverage without a deductible, \$10.00 co-payments for generic drugs, \$30.00 co-payments for drugs on the preferred drug list, and \$50.00 co-payments for nonpreferred drugs;

(E) out-of-pocket maximums of \$800.00 for an individual and \$1,600.00 for a family for in-network services and \$1,500.00 for an individual and \$3,000.00 for a family for out-of-network services; and

(F) a waiver of the deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.

(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 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 2222a of Title 3.

(3) Notwithstanding sections 4516, 4588, and 5115 of this title, a carrier may use financial or other incentives to encourage healthy lifestyles and patient self-management for individuals covered by Catamount Health. These incentives shall comply with the health promotion and disease prevention program rules adopted by the commissioner under subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

(4) To the extent Catamount Health provides coverage for any particular type of health service or for any particular medical condition, it shall cover those health services and conditions when provided by any type of health care professional acting within the scope of practice authorized by law. Catamount Health may establish a term or condition that places a greater financial burden on an individual for access to treatment by the type of health care professional only if it is related to the efficacy or cost-effectiveness of the type of service.

(5) Notwithstanding subsections 4513(c), 4584(c), and 5104(b) of this title, the commissioner may establish a pay-for-performance demonstration project for carriers offering Catamount Health.

(d)(1) A carrier shall guarantee acceptance of any uninsured individual for any Catamount Health plan offered by the carrier. A carrier shall also guarantee acceptance of each dependent of an uninsured individual in Catamount Health. An individual who is eligible for an employer-sponsored insurance plan may not purchase Catamount Health, except as provided for in subdivision (2) of this subsection. Any dispute regarding eligibility shall be resolved by the department in a manner to be determined by rule.

(2) An individual with income under 300 percent of the federal poverty level who is eligible for an employer-sponsored insurance plan may purchase Catamount Health if:

(A) the individual's employer-sponsored insurance plan is not an approved employer-sponsored plan under section 1974 of Title 33;

(B) enrolling the individual in an approved employer-sponsored plan combined with premium assistance under section 1974 of Title 33 offered by the agency of human services is not cost-effective to the state as compared to enrolling the individual in Catamount Health combined with the assistance under subchapter 3a of chapter 19 of Title 33; or

(C) the individual is eligible for employer-sponsored insurance premium assistance under section 1974 of Title 33, but is unable to enroll in the employer's insurance plan until the next open enrollment period.

(3) An individual who loses eligibility for the employer-sponsored premium programs in section 1974 of Title 33 may purchase Catamount Health without being uninsured for 12 months.

(4) An individual of the age of majority who is claimed on a tax return as a dependent of a resident of another state shall not be eligible to purchase Catamount Health.

(e) For a 12-month period from the effective date of coverage, a carrier offering Catamount Health may limit coverage of preexisting conditions which existed during the 12-month period before the effective date of coverage, except that such exclusion or limitation shall not apply to chronic care if the individual is participating in a chronic care management program. A carrier shall waive any preexisting condition provisions for all individuals and their dependents who produce evidence of continuous creditable coverage during the previous nine months. If an individual has a preexisting condition excluded under a subsequent policy, such exclusion shall not continue longer than the period required under the original contract or 12 months, whichever is less. The carrier shall credit prior coverage that occurred without a break in coverage of 63 days or more. For an eligible individual, as such term is defined in Section 2741 of Title XXVII of the Public Health Service Act, a carrier offering Catamount Health shall not limit coverage of preexisting conditions.

(f)(1) Except as provided for in subdivision (2) of this subsection, the

carrier shall pay health care professionals using the Medicare payment methodologies at a level ten percent greater than for levels paid under the Medicare program in 2006. Payments under this subsection shall be indexed to the Medicare economic index developed by the Centers for Medicare and Medicaid Services.

(2) Payments for hospital services shall be calculated using the Medicare payment methodology adjusted for each hospital to ensure payments at 110 percent of the hospital's actual cost for services. 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.

(3) Payments for chronic care and chronic care management shall meet the requirements in section 702 of Title 18 and section 1903a of Title 33.

(4) If Medicare does not pay for a service covered under Catamount Health, the commissioner shall establish some other payment amount for such services, determined after consultation with affected health care professionals and insurers.

(5) A carrier offering Catamount Health shall renegotiate existing contracts with health care professionals as necessary in order to pay the reimbursements provided for in this subsection.

(6) All provisions of this subsection shall apply notwithstanding subsections 4513(c), 4584(c), and 5104(b) of this title.

(g)(1) Approval of rates and forms for Catamount Health shall be pursuant to the process established herein and rules adopted pursuant to this section. Premium rates shall be actuarially determined considering differences in the demographics of the populations and the different levels and methods of reimbursement for health care professionals.

(2) No rate or form shall be approved if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state. A rate shall be approved if it is sufficient not to threaten the financial safety and soundness of the insurer, reflects efficient and economical management, provides Catamount Health at the most reasonable price consistent with actuarial review, is not unfairly discriminatory, and complies with the other requirements of this section.

(h) With each rate filing, a carrier shall file a certification by a member of the American Academy of Actuaries of the carrier's compliance with this section. The requirements for certification shall be as the commissioner by rule prescribes.

(i) Catamount Health shall be offered with a rate structure which at least differentiates among single-person, two-person, and family rates, and the rates shall be guaranteed for 12 months from the date the individual enrolls.

(j) A carrier offering Catamount Health shall use a community rating method acceptable to the commissioner for determining premiums for Catamount Health plans. Catamount Health plans shall constitute a separate

market and shall be rated as a distinct pool, separate from other individual or group insurance products. For Catamount Health, the following risk classification factors are prohibited from use in rating individuals and their dependents:

(1) demographic rating, including age and gender rating;

(2) geographic area rating;

(3) industry rating;

(4) medical underwriting and screening;

(5) experience rating;

(6) tier rating; or

(7) durational rating.

(k) Catamount Health shall be considered an individual health insurance plan, health benefit plan, health insurance contract, and health insurance policy for purposes of Vermont law, but shall not be subject to section 4080b of this title.

(l) Catamount Health shall not be sold prior to October 1, 2007. Rates and forms may be filed and approved prior to that date, and marketing and sales targeted to an effective date of October 1, 2007 shall be allowed in the discretion of the commissioner.

(m) A letter of intent, proposed rates, and proposed forms shall be filed consistent with the requirements of this section and the rules adopted pursuant to this section.

(1) A carrier shall notify the department that it intends to offer Catamount Health by filing written notice of that intent no later than 30 days after the effective date of the expedited adoption of Catamount Health rules.

(2) Forms shall be filed initially no later than five months after the letter of intent and upon any change. Forms may not be used unless and until approved as described in this section. The department shall notify the carrier within 45 days whether the form meets the requirements set by statute and rule.

(3) Rates shall be filed prior to use and initially no later than five months after the letter of intent. Thereafter, rates shall be filed at least annually on a schedule and in a manner established by rule. The department shall notify the carrier within 45 days whether the rates meet the requirements set by statute and rule.

(4) In any notice denying approval of a rate or form, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer, provided that the written request for hearing is filed with the department within 30 days of the notice of disapproval. After the expiration of 30 days from the filing of any such form or premium rate, or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 days' written notice has been given to the insurer using such form or premium rate, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which

shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

(n) A carrier may discontinue sales of Catamount Health upon at least six months' prior written notice to the commissioner. Following such notice, if there are any individuals who continue to be covered by Catamount Health for whom the carrier does not have approved premium rates, the commissioner may approve premium rates adjusted by the average Vermont nongroup trends for cost and utilization for the previous six months.

Sec. 16. Subchapter 3a of chapter 19 of Title 33 is added to read:

Subchapter 3a. Catamount Health Assistance Program

§ 1981. POLICY AND PURPOSE

The Catamount Health assistance program is established to provide uninsured Vermont residents financial assistance in purchasing Catamount Health, a defined benefit package of primary, preventive, hospital, acute episodic care, and chronic care, including assistance in preventing and managing chronic conditions.

§ 1982. DEFINITIONS

As used in this subchapter:

(1) "Catamount Health" means the health benefit plan offered under section 4080f of Title 8.

(2) "Uninsured" means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur and had no private

insurance or employer-sponsored coverage that includes both hospital and physician services within 12 months prior to the month of application, or lost private insurance or employer-sponsored coverage during the prior 12 months for the following reasons:

(A) the individual's private insurance or employer-sponsored coverage ended because of:

(i) loss of employment;

(ii) death of the principal insurance policyholder;

(iii) divorce or dissolution of a civil union;

(iv) no longer qualifying as a dependent under the plan of a parent or caretaker relative; or

(v) no longer qualifying for COBRA, VIPER, or other state continuation coverage; or

(B) college- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of absence, or otherwise terminated studies.

(3) "Vermont resident" means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent.

§ 1983. ELIGIBILITY

(a)(1) Except as provided in subdivisions (3) and (4) of this subsection, an

individual shall be eligible for Catamount Health assistance if the individual is an uninsured Vermont resident without access to an approved employer-sponsored insurance plan under section 1974 of this title.

(2) An individual who has access to an employer-sponsored insurance shall be eligible for assistance under this subchapter only if the individual does not have employer-sponsored insurance approved for premium assistance under section 1974 of this title or if it is more cost-effective to the state for the individual to purchase Catamount Health with the assistance under this subchapter than for the state to provide premium assistance under section 1974 of this title. In addition, an individual may receive assistance under this subchapter temporarily until the individual is able to enroll in an approved employer-sponsored plan and receive premium assistance under section 1974.

(3) An individual shall not be eligible for Catamount Health assistance if the individual is of the age of majority and is claimed on a tax return as a dependent of a resident of another state.

(b) An individual receiving benefits under Medicaid, the Vermont health access plan, Dr. Dynasaur, or premium assistance for employer-sponsored insurance under section 1974 of this title within 12 months of applying for Catamount Health assistance shall not be required to wait 12 months to be eligible.

(c) The agency of administration or designee shall establish rules pursuant to chapter 25 of Title 3 on the specific criteria to demonstrate eligibility

consistent with the requirements essential for federal financial participation, including criteria for and proof of residency, income, and insurance status.

(d) If the emergency board determines that the funds appropriated for the Catamount Health assistance program under this subchapter are insufficient to meet the projected costs of enrolling new program participants, the emergency board shall suspend new enrollment in that program or restrict enrollment to eligible lower income individuals.

§ 1984. INDIVIDUAL CONTRIBUTIONS

(a) The agency shall provide assistance to individuals eligible under this subchapter to purchase Catamount Health. The amount of the assistance shall be the difference between the premium for Catamount Health and the individual's contribution as defined in this section.

(b) Subject to amendment in the fiscal year 2008 budget, the agency of administration or designee shall establish individual and family contribution amounts for Catamount Health under this subchapter for the first year as established in this section and shall index the contributions in future years to the overall growth in spending per enrollee in Catamount Health as established in section 4080f of Title 8. The agency shall establish family contributions by income bracket based on the individual contribution amounts and the average family size. In fiscal year 2008, for the lowest-cost Catamount Health plan offered by all carriers, the individual's contribution shall be as established in subsection (c) of this section. The agency shall determine the percentages that

the amounts in subsection (c) are of the lowest-cost plan and set the individual's contribution for any other plan at the percentage for that income level. In future years, after adjusting the individual premiums in subsection (c) of this section, the same methodology shall be used to determine the individual premiums for any other plans.

(c) An individual's contribution for the lowest-cost plan shall be:

(1) Income less than or equal to 200 percent of FPL: \$60.00 per month.

(2) Income greater than 200 percent and less than or equal to 225 percent of FPL: \$90.00 per month.

(3) Income greater than 225 percent and less than or equal to 250 percent of FPL: \$110.00 per month.

(4) Income greater than 250 percent and less than or equal to 275 percent of FPL: \$125.00 per month.

(5) Income greater than 275 percent and less than or equal to 300 percent of FPL: \$135.00 per month.

(6) Income greater than 300 percent of FPL: the actual cost of Catamount Health.

§ 1985. ADMINISTRATION

(a) The agency shall engage in an aggressive enrollment strategy for Catamount Health and the assistance provided under this subchapter. The agency shall establish a toll-free telephone assistance line to provide information and enrollment assistance on Catamount Health and the assistance

program. The agency shall ensure that individuals may receive any forms or other enrollment information from the carriers offering Catamount Health as well as the agency.

(b) An individual applying for or enrolled in the program established under this subchapter who is aggrieved by an adverse decision of the agency may grieve or appeal the decision under rules and procedures consistent with 42 C.F.R. § 438.402.

§ 1986. CATAMOUNT FUND

(a) The Catamount fund is established in the treasury as a special fund to be a source of financing for the Catamount Health assistance program.

(b) Into the fund shall be deposited:

(1) revenue from the employer health care premium contribution pursuant to chapter 25 of Title 21;

(2) 17.5 percent of the revenue from the cigarette tax levied pursuant to chapter 205 of Title 32;

(3) premium amounts paid by individuals unless paid directly to the insurer; and

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

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

(d) All monies received by or generated to the fund shall be used only as allowed by appropriation of the general assembly for the administration and delivery of the Catamount Health assistance program under this subchapter, employer-sponsored insurance premium assistance under section 1974 of this title, immunizations under section 1130 of Title 18, the nongroup health insurance market assistance under section 4062d of Title 8, and for transfers to the state health care resources fund established in section 1901d of this title as approved by the general assembly.

(e) The agency shall submit annual reports on the receipts, expenditures, and balances in the Catamount Fund established in section 1986 of this title to the joint fiscal committee at its September meeting.

Sec. 17. 8 V.S.A. § 4080d is amended to read:

§ 4080d. COORDINATION OF INSURANCE COVERAGE WITH
MEDICAID

Any insurer as defined in section 4100b of this title is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. § 1396a (section 1902 of the Social Security Act), herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers,

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

Sec. 18. 8 V.S.A. § 4100b is amended to read:

§ 4100b. COVERAGE OF CHILDREN

(a) As used in this subchapter:

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

* * *

Sec. 19. 8 V.S.A. § 5112 is amended to read:

§ 5112. STATUTORY CONSTRUCTION AND RELATIONSHIP TO
OTHER LAWS

Except as provided in this chapter, and except as provided in section 3315, section 4080a, section 4080b, section 4080f, and subchapter 2 of chapter 112 of this title, provisions of the insurance laws and specifically provisions of chapters 123 and 125 of this title shall not be applicable to any health maintenance organization granted a certificate of authority under this chapter.

Sec. 20. EXPEDITED RULEMAKING

No later than August 1, 2006 and notwithstanding the provisions of chapter 25 of Title 3, the department of banking, insurance, securities, and health care administration shall adopt the initial rules for Catamount Health established in

section 4080f of Title 8 pursuant to the following expedited rulemaking process:

(1) After publication in three daily newspapers with the highest average circulation in the state of a notice of the rules to be adopted pursuant to this process and at least a 14-day public comment period following publication, the department shall file final proposed rules with the legislative committee on administrative rules.

(2) The legislative committee on administrative rules shall review and may approve or may object to the final proposed rules under 3 V.S.A. § 842, except that its action shall be completed by the committee no later than 14 days after the final proposed rules are filed with the committee.

(3) The department may adopt a properly filed final proposed rule:

(A) after the passage of 14 days from the date of filing final proposed rules with the legislative committee on administrative rules;

(B) after receiving notice of approval from the committee; or

(C) if the department has received a notice of objection from the legislative committee on administrative rules, after having responded to the objection from the committee pursuant to 3 V.S.A. § 842.

(4) Rules adopted under this section shall be effective upon being filed with the secretary of state and shall have the full force and effect of rules adopted pursuant to chapter 25 of Title 3. Rules filed by the department with the secretary of state pursuant to this section shall be deemed to be in full

compliance with 3 V.S.A. § 843 and shall be accepted by the secretary of state if filed with a certification by the commissioner of banking, insurance, securities, and health care administration that the rule is required to meet the purposes of this section.

Sec. 21. 2 V.S.A. chapter 25 is added to read:

CHAPTER 25. JOINT LEGISLATIVE COMMISSION

ON HEALTH CARE REFORM

§ 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) 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.

(c) The commission may meet as needed and members shall be entitled to compensation and expenses as provided in section 406 of this title.

(d) The commission shall receive administrative, fiscal, and legal support from the joint fiscal office and the legislative council. In addition, with the approval of the speaker of the house and the president pro tempore of the

senate, the commission may retain the services of one or more consultants or experts knowledgeable in health care systems, financing, or delivery to assist in its work and may request funding from the legislative budget.

§ 902. DUTIES

(a) Beginning in the interim of the 2005 legislative session through July 1, 2009, the commission shall:

(1) monitor the development, implementation, and ongoing operation of health care reform initiatives as defined in section 2222a of Title 3 and the initiatives contained in H.861 of the 2005 Adj. Sess. (2006), An Act Relating to Health Care Affordability for Vermonters, including Catamount Health;

(2) study areas of health care reform as required by the general assembly; and

(3) receive input and make recommendations, generally, to the house committees on health care and on ways and means, the senate committees on health and welfare and on finance, and the general assembly regarding the long-term development of policies and programs designed to ensure that, by 2009, Vermont has an integrated system of care that provides all Vermonters access to affordable, high quality health care that is financed in a fair and equitable manner, including the following:

(A) extending universal access to diagnostic or other services to all Vermonters;

(B) methods of reducing the cost of health insurance or providing

alternative coverage through Catamount Health to individuals who pay 10 percent or more of their gross income for premiums and cost-sharing or medical expenses;

(C) strategies for reducing the cost of health insurance or providing alternative coverage through Catamount Health to individuals in the individual or other high cost markets; and

(D) determining needed analysis and criteria for implementing a health insurance requirement by January 1, 2011 if less than 96 percent of Vermonters have health insurance by 2010, including methods of enforcement, providing proof of insurance to individuals, and any other criteria necessary for the requirement to be effective in achieving universal health care coverage.

(b) Nothing in this section shall modify the jurisdiction of the health access oversight committee to monitor Medicaid and Medicaid waiver programs.

(c)(1) The commission may request analysis from the office of Vermont health access, the department of banking, insurance, securities, and health care administration, and other appropriate agencies. The agencies shall report to the commission at such times and with such information as the commission determines is necessary to fulfill its oversight responsibilities.

(2) The agency of administration or designee, the agency of human services, and the department of banking, insurance, securities, and health care administration shall submit monthly progress reports on Catamount Health and the Catamount Health assistance program. For Catamount Health, the reports

shall include enrollment, projected enrollment, and other information as requested by the commission. For the assistance program, the reports shall include revenue and expenditures for the prior months, enrollment and projected enrollment, projected expenditures related to enrollment for the fiscal year, demographic statistics for participating individuals, an analysis of any effect on employer conduct, and other information as requested by the commission.

§ 903. CATAMOUNT HEALTH; REQUEST FOR PROPOSALS

(a) It is the intent of the general assembly first to provide to carriers and insurers in the private market the opportunity to offer Catamount Health with the assumption of risk. In the event that no private carriers or insurers elect to offer such Catamount Health plans or the market is not a cost-effective method of providing coverage, it is the intent of the general assembly to administer Catamount Health under this section.

(b) If no registered small group carrier submits a letter of intent to offer Catamount Health established in section 4080f of Title 8 with the commissioner of banking, insurance, securities, and health care administration within 30 days after the filing of the expedited rules for Catamount Health, the following process shall occur:

(1) the commissioner shall notify the joint fiscal committee and the secretary of administration immediately;

(2) the secretary of administration shall schedule a meeting of the

emergency board within ten days of the commissioner's notification in order to investigate why no carriers entered the market and shall receive analysis from the secretary, the department of banking, insurance, securities, and health care administration, the commission on health care reform, and the joint fiscal office;

(3) the emergency board may extend the deadline for submitting a letter of intent to allow 14 days from the date of the meeting for additional submissions or may trigger the procedures in subsection (c) of this section.

(c) The procedures in this subsection (e) shall be followed if any of the following events occur:

(1) No letter of intent is filed after the process established in subsection (b) of this section;

(2) Initial policy forms and rates for Catamount Health are not filed within five months of the filing of a carrier's letter of intent.

(3) No carrier's policy forms and rates for Catamount Health are approved by the department.

(4) The commission on health care reform determines by April 1, 2007 or 30 days from the date the rates are approved, whichever is later, that the Catamount Health market is not a cost-effective method of providing health care coverage to uninsured Vermonters, taking into consideration the rates and forms approved by the department of banking, insurance, securities, and health care administration, the amount of Catamount Health assistance to be provided

to individuals, whether the Catamount Health assistance is sufficient to make Catamount Health affordable to those individuals, and the number of individuals for whom assistance is available given the appropriated amount.

(d) The commissioner of banking, insurance, securities, and health care administration shall provide the commission with copies of the approved carriers policy forms and rates.

(e) If at any time no carrier offers Catamount Health or if any of the events established in subsection (c) of this section occur, 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.

(f) If Catamount Health is offered as a self-insured product, the requirements of section 4080f of Title 8 and subchapter 3a of chapter 19 of Title 33 shall apply to the extent feasible. The individual contributions set in subchapter 3a of chapter 19 of Title 33 shall be the premium amounts charged

to individuals.

Sec. 21a. CODIFICATION

This section codifies the provisions in Sec. 277c of No. 71 of the Acts of 2005 and amends that section to reflect the provisions in this act. Sec. 277c of No. 71 of the Acts of 2005 (establishing a commission on health care reform) is repealed.

Sec. 22. GLOBAL COMMITMENT FINANCING

To the extent feasible and allowable under federal law, the agencies of administration and of human services shall finance the employer-sponsored premium assistance program under section 1974 of Title 33 and the Catamount Health assistance program under subchapter 3a of chapter 19 of Title 33 through the Global Commitment for Health Medicaid Section 1115 waiver. No later than December 1, 2006, the agencies shall seek a waiver amendment from the Centers for Medicare and Medicaid Services to include these programs in the premium amount paid to the office of Vermont health access under Global Commitment. The agencies may require the office of Vermont health access to use revenue from the capitation payments related to beneficiaries covered under Global Commitment as described in Term and Condition 40 to finance some or all of these programs. The agencies may administer the programs in the manner required by Global Commitment.

* * * Immunizations * * *

Sec. 23. 18 V.S.A. § 1130 is added to read:

§ 1130. IMMUNIZATIONS; PROVISION

(a) As used in this section, “immunizations” means vaccines and the application of the vaccines as recommended by the practice guidelines for children and adults established by the Advisory Committee on Immunization Practices (ACIP) to the Centers for Disease Control and Prevention (CDC).

(b) To the extent allowed by the appropriation, the department shall provide payment for any Vermont resident to receive immunizations without cost to the individual. The department shall be the secondary payer to Medicaid, the Vermont health access plan, Dr. Dynasaur, Medicare, and any federal health insurance or federal program covering immunizations.

Sec. 24. IMMUNIZATIONS; ADMINISTRATION

(a) The secretary of administration or designee shall study methods to ensure that all Vermonters have access to immunizations as provided for in section 1130 of Title 18. In conducting the study, the secretary shall consult with the immunization program advisory committee, the department of health, the department of banking, insurance, securities, and health care administration, the office of Vermont health access, and other interested parties.

(b) The study shall include findings and recommendations concerning the following:

(1) Effective strategies for improving immunization rates, including options for:

(A) enhancing access to vaccination services in both medical and public health settings; and

(B) strengthening school and child care immunization requirements;

(2) Recommendations for expanding the immunization program to adults, including recording of immunizations for adults in the Vermont immunization registry;

(3) Recommendations for improving quality assurance and quality improvement in assuring proper vaccine storage and handling, measuring immunization coverage rates, and addressing barriers to coverage; and

(4) Options for sustainable funding of the purchase and administration of vaccines, including:

(A) Equitable sharing of cost of the state's immunization program between public and private resources;

(B) Payment by the state of a reasonable fee to health care professionals for individuals receiving coverage for immunizations through Catamount Health.

(c) The secretary shall report the findings and recommendations of the study to the house committee on health care and the senate committees on health and welfare and on finance no later than January 15, 2007.

* * * Private Insurance Cost Shift Reviews * * *

Sec. 25. 18 V.S.A. § 9456(b)(9) is amended to read:

(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 ~~resulting from appropriations designed to reduce the Medicaid cost shift, and~~ to any reduction in bad debt or charity care due to an increase in the number of insured individuals.

Sec. 26. COST SHIFT TASK FORCE

Increases in Medicaid rates, reductions in private insurance claims through the nongroup market security trust, a decrease in the number of individuals without insurance, and the provision of minimum preventive services through Catamount Health should reduce the cost shift. The department of banking, insurance, securities, and health care administration shall convene a task force of health care professionals, insurers, hospitals, employers offering private health insurance, the state auditor or designee, a representative of the office of Vermont health access, and other interested parties to determine how to ensure that reductions in the cost shift are reflected in a reduction or slower rate of growth both in hospital and provider charges and in private insurance premiums. The task force shall make written recommendations to the commission on health care reform no later than December 1, 2006 regarding statutory or administrative changes needed to ensure that a reduction in the

cost shift is reflected in a reduction or slower rate of growth in hospital charges and health insurance premiums.

* * * Nongroup Health Insurance Market * * *

Sec. 27. 8 V.S.A. § 4062d is added to read:

§ 4062d. NONGROUP MARKET SECURITY TRUST

(a) The commissioner shall establish the nongroup market security trust for the purpose of lowering the cost of and thereby increasing access to health care coverage in the individual or nongroup health insurance market.

(b) The commissioner shall permit nongroup carriers to transfer five percent of the carriers' claims costs to the nongroup market security trust, based on the earned premium as reported on the most recent annual statement of the carrier. At the close of the year, the commissioner shall reconcile the amount paid against the actual expenses of the carriers and collect or expend the necessary funds to ensure that five percent of the actual expenses are paid under this section. The individuals incurring the claims shall remain enrolled policyholders, members, or subscribers of the carrier's or insurer's plan, and shall be subject to the same terms and conditions of coverage, premiums, and cost sharing as any other policyholder, member, or subscriber.

(c) The commissioner may develop the nongroup market security trust in a manner that permits the trust to be eligible for a federal grant to administer the trust, including a grant under the federal Trade Adjustment Act.

(d) All of the revenues appropriated shall be deposited into the nongroup

market security trust to be administered by the commissioner for the sole purpose of providing financial support for the nongroup market security trust authorized by this section. The trust shall be administered in accordance with subchapter 5 of chapter 7 of Title 32, except that interest earned shall remain in the trust.

(e) The commissioner may adopt rules for the nongroup market security trust relating to:

(1) Criteria governing the circumstances under which a nongroup carrier may transfer five percent of the claims expenses of the carrier to the trust as provided for in this section.

(2) Eligibility criteria for providing financial support to carriers under this section, including carrier claims' expenses eligible for financial support, standards and procedures for the treatment and chronic care management as defined in section 701 of Title 18, and any other eligibility criteria established by the commissioner.

(3) The operation of the trust.

(4) Any other standards or procedures necessary or desirable to carry out the purposes of this section.

(f) As used in this section, "nongroup carrier" means a nongroup carrier registered under section 4080b of this title that has an annual earned premium in excess of \$100,000.00.

Sec. 28. 8 V.S.A. § 4080b(n) is amended to read:

(n) ~~On or before January 15, 1993, the commissioner shall report to the senate finance committee and the house commerce committee concerning implementation of the community rating provisions set forth in subsection (h) of this section, describing areas in which additional legislation may be needed~~
The commissioner shall ensure that any rates filed by any registered nongroup carrier, whether initial or revised, for nongroup insurance policies reflect the reduction in claims costs attributable to the nongroup market security trust established in section 4062d of this title.

* * * Hospital Uncompensated Care * * *

Sec. 29. HOSPITAL UNCOMPENSATED CARE; FINDINGS

(a) The general assembly finds that all of Vermont's community hospitals are nonprofit charity hospitals which provide care regardless of patient ability to pay. Any uncompensated care received is paid for by someone other than the patient receiving it. This uncompensated care is substantial.

(b) Uncompensated care is already being paid for. It is subsidized through the "cost shift" and is absorbed principally by the payers of private health insurance premiums, including self-insurance plans. This cost shift functions as a hidden surcharge for the cost of care to lower income individuals.

Sec. 30. HOSPITAL UNCOMPENSATED CARE; STANDARDS;

REPORTING

(a) The commissioner of banking, insurance, securities, and health care

administration, in consultation with representatives of the Vermont association of hospitals and health systems, third-party payers, and health care consumers, shall review the uncompensated care and bad debt policies of Vermont's hospitals and recommend a standard statewide uniform uncompensated care and bad debt policy. The standard policy shall include criteria for payment forgiveness for the cost of health services received by low income patients, criteria for a sliding scale payment amount for patients under certain income levels, a method for calculating the amount of services received by the patient, and other criteria necessary for ensuring that the care received by the uninsured and underinsured patients is billed in a uniform and consistent manner. In addition to a standard policy, the commissioner may recommend reasons for and a method of approving deviations from the standard policy by a hospital or may recommend a set of standard policies to be applied to hospitals based on particular criteria, such as a designation as a critical access hospital, the income median in an area, or any other rationale.

(b) The commissioner, in consultation with the representatives listed in subsection (a) of this section, shall determine a fair and thorough method for calculating and reporting information about uncompensated care and bad debt to the department of banking, insurance, securities, and health care administration to ensure accurate accounting in the hospital budgets and other health care facility planning, as well as collecting information about the types of patients accessing uncompensated care or who are unable to pay for the care

received. The commissioner shall consider collecting information about the patient receiving the care, including the patient's primary insurance status and employer, the actual cost of the care received, any amounts paid toward the care, and any discounts provided to the patient by the hospital.

(c) The commissioner's findings and recommendations shall be submitted in a report to the senate committees on health and welfare and on finance and the house committee on health care not later than January 15, 2007.

Sec. 31. INDIVIDUAL MARKET STUDY

The department of banking, insurance, securities, and health care administration, in consultation with insurers that participate in the nongroup market, shall recommend to the general assembly no later than January 15, 2007 the best method to consolidate the nongroup market into a single risk pool of insured Vermonters with access to health plans equivalent to or better than that offered by Catamount Health.

Sec. 32. EMPLOYER ASSESSMENT STUDY; SEASONAL

EMPLOYEES

No later than January 15, 2007, the secretary of administration or designee shall study and report on the options for treating seasonal employees in the employer assessment in Sec. 34 of this act.

Sec. 33. COMMUNITY PLANNING; HEALTH CARE COVERAGE

In fiscal year 2007, the department of health shall provide a planning grant of \$100,000.00 to one community organization or corporation to assist in

establishing a local initiative to provide health care coverage or insurance to a community, region, or geographic area of the state.

Sec. 34. 21 V.S.A. chapter 25 is added to read:

CHAPTER 25. EMPLOYERS' HEALTH CARE

PREMIUM CONTRIBUTION

§ 2001. PURPOSE

For the purpose of more equitably distributing the costs of health care to uninsured residents of this state an employers' health care premium contribution is established to provide a fair and reasonable method for sharing health care costs with employers who do not offer their employees health care coverage.

§ 2002. DEFINITIONS

For the purposes of this chapter:

(1) "Employee" means an individual over the age of majority employed full-time or part-time by an employer to perform services in this state.

(2) "Employer" means a person who is required under subchapter 4 of chapter 151 of Title 32 to withhold income taxes from payments of income with respect to services, but shall not include the government of the United States.

(3) "Full-time equivalent" or "FTE" means the number of employees expressed as the number of employee hours worked during a calendar quarter divided by 520.

(4) “Uncovered employee” means:

(A) an employee of an employer who does not offer to pay any part of the cost of health care coverage for its employees.

(B) an employee who is not eligible for health care coverage offered by an employer to any other employees; or

(C) an employee who is offered and is eligible for coverage by the employer but elects not to accept the coverage and has no other health care coverage under either a private or public plan.

§ 2003. PREMIUM CONTRIBUTION ASSESSMENT

(a) The commissioner of labor shall assess and an employer shall pay a quarterly health care premium contribution for each full-time equivalent uncovered employee employed during that quarter in excess of:

(1) eight full-time equivalent employees in fiscal years 2007 and 2008;

(2) six full-time equivalent employees in fiscal year 2009; and

(3) four full-time equivalent employees in fiscal years 2010 and

thereafter.

(b) For any quarter in fiscal years 2007 and 2008, the amount of the health care premium contribution shall be \$91.25 for each full-time equivalent employee in excess of eight. For each fiscal year after fiscal year 2008, the number of excluded full-time equivalent employees shall be adjusted in accordance with subsection (a) of this section, and the amount of the health

care premium contribution shall be adjusted by a percentage equal to any percentage change in premiums for Catamount Health for that fiscal year.

(c) Premium contribution assessments under this chapter shall be determined on a calendar quarter basis, due and payable 30 days after the close of each quarter. Late filings, late payments and underpayments of the premium contribution assessments due shall be subject to the same fees, interest and penalties as pertain to contributions for unemployment compensation under chapter 17 of this title. The commissioner shall establish rules for the administration and collection of premiums under this chapter. To the extent feasible any reports required of employers under this chapter shall be combined with other reports and information collected from employers by the department of labor.

(d) Revenues from the premiums collected shall be deposited into the Catamount Fund established under 33 V.S.A. § 1981 for the purpose of financing health care coverage under Catamount Health assistance, as provided under subchapter 3a of chapter 19 of Title 33.

Sec. 35. EFFECTIVE DATE

Sec. 34 of this act, establishing an employers' health care premium contribution assessment, shall take effect April 1, 2007, with the first premium assessments due and payable 30 days after the close of that quarter.

* * * Cigarette and Tobacco Product Taxes * * *

Sec. 36. 32 V.S.A. § 7702 is amended to read:

§ 7702. DEFINITIONS

The following words and phrases, as used in this chapter, shall have the following meanings, unless the context otherwise requires:

(1) “Cigarette” ~~shall mean the common article of commerce known by this name consisting of a small cylindrical roll composed in whole or in part of finely cut tobacco, wrapped in paper or in any substance other than tobacco~~
means:

(A) any roll of tobacco wrapped in paper or any substance not containing tobacco, and

(B) any roll of tobacco wrapped in substance containing tobacco which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette described in subdivision (A) of this subsection.

(2) “Commissioner” shall mean the commissioner of taxes.

(3) “Dealer” means any wholesale dealer and retail dealer as herein defined.

(4) “Distributor” means any person who imports, or causes to be imported, into this state any tobacco product for sale or who manufactures any tobacco product in this state, and any person within or without the state who is authorized by the commissioner to make returns and pay the tax on tobacco products sold, shipped or delivered by him to any person in the state.

(5) “Licensed wholesale dealer” shall mean a wholesale dealer licensed under the provisions of this chapter.

(6) “Little cigars” means any rolls of tobacco wrapped in leaf tobacco or any substance containing tobacco (other than any roll of tobacco which is a cigarette within the meaning of subdivision (1) of this section) and as to which one thousand units weigh not more than three pounds.

~~(6)~~(7) “Manufacturer” means a person who manufactures and sells tobacco products.

~~(7)~~(8) “Person” shall mean any individual, firm, fiduciary, partnership, corporation, trust or association, however formed.

~~(8)~~(9) “Place of business” means any place where tobacco products are sold or where tobacco products are manufactured, stored, or kept for the purpose of sale or consumption, including any vessel, vehicle, airplane, train, or vending machine.

~~(9)~~(10) “Retail dealer” shall mean a person who sells or furnishes cigarettes or tobacco products, or both, in small quantities to consumers only, but not for the purpose of resale.

(11) “Roll-your-own tobacco” means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes.

~~(10)~~(12) “Sale” or “sell” means any transfer, exchange or barter in any manner or by any means whatever, of any cigarettes or tobacco products.

(13) “Snuff” means any finely cut, ground, or powdered tobacco that is not intended to be smoked.

~~(11)~~(14) “Stamp” shall mean any impression, stamp, label or print manufactured, printed or made as prescribed by the commissioner.

~~(12)~~(15) “Tobacco products” means cigars; cheroots; stogies; periques; granulated, plug cut, crimp cut, ready rubbed, and other smoking tobacco; snuff, snuff flour; cavendish; plug and twist tobacco; fine-cut and other chewing tobaccos; shorts; refuse scraps, clippings, cuttings and sweeping of tobacco, and other kinds and forms of tobacco, prepared in such manner as to be suitable for chewing or smoking in a pipe or otherwise, or both for chewing and smoking; but shall not include cigarettes as defined in this section.

~~(13)~~(16) “Wholesale dealer” shall mean a person who sells or furnishes cigarettes or tobacco products, or both, to wholesale or retail dealers for the purpose of resale, but not by the small quantity or parcel to consumers thereof.

~~(14)~~(17) “Wholesale dealer’s license” shall mean the license granted under the provisions of this chapter to a wholesale dealer for a wholesale outlet.

~~(15)~~(18) “Wholesale outlet” shall mean any premises where cigarettes or tobacco products, or both, are sold, transferred, displayed or held for sale by a wholesale dealer.

~~(16)~~(19) “Wholesale price” means the price at which a distributor sells or furnishes tobacco products to any retail dealer.

Sec. 37. 32 V.S.A. § 7771 is amended to read:

§ 7771. RATE OF TAX

(a) A tax is imposed on all cigarettes, little cigars, and roll-your-own tobacco held in this state by any person for sale or by any person in possession of more than 10,000 cigarettes or little cigars, or \$500.00 or more in retail value of roll-your-own tobacco, unless such ~~cigarettes~~ products shall be:

- (1) in the possession of a licensed wholesale dealer;
- (2) in the course of transit and consigned to a licensed wholesale dealer or retail dealer; or
- (3) in the possession of a retail dealer who has held the ~~cigarettes~~ products for 24 hours or less.

(b) Such tax shall be at the rate of ~~59.5~~ 89.5 mills for each cigarette ~~and the payment thereof to~~ or little cigar and for each 0.09 of an ounce of roll-your-own tobacco. Payment of the tax on cigarettes shall be evidenced by the affixing of stamps to the packages containing the cigarettes as hereinafter provided. Where practicable, the commissioner may also require that stamps be affixed to packages containing little cigars or roll-your-own tobacco. Any cigarette, little cigar, or roll-your-own tobacco, on which the tax imposed by this chapter has been paid, such payment being evidenced by the affixing of such stamp or such evidence as the commissioner may require, shall not be subject to a further tax under this chapter. Nothing contained in this chapter shall be construed to impose a tax on any transaction the taxation of which by

this state is prohibited by the constitution of the United States. The amount of taxes advanced and paid by a licensed wholesale dealer or a retail dealer as herein provided shall be added to and collected as part of the retail sale price on the cigarettes, little cigars, or roll-your-own tobacco. All taxes upon cigarettes, little cigars, or roll-your-own tobacco under this chapter are declared to be a direct tax upon the consumer at retail and shall conclusively be presumed to be precollected for the purpose of convenience and facility only.

Sec. 38. 32 V.S.A. § 7811 is amended to read:

§ 7811. IMPOSITION OF TOBACCO PRODUCTS TAX

There is hereby imposed and shall be paid a tax on all tobacco products except roll-your-own tobacco and little cigars taxed under section 7771 of this title possessed in the state of Vermont by any person for sale on and after July 1, 1959 which were imported into the state or manufactured in the state after said date, except that no tax shall be imposed on tobacco products sold under such circumstances that this state is without power to impose such tax, or sold to the United States, or sold to or by a voluntary unincorporated organization of the armed forces of the United States operating a place for the sale of goods pursuant to regulations promulgated by the appropriate executive agency of the United States. Such tax on tobacco products shall be at the rate of 41 percent of the wholesale price for all tobacco products except snuff which shall be taxed at the rate of \$1.49 per ounce, or fractional part thereof, and is intended to be imposed only once upon any tobacco product. Provided,

however, that upon payment of the tax within ten days, the distributor or dealer may deduct from the tax two percent of the tax due. It shall be presumed that all tobacco products within the state are subject to tax until the contrary is established and the burden of proof that any tobacco products are not taxable hereunder shall be upon the person in possession thereof.

Sec. 39. 32 V.S.A. § 7814 is amended to read:

§ 7814. FLOOR STOCK TAX

(a) ~~Tobacco products~~ Snuff. A floor stock tax is hereby imposed upon every retailer of ~~tobacco products~~ snuff in this state ~~at the rate of 21 percent of the wholesale price of each tobacco product in the amount by which the new tax exceeds the amount of the tax already paid on the snuff.~~ The tax shall apply to ~~tobacco products~~ snuff in the possession or control of the retailer at 12:01 a.m. o'clock on July 1, ~~1995~~ 2006, but shall not apply to retailers who hold less than \$500.00 in wholesale value of such ~~tobacco products~~ snuff. Each retailer subject to the tax shall, on or before July 25, ~~1995~~ 2006 file a report to the commissioner in such form as the commissioner may prescribe showing the ~~tobacco products~~ snuff on hand at 12:01 a.m. o'clock on July 1, ~~1995~~ 2006, and the amount of tax due thereon. The tax imposed by this section shall be due and payable on or before ~~July 25, 1995~~ August 25, 2006, and thereafter shall bear interest at the rate established under section 3108 of this title. In case of timely payment of the tax, the retailer may deduct from the tax due two percent of the tax. Any ~~tobacco product~~ snuff with respect to

which a floor stock tax has been imposed and paid under this section shall not again be subject to tax under section 7811 of this title.

(b) Cigarettes, little cigars, or roll-your-own tobacco. Notwithstanding the prohibition against further tax on stamped cigarettes, little cigars, or roll-your-own tobacco under section 7771 of this title, a floor stock tax is hereby imposed upon every dealer of cigarettes, little cigars, or roll-your-own tobacco in this state who is either a wholesaler, or a retailer who at 12:01 a.m. o'clock on July 1, ~~2003~~ 2006, has more than 10,000 cigarettes or little cigars or who has \$500.00 or more of whole sale value of roll-your-own tobacco, for retail sale in his or her possession or control. The ~~rate of tax shall be 13 mills~~ amount of the tax shall be the amount by which the new tax exceeds the amount of the tax already paid for each cigarette, little cigar, or roll-your-own tobacco in the possession or control of the wholesaler or retailer at 12:01 a.m. o'clock on July 1, ~~2003~~ 2006, and on which cigarette stamps have been affixed before July 1, ~~2003~~ 2006. A floor stock tax is also imposed on each Vermont cigarette stamp in the possession or control of the wholesaler at 12:01 a.m. o'clock on July 1, ~~2003~~ 2006, and not yet affixed to a cigarette package, and the tax shall be at the rate of ~~26~~ 60 cents per stamp. Each wholesaler and retailer subject to the tax shall, on or before ~~September 25, 2003~~ July 25, 2006, file a report to the commissioner in such form as the commissioner may prescribe showing the cigarettes, little cigars, or roll-your-own tobacco and stamps on hand at 12:01 a.m. o'clock on July 1, ~~2003~~ 2006, and the amount of

tax due thereon. The tax imposed by this section shall be due and payable on or before ~~September 25, 2003~~ August 25, 2006, and thereafter shall bear interest at the rate established under section 3108 of this title. In case of timely payment of the tax, the wholesaler or retailer may deduct from the tax due two and three-tenths of one percent of the tax. Any cigarettes, little cigars, or roll-your-own tobacco with respect to which a floor stock tax has been imposed under this section shall not again be subject to tax under section 7771 of this title.

Sec. 40. CIGARETTE AND TOBACCO PRODUCTS; EFFECTIVE DATE;

INCREASE

(a) Secs. 36 through 39 of this act and this section shall take effect July 1, 2006.

(b) On and after July 1, 2008, the tax on cigarettes imposed by 32 V.S.A. § 7771 shall be at the rate of 99.5 mills:

(1) for each cigarette or little cigar; and

(2) for each 0.09 of an ounce of roll-your-own tobacco.

(c) On July 1, 2008, the tax on snuff imposed by 32 V.S.A. § 7811 on snuff shall be at the rate of \$1.66 per ounce or fractional part thereof.

(d) On July 1, 2008, the floor stock tax imposed by 32 V.S.A. § 7814(b) shall be at the rate of 10 mills:

(1) for each cigarette or little cigar in the possession or control of a wholesaler or retailer who has more than 10,000 cigarettes or little cigars on July 1, 2008; and

(2) for each 0.09 of an ounce of roll-your-own tobacco in the possession or control of a wholesaler or retailer who has \$500.00 or more of retail value of roll-your-own tobacco on July 1, 2008.

(e) On July 1, 2008, the floor stock tax imposed by 32 V.S.A. § 7814(a) shall be at the rate of 17 cents per ounce or fraction thereof on snuff in the possession or control of a retailer who has \$500.00 or more in wholesale value of snuff on July 1, 2008.

(f) The floor stock tax imposed by subsections (d) and (e) of this section shall be reported by the wholesaler or dealer on or before July 25, 2008 and shall be due and payable on or before August 25, 2008.

Sec. 41. 33 V.S.A. § 1901d is amended to read:

§ 1901d. STATE HEALTH CARE RESOURCES FUND

(a) The state health care resources fund is established in the treasury as a special fund to be a source of financing health care coverage for beneficiaries of the state health care assistance programs under the global commitment to health care waiver approved by the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act.

(b) Into the fund shall be deposited:

(1) ~~revenue from the cigarette and tobacco products tax established in~~
all revenue from the tobacco products tax and 82.5 percent of the revenue from
the cigarette tax levied pursuant to chapter 205 of Title 32;

(2) revenue from health care provider assessments pursuant to
subchapter 2 of chapter 19 of this title; and

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

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

(d) All monies received by or generated to the fund shall be used only as
allowed by appropriation of the general assembly for the administration and
delivery of health care covered through state health care assistance programs
administered by the agency under the ~~global commitment~~ Global Commitment
for Health Medicaid Section 1115 waiver.

Sec. 42. DISTRIBUTION OF REVENUE

The percentage of revenues from the cigarette tax increase in 2008, which is
distributed between the state health care resources fund in section 1901d of
Title 33 and the Catamount fund in section 1981 of Title 33 shall be amended

to reflect this increase.

Sec. 43. 32 V.S.A. § 435(b) is amended to read:

(b) The general fund shall be composed of revenues from the following sources:

* * *

~~(8) Cigarettes and tobacco products taxes levied pursuant to chapter 205 of this title;~~

* * *

Sec. 44. ALLOCATION OF FLOOR STOCK TAX REVENUE

The revenue from the floor stock tax under subsection 7814(b) of Title 32 as amended by this act shall be deposited in the Catamount fund.

* * * Pharmacy Provisions * * *

Sec. 45. 33 V.S.A. § 2005(3) is amended to read:

(3) The office of the attorney general shall keep confidential all trade secret information, as defined by subdivision 317(b)(9) of Title 1. The disclosure form shall permit the company to identify any information that it claims is a trade secret as defined in subdivision 317(c)(9) of Title 1. In the event that the attorney general receives a request for any information designated as a trade secret, the attorney general shall promptly notify the company of such request. Within 30 days after such notification, the company shall respond to the requester and the attorney general by either consenting to the release of the requested information or by certifying in writing the reasons

for its claim that the information is a trade secret. Any requester aggrieved by the company's response may apply to the superior court of Washington County for a declaration that the company's claim of trade secret is invalid. The attorney general shall not be made a party to the superior court proceeding. Prior to and during the pendency of the superior court proceeding, the attorney general shall keep confidential the information that has been claimed as trade secret information, except that the attorney general may provide the requested information to the court under seal.

* * * Technical Amendments * * *

Sec. 46. 32 V.S.A. § 305a is amended to read:

§ 305a. OFFICIAL STATE REVENUE ESTIMATE

(a) On or about January 15 and on or about July 15 of each year, and at such other times as the emergency board or the governor deems proper, the joint fiscal office and the secretary of administration shall provide to the emergency board their respective estimates of state revenues in the general, transportation, education, ~~and health access trust~~ Catamount, state health care resources, and Global Commitment funds. The January revenue estimate shall be for the current and next two succeeding fiscal years, and the July revenue estimate shall be for the current and immediately succeeding fiscal years. Federal fund estimates shall be provided at the same times for the current fiscal year.

(b) Within 10 days of receipt of such estimates, the board shall determine an official state revenue estimate for deposit in the respective funds for the years covered by the estimates. For the purpose of revising an official revenue estimate only, a majority of the legislative members of the emergency board may convene a meeting of the board.

(c) ~~The health access trust fund estimate~~ estimates shall include estimated caseloads and estimated per member per month expenditures for the current and next succeeding fiscal years for each ~~population category eligible~~ Medicaid enrollment group as defined by the agency and the joint fiscal office for state health care assistance programs or premium assistance programs supported by the fund state health care resources and Global Commitment funds, for Vermont Rx, and for the programs under the Choices for Care Medicaid Section 1115 waiver. For VPharm, the estimates shall include estimated caseloads and estimated per-member per-month expenditures for the current and next succeeding fiscal years by income category. The estimates shall include the expenditures for the current and next succeeding fiscal years for the Medicare Part D phased-down state contribution payment and for the disproportionate share hospital payments.

* * * Oversight and Reporting * * *

Sec. 47. REPORT; HEALTH CARE REFORM

No later than January 15, 2009, the agency of administration shall report to the general assembly on:

(1) the percentage of uninsured Vermonters and the number of insured Vermonters by coverage type based on a new survey conducted by the department of banking, insurance, securities, and health care administration;

(2) an analysis of the trends of Catamount Health costs and trends in the revenue sources for Catamount Health;

(3) the feasibility of allowing individuals who are not uninsured and employers to buy into Catamount Health at full premium cost; and

(4) the number of individuals enrolled in any chronic care management program which complies with the requirements in chapter 13 of Title 18, including those covered by private insurance.

Sec. 48. FUNDING SOURCES

(a)(1) \$2,500,000.00 of the funds appropriated in Sec. 107 of H.881 of the 2005 Adj. Sess. (2006) is to increase Medicaid rates to health care professionals on January 1, 2007, under Sec. 9(a) of this act.

(2) \$1,000,000.00 of the funds appropriated in Sec. 107 of H.881 of the 2005 Adj. Sess. (2006) is to increase Medicaid rates to hospitals on January 1, 2007, under Sec. 9(b) of this act.

(b) \$100,000.00 of the funds appropriated to the department of health in Sec. 115 of H.881 of the 2005 Adj. Sess. (2006) is for the planning grant established in Sec. 33 of this act.

(c) \$1,000,000.00 of the funds appropriated in Sec. 105 of H.881 of the 2005 Adj. Sess. (2006) is for the establishment, initial administration, and

development of the infrastructure for the employer-sponsored premium assistance program under section 1974 of Title 33.

(d) \$400,000.00 of the funds appropriated under Sec. 87 of H.881 of the 2005 Adj. Sess. (2006) is allocated to the department of banking, insurance, securities, and health care administration for further development of the multi-payer database established by 18 V.S.A. § 9410(h), and the consumer price and quality information system.

Sec. 49. EFFECTIVE AND IMPLEMENTATION DATES

This act shall take effect upon passage, except as follows:

(1) Secs. 9 (Medicaid reimbursement), 10 (Blueprint for Health reimbursements), 25 (hospital cost shift analysis), 33 (community health care planning grant) and 41 (state health care resources fund) shall take effect July 1, 2006.

(2) Secs. 11 (VHAP premiums), 12 (Dr. Dynasaur premiums), and 27 (Nongroup market security trust) shall take effect July 1, 2007.

(3) Secs. 13 (Employer-sponsored insurance premium assistance) and 16 (Catamount Health assistance) shall take effect June 30, 2006, for the purposes of establishing and administering the Catamount fund under section 1981 of Title 33, and preparing for administration of and enrollment of the programs; implementation of the programs, however, shall not commence until October 1, 2007.

* * * Wellness Initiatives * * *

* * * Healthy Lifestyle Insurance Discount * * *

Sec. 50. 8 V.S.A. § 4080a(h) is amended to read:

(h)(1) A registered small group carrier shall use a community rating method acceptable to the commissioner for determining premiums for small group plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating small groups, employees, or members of such groups, and dependents of such employees or members:

- (A) demographic rating, including age and gender rating;
- (B) geographic area rating;
- (C) industry rating;
- (D) medical underwriting and screening;
- (E) experience rating;
- (F) tier rating; or
- (G) durational rating.

(2)(A) The commissioner shall, by rule, adopt standards and a process for permitting registered small group carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent (~~20%~~), and provided further that the commissioner's rules may not permit any medical underwriting and screening.

(B) The commissioner's regulations shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health and the director of the office of Vermont health access in the development of health promotion and disease prevention regulations. Such regulations shall:

(i) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (A) of this subdivision (2) does not exceed 30 percent;

(ii) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(iii) provide that the reward under the program is available to all similarly situated individuals; and

(iv) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise

applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(C) The commissioner's regulations shall include:

(i) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(ii) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(iii) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (2).

(3) The commissioner may exempt from the requirements of this section an association as defined in ~~section~~ subdivision 4079(2) of this title which:

(A) offers a small group plan to a member small employer which is community rated in accordance with the provisions of subdivisions (1) and (2) of this subsection. The plan may include risk classifications in accordance with subdivision (2) of this subsection;

(B) offers a small group plan that guarantees acceptance of all persons within the association and their dependents; and

(C) offers one or more of the common health care plans approved by the commissioner under subsection (e) of this section.

(4) The commissioner may revoke or deny the exemption set forth in subdivision (3) of this subsection if the commissioner determines that:

(A) because of the nature, size, or other characteristics of the association and its members, the employees, or members are in need of the protections provided by this section; or

(B) the association exemption has or would have a substantial adverse effect on the small group market.

Sec. 51. 8 V.S.A. § 4080b(h) is amended to read:

(h)(1) A registered nongroup carrier shall use a community rating method acceptable to the commissioner for determining premiums for nongroup plans.

Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating individuals and their dependents:

(A) demographic rating, including age and gender rating;

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

(2)(A) The commissioner shall, by rule, adopt standards and a process for permitting registered nongroup carriers to use one or more risk

classifications in their community rating method. ~~After July 1, 1993, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 40 percent (40%) for two years, and thereafter 20 percent (20%). Such rules may not permit, and provided further that the commissioner's regulations may not permit any medical underwriting and screening and shall give due consideration to the need for affordability and accessibility of health insurance.~~

(B) The commissioner's regulations shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health and the director of the office of Vermont health access in the development of health promotion and disease prevention regulations. Such regulations shall:

(i) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision 4080a(2)(A) of this title does not exceed 30 percent;

(ii) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(iii) provide that the reward under the program is available to all similarly situated individuals; and

(iv) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(C) The commissioner's regulations shall include:

(i) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(ii) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(iii) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (2).

Sec. 52. 8 V.S.A. § 4516 is amended to read:

§ 4516. ANNUAL REPORT TO COMMISSIONER

Annually, on or before March 15, a hospital service corporation shall file with the commissioner of banking, insurance, securities, and health care administration a statement sworn to by the president and treasurer of the corporation showing its condition on December 31. The statement shall be in such form and contain such matters as the commissioner shall prescribe. To qualify for the tax exemption set forth in section 4518 of this title, the statement shall include a certification that the hospital service corporation operates on a nonprofit basis for the purpose of providing an adequate hospital service plan to individuals of the state, both groups and nongroups, without discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

Sec. 53. 8 V.S.A. § 4588 is amended to read:

§ 4588. ANNUAL REPORT TO COMMISSIONER

Annually, on or before March 15, a medical service corporation shall file with the commissioner of banking, insurance, securities, and health care administration a statement sworn to by the president and treasurer of the corporation showing its condition on December 31, which shall be in such form and contain such matters as the commissioner shall prescribe. To qualify for the tax exemption set forth in section 4590 of this title, the statement shall

include a certification that the medical service corporation operates on a nonprofit basis for the purpose of providing an adequate medical service plan to individuals of the state, both groups and nongroups, without discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

Sec. 54. 8 V.S.A. § 5115 is amended to read:

§ 5115. DUTY OF NONPROFIT HEALTH MAINTENANCE

ORGANIZATIONS

Any nonprofit health maintenance organization subject to this chapter shall offer nongroup plans to individuals in accordance with section 4080b of this title without discrimination based on age, gender, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

* * * Administrative Simplification * * *

Sec. 55. COMMON CLAIMS AND PROCEDURES

(a) No later than July 1, 2008, the commissioner shall amend the rules adopted pursuant to section 9408 of Title 18 as may be necessary to implement the recommendations of the final report described in subsection (g) of this section, as the commissioner deems appropriate in his or her discretion.

Nothing in this section shall be construed to alter the commissioner's authority under Title 8 or chapter 221 of Title 18.

(b) No later than July 1, 2006, a common claims and procedures work group shall form, composed of:

- (1) two representatives selected by the Vermont association of hospitals and health systems;
- (2) two representatives selected by the Vermont medical society;
- (3) one representative of each of the three largest health care insurers;
- (4) the director of the office of health access or designee;
- (5) two representatives from business groups appointed by the governor;
- (6) the health care ombudsman or designee;
- (7) one representative of consumers appointed by the governor; and
- (8) the commissioner of the department of banking, insurance, securities and health care administration or designee.

(c) The group shall design, recommend, and implement steps to achieve the following goals:

(1) Simplifying the claims administration process for consumers, health care providers, and others so that the process is more understandable and less time-consuming.

(2) Lowering administrative costs in the health care financing system.

(d) The group shall elect a chair at its first meeting. The chair, or the chair's designee, shall be responsible for scheduling meetings and ensuring the completion of the reports called for in subsection (g) of this section. Each

organization represented on the work group shall be asked to contribute funds for the group's administrative costs.

(e) On or before September 1, 2006, the work group shall present a two-year work plan and budget to the house committee on health care and the senate committee on health and welfare.

(f) This work plan may include the elements of the claims administration process, including claims forms, patient invoices, and explanation of benefits forms, payment codes, claims submission and processing procedures, including electronic claims processing, issues relating to the prior authorization process and reimbursement for services provided prior to being credentialed.

(g) The work group shall make an interim report to the governor and the general assembly on or before January 15, 2007 describing the progress of the group and any interim steps taken to achieve the goals of the work plan. The work group shall make a final report to the governor and the general assembly on or before January 15, 2008 with the findings that illustrate the outcomes of implementations derived from the work group actions along with a list of future actions and goals, which shall specify cost savings achieved and expected future savings.

Sec. 56. 18 V.S.A. § 9408a is added to read:

§ 9408a. UNIFORM PROVIDER CREDENTIALING

(a) Definitions. As used in this section:

(1) “Credentialing” means a process through which an insurer or hospital makes a determination, based on criteria established by the insurer or hospital, concerning whether a provider is eligible to:

(A) provide health care services to an insured or hospital patients;

and

(B) receive reimbursement for the health care services.

(2) “Health care services” means health-care-related services or products rendered or sold by a provider within the scope of the provider’s license or legal authorization, including hospital, medical, surgical, dental, vision, and pharmaceutical services or products.

(3) “Insured” means an individual entitled to reimbursement for expenses of health care services under a policy issued or administered by an insurer.

(4) “Insurer” has the same meaning as in subdivision 9402(9) of this title.

(5) “Provider” has the same meaning as in subdivision 9402(8) of this title.

(b) The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), or a similar, nationally recognized form prescribed by the commissioner, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing.

(c) An insurer or a hospital shall notify a provider concerning a deficiency on a completed credentialing application form submitted by the provider not later than 30 business days after the insurer or hospital receives the completed credentialing application form.

(d) An insurer or a hospital shall notify a provider concerning the status of the provider's completed credentialing application not later than:

(1) Sixty days after the insurer or hospital receives the completed credentialing application form; and

(2) Every 30 days after the notice is provided under subdivision (1) of this subsection, until the insurer or hospital makes a final credentialing determination concerning the provider.

(e) The commissioner may enforce compliance with the provisions of this section as to insurers and as to hospitals as if the hospital were an insurer under section 3661 of Title 8.

* * * Multi-Payer Database and Consumer Price and Quality Information * * *

Sec. 57. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE ~~DATA BASE~~ DATABASE

(a)(1) The commissioner shall establish and maintain a unified health care data base to enable the commissioner to carry out the duties under this chapter and Title 8, including:

~~(1)~~(A) Determining the capacity and distribution of existing resources.

~~(2)~~(B) Identifying health care needs and informing health care policy.

~~(3)~~(C) Evaluating the effectiveness of intervention programs on improving patient outcomes.

~~(4)~~(D) Comparing costs between various treatment settings and approaches.

~~(5)~~(E) Providing information to consumers and purchasers of health care.

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

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

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

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

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

* * *

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other

information determined by the commissioner to be necessary to carry out the purposes of this section. Such information may include:

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

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

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

* * *

(h)(1) Data Collection and Information Sharing. All health insurers shall electronically provide to the commissioner in accordance with standards and procedures adopted by the commissioner by rule:

(A) their ~~encrypted~~ health insurance claims data;

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

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

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

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

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

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

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont ~~and to enhance the ability of Vermont consumers and employers to make informed and cost-effective health care choices.~~ In presenting data for public access, comparative considerations shall be made

regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the commissioner may prescribe by regulation, the Vermont information technology leaders (VITL) shall have access to the database for use in the development of a statewide health information technology plan pursuant to section 9417 of this title, and the Vermont program for quality in health care shall have access to the database for use in improving the quality of health care services in Vermont.

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

(i)(1) As used in this section, and without limiting the meaning of subdivision 9402(9) of this title, the term “health insurer” includes:

(A) any entity defined in subdivision 9402(9) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information

relating to health care provided to Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

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

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

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

* * * Master Provider Index * * *

Sec. 58. MASTER PROVIDER INDEX

(a) No later than September 1, 2006, a work group shall be convened by the area health education centers (AHEC) program for the purpose of making recommendations for the creation of a master provider index designed to assure uniform and consistent identification and cross-reference of all Vermont health care professionals in the development and implementation of health care technology in Vermont. The work group shall:

(1) be composed of interested parties, including representatives of health care provider associations and societies, public and private insurers, the Vermont program for quality health care (VPQHC), appropriate departments of state government, including the commissioner of the department of banking, insurance, securities, and health care administration or designee, the area health education centers (AHEC) program, and Vermont information technology leaders (VITL), for the purpose of creating a set of common data fields for a master provider index of all health care providers, as defined in subdivision 9402(8) of Title 18;

(2) compile recommendations from those parties regarding data fields that are necessary to be included in a database that allows for comprehensive cross-referencing of the multiple “unique identification codes” applied to health care providers through licensure, credentialing, and billing and claims processing mechanisms for the purpose of supporting the implementation of health information exchange and public health and policy research, analysis and planning;

(3) provide cost and time estimates for development and implementation of such an index; and

(4) develop recommendations for the governance of the index and its relationship to other state health information data systems, technologies, and records.

(b) No later than January 15, 2007, the work group shall report to the general assembly on the information obtained and shall make recommendations regarding the advisability of creating and sustaining a master provider index.

Approved: May 25, 2006