H.202

Introduced by Representative Larson of Burlington

Referred to Committee on

Date:

Subject: Health; health insurance; Medicaid; Vermont health benefit exchange; single-payer; public health; payment reform; prescription drugs; health information technology; medical malpractice

Statement of purpose: This bill proposes to set forth a strategic plan for creating a single-payer and unified health system. It would establish a board to ensure cost-containment in health care, to create system-wide budgets, and to pursue payment reform; establish a health benefit exchange for Vermont as required under federal health care reform laws; create a public–private single-payer health care system to provide coverage for all Vermonters after receipt of federal waivers; create a consumer and health care professional advisory board; examine reforms to Vermont's medical malpractice system; modify the insurance rate review process; and create a statewide drug formulary.

An act relating to a single-payer and unified health system

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

Sec. 1. PRINCIPLES

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

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

(2) Health care spending growth in Vermont must be consistent with growth in the state's economy and spending capacity.

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

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

(5) Every Vermonter should be able to choose his or her primary care provider.

(6) Vermonters should be aware of the total cost of the health services they receive. Costs should be transparent and readily understood, and individuals should have a personal responsibility to maintain their own health and to use health resources wisely.

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

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

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

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

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

* * * Road Map to a Single-Payer and a Unified Health Care System * **

Sec. 2. STRATEGIC PLAN; SINGLE-PAYER AND UNIFIED HEALTH SYSTEM

(a) As provided in Sec. 4 of this act, upon receipt by the state of necessary waivers from federal law, all Vermont residents shall be eligible for Green Mountain Care, a universal health care program that will provide health benefits through a single payment system. To the maximum extent allowable under federal law and waivers from federal law, Green Mountain Care shall include health coverage provided under the health benefit exchange established under chapter 18, subchapter 1 of Title 33; under Medicaid; under Medicare; by employers that choose to participate; and to state employees and municipal employees.

(b) The Vermont health reform board is created to develop mechanisms to reduce the rate of growth in health care through cost-containment, establishment of budgets, and payment reform.

(c) The secretary of administration or designee shall create Green Mountain Care as a universal health care program by implementing the following initiatives and planning efforts:

(1) No later than November 1, 2013, the Vermont health benefit exchange established in subchapter 1 of chapter 18 of Title 33 shall begin enrolling individuals and employers with 100 employees or fewer for coverage

beginning January 1, 2014. The intent of the general assembly is to establish the Vermont health benefit exchange in a manner such that it may become the foundation for a single-payer health system.

(2) No later than November 1, 2016, the Vermont health benefit exchange established in subchapter 1 of chapter 18 of Title 33 shall begin enrolling employers with more than 100 employees for coverage beginning January 1, 2017.

(3) No later than January 1, 2014, the commissioner of banking, insurance, securities, and health care administration shall require that all individual and small group health insurance products be sold only through the Vermont health benefit exchange and shall require all large group insurance products to be aligned with the administrative requirements and essential benefits required in the Vermont health benefit exchange. The commissioner shall provide recommendations for statutory changes as part of the integration plan established in Sec. 8 of this act.

(4) The secretary shall supervise the planning efforts, reports of which are due on January 15, 2012, as provided in Sec. 8 and Secs. 10 through 14 of this act, including integration of multiple payers into the Vermont health benefit exchange; a continuation of the planning necessary to ensure an adequate, well-trained primary care workforce; necessary retraining for any employees dislocated from health care professionals or from health insurers

due to the simplification in the administration of health care; and unification of health system planning, regulation, and public health.

(5) The secretary shall supervise the planning efforts, reports of which are due January 15, 2013, as provided in Sec. 9 of this act, to establish the financing necessary for Green Mountain Care, for recruitment and retention programs for primary care health professionals, and for covering the uninsured and underinsured through Medicaid and the Vermont health benefit exchange.

(d) The secretary of administration or designee shall obtain waivers, exemptions, agreements, legislation, or a combination thereof to ensure that all federal payments provided within the state for health services are paid directly to Green Mountain Care. Green Mountain Care shall assume responsibility for the benefits and services previously paid for by the federal programs, including Medicaid, Medicare, and, after implementation, the Vermont health benefit exchange. In obtaining the waivers, exemptions, agreements, legislation, or combination thereof, the secretary shall negotiate with the federal government a federal contribution for health care services in Vermont that reflects medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, and the number of Medicare-eligible individuals and that does not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of Green Mountain Care.

* * * Cost Containment, Budgeting, and Payment Reform * * *

Sec. 3. 18 V.S.A. chapter 220 is added to read:

CHAPTER 220. VERMONT HEALTH REFORM BOARD

§ 9371. PURPOSE

It is the intent of the general assembly to create an independent board to develop mechanisms to reduce the per capita rate of growth in health care expenditures in Vermont across all payers for health services.

§ 9372. DEFINITIONS

As used in this chapter:

(1) "Board" means the Vermont health reform board established in this chapter.

(2) "Green Mountain Care" means the public–private single-payer health system established in 33 V.S.A. chapter 18, subchapter 2.

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

(4) "Health services" 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.

(5) "Manufacturers of prescribed products" shall have the same meaning as "manufacturers" in section 4631a of this title.

§ 9373. BOARD MEMBERSHIP

(a) On July 1, 2011, a Vermont health reform board is created and shall consist of a chair and four members. The chair shall be a full-time state employee and the four other members shall be part-time state employees. All members shall be exempt from the state classified system.

(b) The chair and the four members shall be appointed by the governor with the advice and consent of the senate. The governor shall appoint one member who is an expert in health policy or health financing, one member who is a practicing physician, one member who has experience in or who represents hospitals, one member representing employers who purchase health insurance, and one member who represents consumers. The governor shall name the chair.

(c) The term of each member shall be six years; except that of the members first appointed, two shall serve for a term of two years and two shall serve for a term of four years. Members of the board may be removed only for cause.

(d) The chair shall have general charge of the offices and employees of the board but may hire a director to oversee the administration and operation.

§ 9374. DUTIES

(a) In carrying out its duties, the board shall have the following objectives:

(1) Improve the health of the population;

(2) Enhance the patient experience of care, including quality, access, and reliability;

(3) reduce or control the total cost of health care in order to contain costs consistent with appropriate measures of economic growth and the state's capacity to fund the system; and

(4) in carrying out the planning duties in this subsection, to the extent feasible:

(A) improve health care delivery and health outcomes, including by promoting integrated care, care coordination, prevention and wellness, and quality and efficiency improvement;

(B) protect and improve individuals' access to necessary and evidence-based health care;

(C) target reductions in costs to sources of excess cost growth;

(D) consider the effects on individuals of any changes in payments to health care professionals and suppliers;

(E) consider the effects of payment reform on health care professionals; and

(F) consider the unique needs of individuals who are eligible for both Medicare and Medicaid.

(b) Beginning on October 1, 2011, the board shall have the following duties:

(1) review and recommend statutory modifications to the following regulatory duties of the department of banking, insurance, securities, and health care administration: the hospital budget review process provided in chapter 221, subchapter 7 of this title and the certificate of need process provided in chapter 221, subchapter 5 of this title.

(2) develop and approve the payment reform pilot projects set forth in section 9376 of this title to manage total health care costs, improve health care outcomes, and provide a positive health care experience for patients and health care professionals.

(3) develop methodologies for health care professional cost-containment targets, global budgets, and uniform payment methods and amounts pursuant to section 9375 of this title.

(4) review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration on any insurance rate increases pursuant to 8 V.S.A. chapter 107, taking into consideration changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board.

(c) Beginning on July 1, 2013, the board shall have the following duties in addition to the duties described in subsection (b) of this section:

(1) establish cost-containment targets and global budgets for each sector of the health care system.

(2) review and approve global payments or capitated payments to accountable care organizations, health care professionals, or other provider arrangements.

(3) review and approve of any fee-for-service payment amounts provided outside of the global payment or capitated payment.

(4) negotiate with health care professionals pursuant to section 9475 of this title.

(5) provide information and recommendations to the deputy commissioner of the department of Vermont health access for the Vermont health benefit exchange established in chapter 18, subchapter 1 of Title 33 necessary to contract with health insurers to provide qualified health benefit plans in the Vermont health benefit exchange.

(6) review and approve, with recommendations from the deputy commissioner for the Vermont health benefit exchange, the benefit package for qualified health benefit plans pursuant to chapter 18, subchapter 1 of Title 33.

(7) evaluate system-wide performance, including by identifying the appropriate outcome measures:

(A) for utilization of health services;

(B) in consultation with the department of health, for quality of health services and the effectiveness of prevention and health promotion programs;

(C) for cost-containment and limiting the growth in health care expenditures; and

(D) for other measures as determined by the board.

(d) Upon implementation of Green Mountain Care, the board shall have the following duties in addition to the duties described in subsections (b) and (c) of this section:

(1) review and approve, upon recommendation from the agency of human services, the initial Green Mountain Care benefit package within the parameters established in chapter 18, subchapter 2 of Title 33.

(2) review and approve the Green Mountain Care budget, including any modifications to the benefit package.

(3) recommend appropriation estimates for Green Mountain Care pursuant to 32 V.S.A. chapter 5.

§ 9375. PAYMENT AMOUNTS; METHODS

(a) It is the intent of the general assembly to ensure reasonable payments to health care professionals and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals is sufficient and distributed equitably.

(b) The board shall negotiate payment amounts with health care professionals, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies in order to have a consistent reimbursement amount accepted by these persons.

(c) The board shall establish payment methodologies for health services, including using innovative payment methodologies consistent with any payment reform pilot projects and with evidence-based practices. The payment methods shall encourage cost containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; and healthy lifestyles.

§ 9376. PAYMENT REFORM; PILOTS

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

(2) The director of payment reform in the department of Vermont health access shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional

organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local governments to advise the director in developing and implementing the pilot projects.

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

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

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

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

(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner.

(4) In addition to the objectives identified in subdivision (a)(3) of this section, the design and implementation of payment reform pilot projects may consider:

(A) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(B) with input from long-term care providers, whether to include home health services and long-term care services as part of capitated payments.

(b) Health insurer participation.

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

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

(C) After the pilot projects are implemented, health insurers shall have the same appeal rights as provided in section 706 of this title for participation in the Blueprint for Health.

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

(c) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if

appropriate. The department shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions.

(d) The board or designee shall apply for grant funding, if available, for the design and implementation of the pilot projects described in this section.

(e) The first pilot project shall become operational no later than January 1, 2012, and two or more additional pilot projects shall become operational no later than July 1, 2012.

§ 9377. AGENCY COOPERATION

The secretary of administration shall ensure that the Vermont health reform board has access to data and analysis held by any executive branch agency which is necessary to carry out the board's duties as described in this chapter.

§ 9378. RULES

The board may adopt rules pursuant to chapter 25 of Title 3 as needed to carry out the provisions of this chapter.

* * * Public–Private Single-Payer System * * *

Sec. 4. 33 V.S.A. chapter 18 is added to read

CHAPTER 18. PUBLIC–PRIVATE SINGLE-PAYER SYSTEM

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

(a) It is the intent of the general assembly to establish a Vermont health benefit exchange which meets the policy established in 18 V.S.A. § 9401 and, to the extent allowable under federal law or a waiver of federal law, becomes the mechanism to create a single-payer health care system.

(b) The purpose of the Vermont health benefit exchange is to facilitate the purchase of affordable, qualified health plans in the individual and group markets in this state in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

§ 1802. DEFINITIONS

For purposes of this subchapter:

(1) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health

Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended.

(2) "Deputy commissioner" means the deputy commissioner of the department of Vermont health access for the Vermont health benefit exchange.

(3) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. This term does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage where benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

(4) "Health insurer" shall have the same meaning as in 18 V.S.A. § 9402.

(5) "Qualified employer" means:

(A) an entity which employed an average of not more than 100 employees during the preceding calendar year and which:

(i) has its principal place of business in this state and elects to provide coverage for its eligible employees through the Vermont health benefit exchange, regardless of where an employee resides; or

(ii) elects to provide coverage through the Vermont health benefit exchange for all of its eligible employees who are principally employed in this state.

(B) After January 1, 2017, the term "qualified employer" shall include employers who meet these requirements regardless of size.

(6) "Qualified health benefit plan" means a health benefit plan which meets the requirements set forth in section 1806 of this title.

(7) "Qualified individual" means an individual, including a minor, who is a Vermont resident and, at the time of enrollment:

(A) is not incarcerated, or is only incarcerated awaiting disposition of charges; and

(B) is, or is reasonably expected to be during the time of enrollment, a citizen or national of the United States or a lawfully present immigrant in the United States as defined by federal law.

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

(a)(1) The department of Vermont health access shall establish the Vermont health benefit exchange, which shall be administered by the department in consultation with the advisory board established in section 402 of this title.

(2) The Vermont health benefit exchange shall be considered a division within the department of Vermont health access and shall be headed by a deputy commissioner as provided in chapter 53 of Title 3.

(b)(1)(A) The Vermont health benefit exchange shall provide qualified individuals and qualified employers with qualified health plans with effective dates beginning on or before January 1, 2014. The Vermont health benefit exchange may contract with qualified entities or enter into intergovernmental agreements to facilitate the functions provided by the Vermont health benefit exchange.

(B) Prior to contracting with a health insurer, the Vermont health benefit exchange shall consider the insurer's historic rate increase information required under section 1806 of this title, along with the information and the recommendations provided to the Vermont health benefit exchange by the commissioner of banking, insurance, securities, and health care administration under section 2794(b)(1)(B) of the federal Public Health Service Act.

(2) To the extent allowable under federal law, the Vermont health benefit exchange may offer health benefits to populations in addition to those eligible under Subtitle D of Title I of the Affordable Care Act, including:

(A) comprehensive health benefits to individuals and employers who are not qualified individual or qualified employers as defined by this subchapter and by the Affordable Care Act;

(B) Medicaid benefits to individuals who are eligible, upon approval by the Centers for Medicare and Medicaid Services and provided that including these individuals in the health benefit exchange would not reduce their Medicaid benefits;

(C) Medicare benefits to individuals who are eligible, upon approval by the Centers for Medicare and Medicaid Services and provided that including these individuals in the health benefit exchange would not reduce their Medicare benefits; and

(D) state employees and municipal employees.

(3) To the extent allowable under federal law, the Vermont health benefit exchange may offer health benefits to employees for injuries arising out of or in the course of employment in lieu of medical benefits provided pursuant to chapter 9 of Title 21 (workers' compensation).

(c) If the Vermont health benefit exchange is required by the secretary of the U.S. Department of Health and Human Services to contract with more than

one health insurer, the Vermont health benefit exchange shall determine the appropriate method to provide a unified, simplified claims administration, benefit management, and billing system for any health insurer offering a qualified health benefit plan. The Vermont health benefit exchange may offer this service to other health insurers, workers' compensation insurers, employers, or other entities in order to simplify administrative requirements for health benefits.

(d) The Vermont health benefit exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this subchapter provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and provided such agreements comply with all applicable state and federal laws and regulations.

§ 1804. QUALIFIED EMPLOYERS

(a) A qualified employer shall be an employer who, on at least 50 percent of its working days during the preceding calendar quarter, employed at least one and no more than 100 employees, and the term "qualified employer" includes self-employed persons. Calculation of the number of employees of a qualified employer shall not include a part-time employee who works less than 30 hours per week.

(b) An employer with 100 or fewer employees that offers a qualified health benefit plan to its employees through the Vermont health benefit exchange may continue to participate in the exchange even if the employer's size grows beyond 100 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

§ 1805. DUTIES AND RESPONSIBILITIES

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

(1) offer coverage for health services through qualified health benefit plans, including by creating a process for:

(A) the certification, decertification, and recertification of qualified health benefit plans as described in section 1806 of this title;

(B) enrolling individuals in qualified health benefit plans, including through open enrollment periods as provided in the Affordable Care Act and ensuring that individuals may transfer coverage between qualified health benefit plans and other sources of coverage as seamlessly as possible;

(C) collecting premium payments made for qualified health benefit plans from employers and individuals on a pretax basis, including collecting premium payments from multiple employers of one individual for a single plan covering that individual; and

(D) creating a simplified and uniform system for the administration of health benefits.

(2) Determining eligibility for and enrolling individuals in Medicaid, Dr. Dynasaur, VPharm, and VermontRx pursuant to chapter 19 of this title.

(3) Creating and maintaining consumer assistance tools, including a website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans and a toll-free telephone hotline to respond to requests for assistance.

(4) Creating standardized forms and formats for presenting health benefit options in the Vermont health benefit exchange, including the use of the uniform outline of coverage established under section 2715 of the federal Public Health Services Act.

(5) Assigning a quality and wellness rating to each qualified health plan offered through the Vermont health benefit exchange and determining each qualified health plan's level of coverage in accordance with regulations issued by the U.S. Department of Health and Human Services.

(6) Determining enrollee premiums and subsidies as required by the secretary of the U.S. Treasury or of the U.S. Department of Health and Human Services and informing consumers of eligibility for premiums and subsidies, including by providing an electronic calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the

Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Affordable Care Act.

(7) Transferring to the federal secretary of the Treasury the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 for the following reasons:

(A) The employer did not provide minimum essential coverage; or

(B) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to be either unaffordable to the employee or not to provide the required minimum actuarial value.

(8) Performing duties required by the secretary of the U.S. Department of Health and Human Services or the secretary of the Treasury related to determining eligibility for the individual responsibility requirement exemptions, including:

(A) Granting a certification attesting that an individual is exempt from the individual responsibility requirement or from the penalty for violating that requirement, if there is no affordable qualified health plan available through the Vermont health benefit exchange or the individual's employer for that individual or if the individual meets the requirements for any exemption

from the individual responsibility requirement or from the penalty pursuant to section 5000A of the Internal Revenue Code of 1986; and

(B) transferring to the federal secretary of the Treasury a list of the individuals who are issued a certification under subdivision (8)(A) of this section, including the name and taxpayer identification number of each individual.

(9)(A) Transferring to the federal secretary of the Treasury the name and taxpayer identification number of each individual who notifies the Vermont health benefit exchange that he or she has changed employers and of each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation; and

(B) Communicating to each employer the name of each of its employees and the effective date of the cessation reported to the Treasury under this subdivision.

(10) Establishing a navigator program as described in section 1807 of this title.

(11) Reviewing the rate of premium growth within and outside of the Vermont health benefit exchange.

(12) Crediting the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled and collecting the amount credited from the offering employer.

(13) Providing consumers with satisfaction surveys and other mechanisms for evaluating and informing the deputy commissioner and the commissioner of banking, insurance, securities, and health care administration of the performance of qualified health benefit plans.

(14) Ensuring consumers have easy and simple access to the relevant grievance and appeals processes pursuant to 8 V.S.A. chapter 107 and 3 V.S.A. § 3090 (human services board).

(15) Consulting with the advisory board established in section 402 of this title to obtain information and advice as necessary to fulfill the duties outlined in this subchapter.

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

(a) Prior to contracting with a qualified health benefit plan, the deputy commissioner shall determine that making the plan available through the Vermont health benefit exchange is in the best interest of individuals and qualified employers in this state.

(b) A qualified health benefit plan shall provide the following benefits:

(1)(A) The essential benefits package required by section 1302(a) of the Affordable Care Act and any additional benefits required by the deputy commissioner by rule after consultation with the advisory board established in section 402 of this title and after approval from the Vermont health reform board established in chapter 220 of Title 18.

(B) Notwithstanding subdivision (1)(A) of this subsection, a health insurer may offer a plan that provides more limited dental benefits if such plan meets the requirements of section 9832(c)(2)(A) of the Internal Revenue Code and provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Affordable Care Act either separately or in conjunction with a qualified health plan.

(2) At least the silver level of coverage as defined by section 1302 of the Affordable Care Act and the cost-sharing limitations for individuals provided in section 1302 of the Affordable Care Act, as well as any more restrictive requirements specified by the deputy commissioner by rule after consultation with the advisory board established in section 402 of this title and after approval from the Vermont health reform board established in chapter 220 of Title 18.

(3) For qualified health benefit plans offered to employers, a deductible which meets the limitations provided in section 1302 of the Affordable Care Act and any more restrictive requirements required by the deputy commissioner by rule after consultation with the advisory board and after approval from the Vermont health reform board established in chapter 220 of Title 18.

(c) A qualified health benefit plan shall meet the following minimum prevention, quality, and wellness requirements:

(1) standards for marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, and information on quality measures for health benefit plan performance as provided in section 1311 of the Affordable Care Act and more restrictive requirements provided by 8 V.S.A. chapter 107;

(2) quality and wellness standards as specified in rule by the deputy commissioner, after consultation with the commissioners of health and of banking, insurance, securities, and health care administration and with the advisory board established in section 402 of this title; and

(3) standards for participation in the Blueprint for Health as provided in 18 V.S.A. chapter 13.

(d) A qualified health benefit plan shall provide uniform enrollment forms and descriptions of coverage as determined by the deputy commissioner and the commissioner of banking, insurance, securities, and health care administration.

(e)(1) A qualified health benefit plan shall comply with the following insurance and consumer information requirements:

(A)(i) Obtain premium approval through the rate review process provided in 8 V.S.A. chapter 107; and

(ii) Submit to the commissioner of banking, insurance, securities, and health care administration a justification for any premium increase before

implementation of that increase and prominently post this information on the health insurer's website.

(B) Offer at least one qualified health plan at the silver level and at least one qualified health plan at the gold level, as defined in section 1302 of the Affordable Care Act.

(C) Charge the same premium rate for each qualified health plan without regard to whether the plan is offered through the Vermont health benefit exchange and without regard to whether the plan is offered directly from the carrier or through an insurance agent.

(D) Provide accurate and timely disclosure of information to the public and to the Vermont health benefit exchange relating to claims denials, enrollment data, rating practices, out-of-network coverage, enrollee and participant rights provided by Title I of the Affordable Care Act, and other information as required by the deputy commissioner or by the commissioner of banking, insurance, securities, and health care administration.

(E) Provide information in a timely manner to individuals, upon request, regarding the cost-sharing amounts for that individual's health benefit plan.

(2) A qualified health benefit plan shall comply with all other insurance requirements for health insurers as provided in 8 V.S.A. chapter 107, including

licensure or solvency requirements, and as specified by the commissioner of banking, insurance, securities, and health care administration.

(f) The Vermont health benefit exchange shall not exclude a health benefit plan:

(1) on the basis that the plan is a fee-for-service plan;

(2) through the imposition of premium price controls by the Vermont health benefit exchange; or

(3) on the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Vermont health benefit exchange determines are inappropriate or too costly.

§ 1807. NAVIGATORS

(a) The Vermont health benefit exchange shall establish a navigator program to assist individuals and employers in enrolling in a qualified health benefit plan offered under the Vermont health benefit exchange. The Vermont health benefit exchange shall select individuals and entities qualified to serve as navigators and shall award grants to navigators for the performance of their duties.

(b) Navigators shall have the following duties:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans and concerning the availability of premium tax credits and cost-sharing reductions;

(3) Facilitate enrollment in qualified health plans, Medicaid, Dr. Dynasaur, VPharm, and VermontRx;

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

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

(6) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRx, or the Vermont health benefit exchange in order to ensure that all eligible individuals are enrolled.

§ 1808. FINANCIAL INTEGRITY

(a) The Vermont health benefit exchange shall:

(1) Keep an accurate accounting of all activities, receipts, and expenditures and submit this information annually as required by federal law;

(2) Cooperate with the secretary of the U.S. Department of Health and Human Services or the inspector general of the U.S. Department of Health and Human Services in any investigation into the affairs of the Vermont health benefit exchange, examination of the properties and records of the Vermont health benefit exchange, or requirement for periodic reports in relation to the activities undertaken by the Vermont health benefit exchange.

(b) In carrying out its activities under this subchapter, the Vermont health benefit exchange shall not use any funds intended for the administrative and operational expenses of the Vermont health benefit exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

§ 1809. PUBLICATION OF COSTS

The Vermont health benefit exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange and shall publish the administrative costs of the exchange on a website intended to educate consumers about such costs. This information shall include information on monies lost to waste, fraud, and abuse.

§ 1810. RULES

The secretary of human services may adopt rules pursuant to chapter 25 of Title 3 as needed to carry out the duties and functions established in this subchapter.

Subchapter 2. Green Mountain Care

§ 1821. PURPOSE

The purpose of Green Mountain Care is to provide comprehensive, affordable, high-quality health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health insurance. Green Mountain Care shall contain costs: by providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits; by innovative payment mechanisms to health care professionals, such as global payments; and by encouraging the management of health services through the Blueprint for Health.

§ 1822. DEFINITIONS

For purposes of this subchapter:

(1) "Agency" means the agency of human services.

(2) "CHIP funds" means federal funds available under Title XXI of the Social Security Act.

(3) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last one year or more and that requires ongoing clinical management, health services that attempt to restore the individual to highest function and that 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) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(5) "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.

(6) "Hospital" shall have the same meaning as in 18 V.S.A. § 1902 and may include hospitals located out of the state.

(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 mental health and substance abuse treatment.

(9) "Secretary" means the secretary of human services.

(10) "Smart card" means a card to authenticate patient identity which, consistent with the privacy and security standards provided in the state's health information technology plan established under 18 V.S.A. chapter 219, enables a health care professional or provider to access patients' health records and facilitates payment for health services.

(11) "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.

§ 1823. ELIGIBILITY

(a) Upon implementation, all Vermont residents shall be eligible for Green Mountain Care. The agency shall establish standards for the verification of residency.

(b) An individual may enroll in Green Mountain Care regardless of whether the individual's employer offers health insurance for which the individual is eligible.

(c) The agency shall establish a procedure to enroll residents and shall provide each with a smart card that may be used by health care professionals for payment.

(d)(1) The agency shall establish by rule a process to allow health care professionals to presume an individual is eligible based on the information provided on a simplified application.

(2) After submission of the application, the agency shall collect additional information as necessary to determine whether Medicaid or CHIP funds may be applied toward the cost of the health services provided, but shall provide payment for any health services received by the individual from the time the application is submitted.

(e) Vermont residents who are temporarily out of the state on a short-term basis and who intend to return and reside in Vermont shall remain eligible for Green Mountain Care while outside Vermont.

(f) A nonresident visiting Vermont, or his or her insurer, shall be billed for all services received. The agency may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors.

(g) An employer with an existing retiree benefit program may elect to provide retiree benefits through Green Mountain Care. However, if an employer does not elect to provide retiree benefits through Green Mountain

Care, Green Mountain Care shall be the secondary payer to the retiree's health benefit plan.

(h) Green Mountain Care shall maintain a robust and adequate network of health care professionals, including mental health professionals.

§ 1824. HEALTH BENEFITS

(a)(1) Green Mountain Care shall provide coverage at least as comprehensive as the essential benefit package provided for the Vermont health benefit exchange established in subchapter 1 of this chapter, which shall include primary care, preventive care, chronic care, acute episodic care, and hospital services. The Vermont health reform board established in 18 V.S.A. chapter 220 shall approve the scope of the benefit package as part of its review of the Green Mountain Care budget.

(2) If funds allow, Green Mountain Care shall provide a basic dental and vision benefit modeled on common benefits offered in stand-alone dental and vision plans available in this state.

(b) Green Mountain Care shall include cost-sharing and out-of-pocket limitations as determined by the Vermont health reform board, after recommendations from the agency, as part of its review of the Green Mountain Care budget. There shall be a waiver of the cost-sharing requirement for chronic care for individuals participating in chronic care management and for primary and preventive care.

(c)(1) For individuals eligible for Medicaid, the benefit package shall include the scope of benefits provided to these individuals on January 1, 2014, except that, consistent with federal law, the Vermont health reform board may modify benefits to these individuals; provided that individuals whose benefits are paid for with Medicaid or CHIP funds shall receive, at a minimum, the Green Mountain Care benefit package.

(2) For children eligible for benefits paid for with Medicaid funds, the benefit package shall include early and periodic screening, diagnosis, and treatment services as defined under federal law.

(3) For individuals eligible for Medicare, the benefit package shall include, at a minimum, the scope of benefits provided to these individuals on January 1, 2014.

§ 1825. BLUEPRINT FOR HEALTH

(a) All individuals enrolled in Green Mountain Care shall have a primary health care professional who is involved with the Blueprint for Health established in 18 V.S.A. chapter 13, which includes patient-centered medical homes and multi-disciplinary community health teams to support well-coordinated health services. The agency shall determine a method to approve a specialist as a patient's primary health care professional for the purposes of establishing a medical home for the patient.

(b) The Blueprint for Health established in 18 V.S.A. chapter 13 shall be integrated with Green Mountain Care.

§ 1826. ADMINISTRATION; ENROLLMENT

(a) The agency may, under an open bidding process, solicit and receive bids from insurance carriers or third-party administrators for administration of certain elements of Green Mountain Care.

(b)(1) Nothing in this subchapter shall require an individual covered by health insurance to terminate that insurance.

(2) Notwithstanding the provisions of subdivision (1) of this subsection, after implementation of Green Mountain Care, private insurance companies shall be prohibited from selling health insurance policies in Vermont that cover services also covered by Green Mountain Care.

(c) An individual may elect to maintain supplemental health insurance if the individual so chooses, provided that after implementation of Green Mountain Care, the supplemental insurance shall cover only services that are not also covered by Green Mountain Care.

(d) Except for cost-sharing, Vermonters shall not be billed any additional amount for health services covered by Green Mountain Care.

(e) The agency shall seek permission from the Centers for Medicare and Medicaid Services to be the administrator for the Medicare program in Vermont. If the agency is unsuccessful in obtaining such permission, Green

Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XVIII of the Social Security Act (Medicare).

(f) Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by any other health benefit plan funded solely with federal funds, such as federal health benefit plans offered by the Veterans' Administration, by the military, or to federal employees.

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

(h) Any prescription drug coverage offered by Green Mountain Care shall be consistent with the standards and procedures applicable to the pharmacy best practices and cost control program established in sections 1996 and 1998 of this title and the state drug formulary established in chapter 91, subchapter 4 of Title 18.

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

(j) An individual aggrieved by an adverse decision of the agency or plan administrator may appeal to the human services board as provided in 3 V.S.A. § 3090.

§ 1827. BUDGET PROPOSAL; COST-CONTAINMENT

For each state fiscal year, the agency shall develop a budget for Green Mountain Care based on the payment methodologies, payment amounts, and cost-containment targets established by the Vermont health reform board. The agency shall propose its budget for Green Mountain Care to the Vermont health reform board at such time as required by the board for its consideration.

§ 1828. GREEN MOUNTAIN CARE FUND

(a) The Green Mountain Care fund is established in the state treasury as a special fund to be the single source to finance health care coverage for all Vermonters.

(b) Into the fund shall be deposited:

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

(2) if authorized by a waiver from federal law, federal funds for Medicaid, Medicare, and the Vermont health benefit exchange established in chapter 18, subchapter 1 of this title; and

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

(c) The fund shall be administered pursuant to chapter 7, subchapter 5 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 for the administration and delivery of health services covered by Green Mountain Care as provided in this subchapter.

§ 1829. IMPLEMENTATION

Green Mountain Care shall be implemented upon receipt of a waiver pursuant to Section 1332 of the Affordable Care Act. As soon as available under federal law, the secretary of administration shall seek a waiver to allow the state to suspend operation of the Vermont health benefit exchange and to enable Vermont to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the Affordable Care Act. The secretary may seek a waiver

from other provisions of the Affordable Care Act as necessary to ensure the operation of Green Mountain Care.

Sec. 5. 33 V.S.A. § 401 is amended to read:

§ 401. COMPOSITION OF DEPARTMENT

The department of Vermont health access, created under 3 V.S.A. § 3088, shall consist of the commissioner of Vermont health access, the medical director, a health care eligibility unit; and all divisions within the department, including the divisions of managed care; health care reform; the Vermont health benefit exchange; and Medicaid policy, fiscal, and support services.

Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY UNIT

Effective October 1, 2011, the secretary of administration shall transfer to and place under the supervision of the commissioner of Vermont health access all employees, professional and support staff, consultants, positions, and all balances of all appropriation amounts for personal services and operating expenses for the administration of health care eligibility currently contained in the department for children and families.

* * * Consumer and Health Care Professional Advisory Board * * *

Sec. 7. 33 V.S.A. § 402 is added to read:

§ 402. CONSUMER AND HEALTH CARE PROFESSIONAL ADVISORY BOARD

(a)(1) A consumer and health care professional advisory board is created for the purpose of advising the commissioner of Vermont health access with respect to policy development and program administration for the Vermont health benefit exchange, Medicaid, the Vermont health access plan, VPharm, and VermontRx.

(2) The board shall have an opportunity to review and comment upon agency policy initiatives pertaining to quality improvement initiatives and to health care benefits and eligibility for individuals receiving services through Medicaid, programs funded with Medicaid funds under a Section 1115 waiver, or the Vermont health benefit exchange. It also shall have the opportunity to comment on proposed rules prior to commencement of the rulemaking process pursuant to chapter 25 of Title 3 and on waiver or waiver amendment applications prior to submission to the Centers for Medicare and Medicaid Services.

(3) Prior to the annual budget development process, the department of Vermont health access shall engage the advisory committee in setting

priorities, including consideration of scope of benefits, beneficiary eligibility, funding outlook, financing options, and possible budget recommendations.

(b) The advisory committee shall make policy recommendations on proposals of the department of Vermont health access to the department, the health access oversight committee, the senate committee on health and welfare, and the house committees on health care and on human services. When the general assembly is not in session, the commissioner shall respond in writing to these recommendations, a copy of which shall be provided to each of the legislative committees of jurisdiction.

(c) During the legislative session, the commissioner shall provide the committee at regularly scheduled meetings with updates on the status of policy and budget proposals.

(d) The commissioner shall convene the advisory committee at least six times during each calendar year.

(e)(1) At least one-third of the members of the advisory committee shall be recipients of Medicaid, VHAP, VPharm, VermontRx, or enrollees in the Vermont health benefit exchange. Such members shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, including costs of travel, child care, personal assistance services, and any other service necessary for participation on the committee and approved by the commissioner.

(2) The commissioner shall ensure broad representation from health care professionals.

(f) The commissioner shall appoint members of the advisory committee, who shall serve staggered three-year terms. The commissioner may remove members of the committee who fail to attend three consecutive meetings and may appoint replacements.

* * * Planning Initiatives * * *

Sec. 8. INTEGRATION PLAN

No later than January 15, 2012, the secretary of administration or designee shall make recommendations to the house committee on health care and the senate committee on health and welfare on the following issues:

(1) How to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with the Vermont health benefit exchange and Green Mountain Care established in chapter 18 of Title 33, including:

(A) Whether it is necessary to establish a basic health program for individuals with incomes above 133 percent of the federal poverty level (FPL) and at or below 200 percent of FPL pursuant to Section 1331 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law

111-152), and as further amended ("Affordable Care Act"), to ensure that the health coverage is affordable for this population.

(B) The statutory changes necessary to integrate the private insurance markets with the Vermont health benefit exchange, including whether to impose a moratorium on the issuance of new association policies prior to 2014, as well as whether to continue exemptions for associations pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health benefit exchange and if so, what criteria to use.

(C) In consultation with the Vermont health reform board, the design of a common benefit package for the Vermont health benefit exchange. When creating the common benefit package, the secretary shall compare the essential benefits package defined under federal regulations implementing the Affordable Care Act with Vermont's insurance mandates, consider the affordability of cost-sharing both with and without the cost-sharing subsidy provided under federal regulations implementing the Affordable Care Act, and determine the feasibility and appropriate design of cost-sharing amounts which provide an incentive to patients to seek evidence-based health interventions and to avoid health services with less proven effectiveness.

(2) Once Green Mountain Care is implemented, whether to allow employers and individuals to purchase coverage for supplemental health

services from Green Mountain Care or to allow private insurers to provide supplemental insurance plans.

Sec. 9. FINANCING PLANS

(a) The secretary of administration or designee shall recommend two financing plans to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance no later than January 15, 2013.

(1) One plan shall recommend the amounts and necessary mechanisms to finance any initiatives which must be implemented by January 1, 2014 in order to provide coverage to all Vermonters in the absence of a waiver from certain federal health care reform provisions established in section 1332 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended ("Affordable Care Act").

(2) The second plan shall recommend the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private single payer health care system. The secretary shall recommend whether nonresidents employed by Vermont businesses should be eligible for Green Mountain Care and other cross-border issues.

(b) In developing both financing plans, the secretary shall consider the following:

(1) financing sources, including adjustments to the income tax, a payroll tax, consumption taxes, provider assessments required under 33 V.S.A. chapter 19, the employer assessment required by 21 V.S.A. chapter 25, other new or existing taxes, and additional options as determined by the secretary;

(2) the impacts of the various financing sources, including levels of deductibility of any tax or assessment system contemplated;

(3) issues involving federal law and taxation;

(4) impacts of tax system changes:

(A) on individuals, households, businesses, public sector entities, and the nonprofit community;

(B) over time, on changing revenue needs; and

(C) for the transitional period, while the tax system and health care cost structure are changing, strategies may be needed to avoid double payments, such as premiums and tax obligations;

(5) growth in health care spending relative to needs and capacity to pay;

(6) the costs of maintaining existing state insurance mandates and other appropriate considerations in order to determine the state contribution required under the Affordable Care Act;

(7) additional funds needed to support recruitment and retention programs for primary care health professionals in order to address the primary care shortage;

(8) additional funds needed to provide coverage for the uninsured who are eligible for Medicaid, Dr. Dynasaur, and the Vermont health benefit exchange in 2014;

(9) funding mechanisms to ensure that operations of both the Vermont health benefit exchange and Green Mountain Care are self-sustaining.

Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

(a) The secretary of administration or designee, in consultation with the Vermont health reform board and the commissioner of Vermont health access, shall review the health information technology plan required by 18 V.S.A. § 9351 to ensure that the plan reflects the creation of the Vermont health benefit exchange; the transition to a public-private single payer health system pursuant to 33 V.S.A. chapter 18, subchapter 2; and any necessary development or modifications to public health information technology and data and to public health surveillance systems, to ensure that there is progress toward full implementation.

(b) In conducting this review, the secretary of administration may issue a request for proposals for an independent design and implementation plan which would describe how to integrate existing health information systems to

carry out the purposes of this act, detail how to develop the necessary capacity in health information systems, determine the funding needed for such development, and quantify the existing funding sources available for such development. The health information technology plan or design and implementation plan shall also include:

(1) the creation of a smart card as defined in 33 V.S.A. § 1822 in order to ensure that this technology is developed prior to the implementation of Green Mountain Care;

(2) a review of the multi-payer database established in 18 V.S.A. § 9410 to determine whether there are systems modifications needed to use the database to reduce fraud, waste, and abuse; and

(3) other systems analysis as specified by the secretary.

(c) The secretary shall make recommendations to the house committee on health care and the senate committee on health and welfare based on the design and implementation plan no later than January 15, 2012.

Sec. 11. HEALTH SYSTEM PLANNING, REGULATION, AND PUBLIC HEALTH

No later than January 15, 2012, the secretary of administration or designee shall make recommendations to the house committee on health care and the senate committee on health and welfare on how to unify Vermont's current efforts around health system planning, regulation, and public health, including:

(1) How best to align the agency of human services' public health promotion activities with Medicaid, the Vermont health benefit exchange functions, Green Mountain Care, and activities of the Vermont health reform board established in 18 V.S.A. chapter 220.

(2) After reviewing current resources, including the community health assessments, how to create an integrated system of community health assessments, health promotion, and planning, including by:

(A) improving the use and usefulness of the health resource allocation plan established in 18 V.S.A. § 9405 in order to ensure that health resource planning is effective and efficient; and

(B) recommending whether to institute a public health audit process to ensure appropriate consideration of the impacts on public health resulting from major policy or planning decisions made by municipalities, local entities, and state agencies.

(3) In collaboration with the director of the Blueprint for Health established in 18 V.S.A. chapter 13 and health care professionals, coordinate quality efforts across state government and private payers; optimize quality assurance programs; and ensure that health care professionals in Vermont utilize, are informed of, and engage in evidence-based practice.

(4) Provide a progress report on payment reform planning and other activities authorized in 18 V.S.A. chapter 220.

Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

No later than January 15, 2012, the Vermont health reform board established in chapter 220 of Title 18, in consultation with the commissioner of banking, insurance, securities, and health care administration and the commissioner of Vermont health access, shall recommend to the house committee on health care and the senate committee on health and welfare any necessary modifications to the regulatory processes for health care professionals and managed care organizations in order to align these processes with the payment reform strategic plan.

Sec. 13. WORKFORCE ISSUES

(a)(1) Currently, Vermont has a shortage of primary care professionals, and many practices are closed to new patients. In order to ensure sufficient patient access now and in the future, it is necessary to plan for the implementation of Green Mountain Care and utilize Vermont's health care professionals to the fullest extent of their professional competence.

(2) The board of nursing, the board of medical practice, and the office of professional regulation shall collaborate to determine how to optimize the primary care workforce by reviewing the licensure process, scope of practice requirements, reciprocity of licensure, and efficiency of the licensing process, and by identifying any other barriers to augmenting Vermont's primary care workforce. No later than January 15, 2012, the boards and office shall provide

to the house committee on health care and the senate committee on health and welfare joint recommendations for improving the primary care workforce through the boards' and office's rules and procedures.

(b) The department of labor and the agency of human services shall collaborate to create a plan to address the retraining needs of employees who may become dislocated due to a reduction in health care administrative functions when the Vermont health benefit exchange and Green Mountain Care are implemented. The plan shall include consideration of new training programs and scholarships or other financial assistance necessary to ensure adequate resources for training programs and to ensure that employees have access to these programs. The department and agency shall provide information to employers whose workforce may be reduced in order to ensure that the employees are informed of available training opportunities. The department shall provide the plan to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.

Sec. 14. MEDICAL MALPRACTICE STUDY

(a) The secretary of administration or designee shall study:

(1) the feasibility of creating a no-fault medical malpractice system in Vermont;

(2) medical malpractice insurance reform in other states;

(3) opportunities for captive insurance to expand into the area of malpractice; and

(4) the impacts in Vermont and other states of the SorryWorks program.

(b) The secretary shall also consider the impacts of the medical malpractice reforms reviewed in subdivisions (a)(1) through (4) of this section on health care professionals and on patients, including the impacts on patient safety and the costs associated with preventable medical errors, on health care professionals who may currently practice defensive medicine and any savings attributable to a decline in this practice, on the availability of compensation for patients, on medical malpractice insurance availability and premium rates, and such other issues as the secretary deems appropriate.

(c) The secretary shall report his or her findings to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary no later than January 15, 2012.

* * * Rate Review * * *

Sec. 15. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates, and rules

for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate, or rule be so used until the expiration of ~~30~~ 60 days after having been filed, or in the case of a request for a rate increase, until a decision by the Vermont health reform board as provided herein, unless the commissioner shall sooner give his or her written approval thereto. The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, and promotes access to health care. Prior to approving a rate, the commissioner shall seek approval for any rate increase from the Vermont health reform board established in 18 V.S.A. chapter 220, which shall approve or disapprove the rate increase within 10 business days. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of this state or if it does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. ~~In all other cases, the commissioner shall give his or her approval.~~ After the expiration of ~~such 30 days from the filing of any such form, premium rate or rule,~~ the review period provided herein or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 ~~days~~ days' written

notice has been given to the insurer using such form, premium rate, or rule, 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.

* * * Employer Benefit Information * * *

Sec. 16. 21 V.S.A. § 2004 is added to read:

§ 2004. HEALTH BENEFIT COSTS

Employers shall provide their employees with an annual statement indicating the total monthly premium cost paid for any employer-sponsored health benefit plan and the employee's share of the cost. The department shall develop a simple form for employers to use for this annual statement.

* * * Single Formulary * * *

Sec. 17. 18 V.S.A. chapter 91, subchapter 4 is added to read:

Subchapter 4. Statewide Prescription Drug Formulary

§ 4635. STATEWIDE PREFERRED DRUG LIST

(a) The drug utilization review board established in connection with Vermont's Medicaid program shall develop and maintain a preferred drug list applicable to all health benefit plans covering Vermont lives.

(b)(1) The drug utilization review board's selection of drugs for inclusion on the preferred drug list shall be based upon evidence-based considerations of

clinical efficacy, adverse side-effects, safety, appropriate clinical trials, and cost-effectiveness. In this subchapter, "evidence-based" shall have the same meaning as in section 4622 of this title. The commissioner of Vermont health access shall provide the board with evidence-based information about clinical efficacy, adverse side-effects, safety, and appropriate clinical trials, and shall provide information about cost-effectiveness of available drugs in the same therapeutic class. Health benefit plans covering Vermont lives may also submit evidence-based information listed in this subdivision to the board for its consideration.

(2) The board may identify different drugs within the same therapeutic class as preferred for health insurance plans and for state public assistance programs to reflect differences in available manufacturer rebates and discounts.

(3) The board shall meet at least quarterly. The board shall comply with the requirements of subchapter 2 of chapter 5 of Title 1 (open meetings) and subchapter 3 of chapter 5 of Title 1 (open records), except that the board may go into executive session to discuss drug alternatives and receive information on the relative price, net of any rebates or discounts, of a drug under discussion and the drug price in comparison to the prices, net of any rebates or discounts, of alternative drugs available in the same class to determine cost-effectiveness, and in order to comply with 33 V.S.A. § 2002(c) to consider information

relating to a pharmaceutical rebate, supplemental rebate, or Section 340b discount, which is protected from disclosure by federal law or the terms and conditions required by the Centers for Medicare and Medicaid Services or the federal Health Resources and Service Administration as a condition of rebate authorization under the Medicaid program.

(4) To the extent feasible, the board shall review all drug classes included in the preferred drug list at least every 24 months, and may make additions to or modifications of the preferred drug list.

(5) The program shall establish board procedures for the timely review of prescription drugs newly approved by the federal Food and Drug Administration, including procedures for the review of newly approved prescription drugs in emergency circumstances.

(6) Members of the board shall receive per diem compensation and reimbursement of expenses in accordance with 32 V.S.A. § 1010.

(c) As used in this section:

(1) "Health benefit plan" means a health benefit plan with prescription drug coverage offered or administered by a health insurer, as defined by section 9402 of this title. The term includes:

(A) any state public assistance program with a health benefit plan that provides coverage of prescription drugs;

(B) any health benefit plan offered by or on behalf of the state of Vermont or any instrumentality of the state providing coverage for government employees and their dependents; and

(C) any self-insured health benefit plan that agrees to participate in the preferred drug list.

(2) "State public assistance program" includes the Medicaid program, the Vermont health access plan, VPharm, VermontRx, the state children's health insurance program, the state of Vermont AIDS medication assistance program, the general assistance program, the pharmacy discount plan program, and the out-of-state counterparts to such programs.

Sec. 18. 1 V.S.A. § 313(a)(9) is amended to read:

(9) Information relating to a pharmaceutical rebate or to supplemental rebate agreements, which is protected from disclosure by federal law or the terms and conditions required by the Centers for Medicare and Medicaid Services as a condition of rebate authorization or discounts under the Medicaid program, considered pursuant to ~~33 V.S.A. §§ 1998(f)(2)~~ 18 V.S.A. § 4635(b)(3) and ~~2002(c)~~ 33 V.S.A. § 2002(c).

Sec. 19. 8 V.S.A. § 4088e is amended to read:

§ 4088e. NOTICE OF PREFERRED DRUG LIST CHANGES

On a periodic basis, no less than once per calendar year, a health insurer as defined in ~~subdivisions~~ 18 V.S.A. § 9471(2)(A), (C), and (D) ~~of Title 18~~ shall

notify beneficiaries of changes in pharmaceutical coverage and provide access to the preferred drug list established and maintained ~~by the insurer~~ pursuant to 18 V.S.A. § 4635.

Sec. 20. 33 V.S.A. § 1998 is amended to read:

§ 1998. PHARMACY BEST PRACTICES AND COST CONTROL PROGRAM ESTABLISHED

(a) The commissioner of Vermont health access shall establish and maintain a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include:

(1) ~~Use of an evidence-based preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives and over-the-counter drugs.~~

~~(2)~~ Utilization review procedures, including a prior authorization review process.

~~(3)~~(2) Any strategy designed to negotiate with pharmaceutical manufacturers to lower the cost of prescription drugs for program participants, including a ~~supplemental~~ purchasing agreement, discounts, and rebate ~~program~~ programs.

~~(4)~~(3) Alternative pricing mechanisms, including consideration of using maximum allowable cost pricing for generic and other prescription drugs.

~~(5)~~(4) Alternative coverage terms, including consideration of providing coverage of over-the-counter drugs where cost-effective in comparison to prescription drugs, and authorizing coverage of dosages capable of permitting the consumer to split each pill if cost-effective and medically appropriate for the consumer.

~~(6)~~(5) ~~A simple, uniform prescription form, designed~~ Methods to implement the preferred drug list established pursuant to 18 V.S.A. § 4635, and to enable prescribers and consumers to request an exception to the preferred drug list choice with a minimum of cost and time to prescribers, pharmacists, and consumers.

~~(7) A joint pharmaceuticals purchasing consortium as provided for in subdivision (c)(1) of this section.~~

~~(8)~~(6) Any other cost containment activity adopted, by rule, by the commissioner that is designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies.

* * *

(c)~~(1) The commissioner may implement the pharmacy best practices and cost control program for any other health benefit plan within or outside this state that agrees to participate in the program. For entities in Vermont, the~~

~~commissioner shall directly or by contract implement the program through a joint pharmaceuticals purchasing consortium. The joint pharmaceuticals purchasing consortium shall be offered on a voluntary basis no later than January 1, 2008, with mandatory participation by state or publicly funded, administered, or subsidized purchasers to the extent practicable and consistent with the purposes of this chapter, by January 1, 2010. If necessary, the department of Vermont health access shall seek authorization from the Centers for Medicare and Medicaid to include purchases funded by Medicaid. "State or publicly funded purchasers" shall include the department of corrections, the department of mental health, Medicaid, the Vermont Health Access Program (VHAP), Dr. Dynasaur, Vermont Rx, VPharm, Healthy Vermonters, workers' compensation, and any other state or publicly funded purchaser of prescription drugs.~~

~~(2) The commissioner of Vermont health access and the secretary of administration shall take all steps necessary to enable Vermont's participation in joint prescription drug purchasing agreements with any other health benefit plan or organization within or outside this state that agrees to participate with Vermont in such joint purchasing agreements.~~

~~(3) The commissioner of human resources shall take all steps necessary to enable the state of Vermont to participate in joint prescription drug purchasing agreements with any other health benefit plan or organization~~

~~within or outside this state that agrees to participate in such joint purchasing agreements, as may be agreed to through the bargaining process between the state of Vermont and the authorized representatives of the employees of the state of Vermont.~~

~~(4)~~ The actions of the commissioners and the secretary shall include:

~~(A)~~(1) active collaboration with the National Legislative Association on Prescription Drug Prices;

~~(B)~~(2) active collaboration with ~~the Pharmacy RFP Issuing States initiative organized by the West Virginia Public Employees Insurance Agency~~ multi-state purchasing pools; and

~~(C)~~(3) the execution of any joint purchasing agreements or other contracts with any participating health benefit plan or organization within or outside the state which the commissioner of Vermont health access determines will lower the cost of prescription drugs for Vermonters while maintaining high quality in prescription drug therapies~~; and~~

~~(D) with regard to participation by the state employees health benefit plan, the execution of any joint purchasing agreements or other contracts with any health benefit plan or organization within or outside the state which the commissioner of Vermont health access determines will lower the cost of prescription drugs and provide overall quality of integrated health care services to the state employees health benefit plan and the beneficiaries of the plan, and~~

~~which is negotiated through the bargaining process between the state of Vermont and the authorized representatives of the employees of the state of Vermont~~.

~~(5)~~(d) The commissioners of human resources and of Vermont health access may renegotiate and amend existing contracts to which the departments of Vermont health access and of human resources are parties if such renegotiation and amendment will be of economic benefit to the health benefit plans subject to such contracts, and to the beneficiaries of such plans. Any renegotiated or substituted contract shall be designed to improve the overall quality of integrated health care services provided to beneficiaries of such plans.

~~(6)~~(e) The commissioners and the secretary shall report quarterly to the health access oversight committee and the joint fiscal committee on their progress in securing Vermont's participation in such joint purchasing agreements.

~~(7)~~(f) The commissioner of Vermont health access, the commissioner of human resources, the commissioner of banking, insurance, securities, and health care administration, and the secretary of human services shall establish a collaborative process with the Vermont medical society, pharmacists, health insurers, consumers, employer organizations and other health benefit plan sponsors, the National Legislative Association on Prescription Drug Prices,

pharmaceutical manufacturer organizations, and other interested parties designed to consider and make recommendations to reduce the cost of prescription drugs for all Vermonters.

~~(d) A participating health benefit plan other than a state public assistance program may agree with the director to limit the plan's participation to one or more program components. The commissioner shall supervise the implementation and operation of the pharmacy best practices and cost control program, including developing and maintaining the preferred drug list, to carry out the provisions of the subchapter. The director may include such insured or self-insured health benefit plans as agree to use the preferred drug list or otherwise participate in the provisions of this subchapter. The purpose of this subchapter is to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies.~~

* * *

(f)~~(1) The drug utilization review board shall make recommendations to the commissioner for the adoption of the preferred drug list. The board's recommendations shall be based upon evidence-based considerations of clinical efficacy, adverse side effects, safety, appropriate clinical trials, and cost-effectiveness. "Evidence-based" shall have the same meaning as in 18 V.S.A. § 4622. The commissioner shall provide the board with evidence-based information about clinical efficacy, adverse side effects, safety, and~~

~~appropriate clinical trials and shall provide information about cost-effectiveness of available drugs in the same therapeutic class.~~

~~(2) The board shall meet at least quarterly. The board shall comply with the requirements of subchapter 2 of chapter 5 of Title 1 (open meetings) and subchapter 3 of chapter 5 of Title 1 (open records), except that the board may go into executive session to discuss drug alternatives and receive information on the relative price, net of any rebates, of a drug under discussion and the drug price in comparison to the prices, net of any rebates, of alternative drugs available in the same class to determine cost-effectiveness, and in order to comply with subsection 2002(c) of this title to consider information relating to a pharmaceutical rebate or to supplemental rebate agreements, which is protected from disclosure by federal law or the terms and conditions required by the Centers for Medicare and Medicaid Services as a condition of rebate authorization under the Medicaid program.~~

~~(3) To the extent feasible, the board shall review all drug classes included in the preferred drug list at least every 12 months and may recommend that the commissioner make additions to or deletions from the preferred drug list.~~

~~(4) The program shall establish board procedures for the timely review of prescription drugs newly approved by the federal Food and Drug~~

~~Administration, including procedures for the review of newly-approved prescription drugs in emergency circumstances.~~

~~(5) Members of the board shall receive per diem compensation and reimbursement of expenses in accordance with 32 V.S.A. § 1010.~~

~~(6) The commissioner shall encourage participation in the joint purchasing consortium by inviting representatives of the programs and entities specified in subdivision (c)(1) of this section to participate as observers or nonvoting members in the drug utilization review board and by inviting the representatives to use the preferred drug list in connection with the plans' prescription drug coverage.~~

(g) The department shall seek assistance from entities conducting independent research into the safety and effectiveness of prescription drugs to provide technical and clinical support in the development and the administration of the preferred drug list pursuant to 18 V.S.A. § 4635 and the evidence-based education program established in subchapter 2 of chapter 91 of Title 18.

Sec. 21. 33 V.S.A. § 1999(a)(1) is amended to read:

(a)(1) The pharmacy best practices and cost control program shall authorize pharmacy benefit coverage when a patient's health care provider prescribes a prescription drug not on the preferred drug list established pursuant to 18 V.S.A. § 4635, or a prescription drug which is not the list's preferred

choice, if either of the circumstances set forth in subdivision (2) or (3) of this subsection applies.

Sec. 22. 33 V.S.A. § 2001 is amended to read:

§ 2001. LEGISLATIVE OVERSIGHT

(a) In connection with the pharmacy best practices and cost control program pursuant to this subchapter and the statewide preferred drug list pursuant to subchapter 4 of chapter 91 of Title 18, the commissioner of Vermont health access shall report for review by the health access oversight committee, prior to initial implementation, and prior to any subsequent modifications:

* * *

(c) The commissioner of Vermont health access shall report quarterly to the health access oversight committee concerning the following aspects of the pharmacy best practices and cost control program and the statewide preferred drug list:

* * *

Sec. 23. 33 V.S.A. § 2002(a) is amended to read:

(a) The commissioner of Vermont health access~~, separately or in concert with the authorized representatives of any participating health benefit plan,~~ or designee shall use the preferred drug list ~~authorized by the pharmacy best practices and cost control program~~ established pursuant to 18 V.S.A. § 4635 to

negotiate with pharmaceutical companies for the payment to the commissioner of supplemental rebates or price discounts, including 340B discounts, for Medicaid and for any other state public assistance health benefit plans designated by the commissioner, in addition to those required by Title XIX of the Social Security Act. The commissioner may also use the preferred drug list to negotiate for the payment of rebates or price discounts in connection with drugs covered under any other participating health benefit plan within or outside this state, provided that such negotiations and any subsequent agreement shall comply with the provisions of 42 U.S.C. § 1396r-8. The program, or such portions of the program as the commissioner shall designate, shall constitute a state pharmaceutical assistance program under 42 U.S.C. § 1396r-8(c)(1)(C).

Sec. 24. 33 V.S.A. § 2076(a) is amended to read:

(a) All public pharmaceutical assistance programs shall provide coverage for those over-the-counter pharmaceuticals on the preferred drug list developed ~~under section 1998 of this title~~ pursuant to 18 V.S.A. § 4635, provided the pharmaceuticals are authorized as part of the medical treatment of a specific disease or condition, and they are a less costly, medically appropriate substitute for or an alternative to currently covered pharmaceuticals.

* * * Conforming Revisions * * *

Sec. 25. 3 V.S.A. § 2222a is amended to read:

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

(a) The secretary of administration shall be responsible for the coordination of health care system reform initiatives 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, evidence-based, and seeks to inform and improve the quality and affordability of patient care and public health.

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

(1) The state's chronic care infrastructure, disease 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 all Vermonters with or at risk for a chronic condition or disease.

(2) The Vermont health information technology project pursuant to chapter 219 of Title 18.

(3) The multi-payer data collection project pursuant to 18 V.S.A. § 9410.

(4) The common claims administration project pursuant to 18 V.S.A. § 9408.

(5) The consumer price and quality information system pursuant to 18 V.S.A. § 9410.

(6) Any information technology work done by the quality assurance system pursuant to 18 V.S.A. § 9416.

(7) The public health promotion programs of the agency of human services, including primary prevention for chronic disease, community assessments, school wellness programs, public health information technology, data and surveillance systems, healthy retailers, healthy community design, and alcohol and substance abuse treatment and prevention programs.

(8) ~~Medicaid, the Vermont health access plan, Dr. Dynasaur, premium assistance programs for employer-sponsored insurance, VPharm, and Vermont Rx, which are established in chapter 19 of Title 33 and provide health care coverage to elderly, disabled, and low to middle income Vermonters.~~ The creation of a single-payer health care system to provide affordable, high-quality health care coverage to all Vermonters and to include federal funds to the maximum extent allowable under federal law and waivers from federal law.

(9) ~~Catamount Health, established in 8 V.S.A. § 4080f, which provides a comprehensive benefit plan with a sliding-scale premium based on income to uninsured Vermonters.~~ A reformation of the payment system for health care set forth in 18 V.S.A. chapter 220 in order to ensure that payment for services encourages health care quality and efficiency, and reduces unnecessary services.

(10) ~~The uniform hospital uncompensated car policies.~~ A strategic approach to workforce needs, including retraining programs for workers displaced through increased efficiency and reduced administration in the health care system and ensuring an adequate primary care workforce to provide access to primary care for all Vermonters.

(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 committee on health and welfare, 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 the health access

oversight committee, the commission on health care reform, and to any legislative committee upon request.

Sec. 26. 18 V.S.A. § 5 is amended to read:

§ 5. DUTIES OF DEPARTMENT OF HEALTH

The department of health ~~is hereby designated as the sole state agency for the purposes of~~ shall:

(1) ~~Conducting~~ Conduct studies, ~~developing~~ develop state plans, and ~~administering~~ administer programs and state plans for hospital survey and construction, hospital operation and maintenance, medical care, treatment of alcoholics, and alcoholic rehabilitation.

(2) ~~Providing~~ Provide methods of administration and such other action as may be necessary to comply with the requirements of federal acts and regulations as relate to studies, ~~developing~~ development of plans and ~~administering~~ administration of programs in the fields of health, public health, health education, hospital construction and maintenance, and medical care.

(3) ~~Appointing~~ Appoint advisory councils, with the approval of the governor.

(4) ~~Cooperating~~ Cooperate with necessary federal agencies in securing federal funds ~~now or~~ which ~~may hereafter~~ become available to the state for all prevention, public health, wellness, and medical programs.

(5) Obtain and maintain accreditation through the Public Health Accreditation Board.

(6) Create a state health improvement plan and facilitate local health improvement plans in order to encourage the design of healthy communities and to promote policy initiatives that contribute to community, school, and workplace wellness.

Sec. 27. 18 V.S.A. § 9410(a)(1) is amended to read:

(a)(1) The commissioner shall establish and maintain a unified health care data base to enable the commissioner and the Vermont health reform board to carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title 8, including:

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

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

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

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

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

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

Sec. 28. Sec. 10 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

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

(a) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of health shall undertake such planning steps and other actions as are necessary to secure grants and other beneficial opportunities for Vermont provided by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

(b) From the effective date of this act through July 1, ~~2011~~ 2014, the commissioner of Vermont health access shall undertake such planning steps as are necessary to ensure Vermont's participation in beneficial opportunities created by the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

Sec. 29. Sec. 31(d) of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

(d) Term of committee. The committee shall cease to exist on January 31, ~~2011~~ 2012.

Sec. 30. REPEAL

(a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective December 31, 2013.

(b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective June 30, 2011.

Sec. 31. EFFECTIVE DATES

(a) Secs. 1 (principles), 2 (strategic plan), 8 (integration plan), 9 (financing plans), 10 (HIT), 11 (health planning), 12 (regulatory process), 13 (workforce), 14 (medical malpractice), 25 (health care reform), 26 (department of health), 28 (ACA grants), and 29 (primary care workforce committee) of this act and this section shall take effect on passage.

(b) Secs. 3 (Vermont health care reform), 5 (DVHA), 6 (Health care eligibility), and 30 (repeal) shall take effect on July 1, 2011.

(c) Sec. 4 (Vermont health benefit exchange; Green Mountain Care) shall take effect on July 1, 2011. The Vermont health benefit exchange shall begin enrolling individuals no later than November 1, 2013 and shall be fully operational no later than January 1, 2014. Green Mountain Care shall be implemented upon approval by the U.S. Department of Health and Human Services of a waiver under Section 1332 of Affordable Care Act.

(d) Sec. 7, 3 V.S.A. § 402 (patient and health care professionals advisory board), shall take effect on January 1, 2014.

(e) Sec. 15 (rate review) shall take effect on October 1, 2011 and shall apply to all filings on and after October 1, 2011.

(f) Secs. 16 (health benefit information) and 27 (VHCURES) shall take effect on October 1, 2011.

(g) Secs. 17–24 (drug formulary) shall take effect on October 1, 2011, except the provisions in Sec. 17 of this act (18 V.S.A. § 4635, statewide preferred drug list), allowing the drug utilization and review board to develop the statewide preferred drug list, shall take effect immediately upon passage to ensure implementation on October 1, 2011.