H.233

Introduced by Representatives Hube of Londonderry and Poirier of Barre City

Referred to Committee on

Date:

Subject: Health; health insurance; Catamount Health; health savings accounts

Statement of purpose: This bill proposes to split Catamount Health into two separate plans. One plan would implement sliding-scale deductibles ranging from $250.00 for an individual or $500.00 for a family with income up to 150 percent of the federal poverty level (FPL) to $1,000.00 for an individual or $2,000.00 for a family with income over 225 percent of FPL, with premium assistance available for eligible individuals and families under 300 percent of FPL. The second plan would utilize health savings accounts and would offer a choice of two different deductible levels for individuals and families, regardless of income, with a further option of having the out-of-pocket maximum greater than the deductible amount or the same as the deductible amount. The health savings account plans would not include premium assistance. The bill would also raise the co-payments for office visits and brand-name prescription drugs under both Catamount Health plan options.

An act relating to Catamount Health plans

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

Sec. 1. 8 V.S.A. § 4080f is amended to read:

§ 4080f. CATAMOUNT HEALTH

(a) As used in this section:

(1) "Anniversary date" means the month and day that the named insured enrolled in Catamount Health.

(2) "Carrier" means a registered small group carrier as defined in section 4080a of this title.

~~(2)~~(3) "Catamount Health" means ~~the plan for~~ coverage ~~of~~ under either the Catamount Health income sensitive deductible plan (Catamount Health ISD plan) or one of the Catamount Health health savings account plans (Catamount Health HSA plan) for primary care, preventive care, chronic care, acute episodic care, and hospital services as established in this section to be provided through a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization subscriber contract which is offered or issued to an individual and which meets the requirements of this section.

(4) "Catamount Health health savings account plan" or "Catamount Health HSA plan" means a Catamount Health plan with the benefit levels described in subdivision (c)(1)(C) of this section.

(5) "Catamount Health income sensitive deductible plan" or "Catamount Health ISD plan" means a Catamount Health plan with the benefit levels described in subdivision (c)(1)(A) of this section.

~~(3)~~(6) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, and prevent complications related to chronic conditions. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, and hyperlipidemia.

~~(4)~~(7) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

~~(5)~~(8) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

~~(6)~~(9) "Health service" means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services ordered by a health care professional and medically necessary services to assist in activities of daily living.

~~(7)~~(10) "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)~~(11) "Primary care" means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include prenatal care and the treatment of mental illness.

~~(9)~~(12) "Uninsured" means an individual who does not qualify for Medicare, Medicaid, the Vermont health access plan, or Dr. Dynasaur, and: who had no private insurance or employer-sponsored coverage that includes

both hospital and physician services within 12 months prior to the month of application; who has had a nongroup health insurance plan with an annual deductible of no less than $10,000.00 for an individual or an annual deductible of no less than $20,000.00 for two-person or family coverage for at least six months; or who lost private insurance or employer-sponsored coverage during the prior 12 months for any of the following reasons:

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

(i) loss of employment, including a reduction in hours that results in ineligibility for employer-sponsored coverage, unless the employer has terminated its employees or reduced their hours for the primary purpose of discontinuing employer-sponsored coverage and establishing their eligibility for Catamount Health;

(ii) death of the principal insurance policyholder;

(iii) divorce or dissolution of a civil union;

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

(v) no longer receiving COBRA, VIPER, or other state continuation coverage.

(B) College- or university-sponsored health insurance became unavailable to the individual because the individual graduated, took a leave of

absence, decreased enrollment below a threshold set for continued coverage, or otherwise terminated studies.

(C)(i) The individual lost health insurance as a result of domestic violence. The individual shall provide the agency of human services with satisfactory documentation of the domestic violence. The documentation may include a sworn statement from the individual attesting to the abuse, law enforcement or court records, or other documentation from an attorney or legal advisor, member of the clergy, or health care provider, as defined in section 9402 of Title 18. Information relating to the domestic violence, including the individual's statement and corroborating evidence, provided to the agency shall not be disclosed by the agency unless the individual has signed a consent to disclose form. In the event the agency is legally required to release this information without consent of the individual, the agency shall notify the individual at the time the notice or request for release of information is received by the agency and prior to releasing the requested information.

(ii) Subdivision (i) of this subdivision (C) shall take effect upon issuance by the Centers for Medicare and Medicaid Services of approval of an amendment to the Global Commitment for Health Medicaid Section 1115 Waiver allowing for a domestic violence exception to the Catamount Health waiting period.

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

(c)(1)(A) Catamount Health ISD plans shall provide coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services. The benefits for Catamount Health ISD plans shall be a preferred provider organization plan with the following benefit design:

(i) For applicants with income less than or equal to 150 percent of FPL:

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

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

~~(C)~~(III) a ~~$10.00~~ $25.00 office co-payment;

~~(D)~~(IV) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, ~~$30.00~~ $35.00 co-payments for drugs on the preferred drug list, and ~~$50.00~~ $55.00 co-payments for nonpreferred drugs;

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

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

(ii) For applicants with income greater than 150 percent and less than or equal to 175 percent of FPL:

(I) a $500.00 deductible for an individual and a $1,000.00 deductible for a family for health services received in network, and a $1,000.00 deductible for an individual and a $2,000.00 deductible for a family for health services received out of network;

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

(III) a $25.00 office co-payment;

(IV) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(V) out-of-pocket maximums of $1,050.00 for an individual and $2,100.00 for a family for in-network services and $2,000.00 for an individual and $4,000.00 for a family for out-of-network services; and

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

(iii) For applicants with income greater than 175 percent and less than or equal to 225 percent of FPL:

(I) an $800.00 deductible for an individual and a $1,600.00 deductible for a family for health services received in network, and a $1,600.00 deductible for an individual and a $3,200.00 deductible for a family for health services received out of network;

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

(III) a $25.00 office co-payment;

(IV) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(V) out-of-pocket maximums of $1,350.00 for an individual and $2,700.00 for a family for in-network services and $2,600.00 for an individual and $5,200.00 for a family for out-of-network services; and

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

(iv) For applicants with income greater than 225 percent of FPL:

(I) a $1,000.00 deductible for an individual and a $2,000.00 deductible for a family for health services received in network, and a $2,000.00 deductible for an individual and a $4,000.00 deductible for a family for health services received out of network;

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

(III) a $25.00 office co-payment;

(IV) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(V) out-of-pocket maximums of $1,550.00 for an individual and $3,100.00 for a family for in-network services and $3,000.00 for an individual and $6,000.00 for a family for out-of-network services; and

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

(B) The agency of human services shall evaluate an applicant's income upon enrollment in Catamount Health ISD and annually on the insured's anniversary date.

(C) Catamount Health HSA plans shall provide coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services. The benefits for the Catamount Health HSA plan shall be a preferred provider

organization plan with the following four benefit designs, at the option of the insured:

(i) an HSA-qualified high-deductible health plan in which the out-of-pocket maximum exceeds the deductible amount, with the following benefit options:

(I) a $1,150.00 deductible for an individual and a $2,300.00 deductible for a family for health services received in network, and a $2,300.00 deductible for an individual and a $4,600.00 deductible for a family for health services received out of network;

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

(III) a $25.00 office co-payment;

(IV) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(V) out-of-pocket maximums of $1,800.00 for an individual and $3,500.00 for family for in-network services and $3,500.00 for an individual and $9,000.00 for a family for out-of-network services; and

(VI) a waiver of the deductible and other cost-sharing payments for preventive care.

(ii) an HSA-qualified high-deductible health plan in which the out-of-pocket maximum exceeds the deductible amount, with the following benefit options:

(I) a $3,500.00 deductible for an individual and a $7,000.00 deductible for a family for health services received in network, and a $5,500.00 deductible for an individual and a $10,500.00 deductible for a family for health services received out of network;

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

(III) a $25.00 office co-payment;

(IV) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(V) out-of-pocket maximums of $4,500.00 for an individual and $9,000.00 for family for in-network services and $6,500.00 for an individual and $11,600.00 for a family for out-of-network services; and

(VI) a waiver of the deductible and other cost-sharing payments for preventive care.

(iii) an HSA-qualified high-deductible health plan in which the out-of-pocket maximum equals the deductible amount, with the following benefit options:

(I) a $1,150.00 deductible for an individual and a $2,300.00 deductible for a family for health services received in network, and a $2,300.00 deductible for an individual and a $4,600.00 deductible for a family for health services received out of network;

(II) a $25.00 office co-payment;

(III) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(IV) out-of-pocket maximums of $1,150.00 for an individual and $2,300.00 for a family for in-network services and $2,300.00 for an individual and $4,600.00 for a family for out-of-network services; and

(V) a waiver of the deductible and other cost-sharing payments for preventive care.

(iv) an HSA-qualified high-deductible health plan in which the out-of-pocket maximum equals the deductible amount, with the following benefit options:

(I) a $3,500.00 deductible for an individual and a $7,000.00 deductible for a family for health services received in network, and a $5,500.00 deductible for an individual and a $10,500.00 deductible for a family for health services received out of network;

(II) a $25.00 office co-payment;

(III) prescription drug coverage without a deductible, $10.00 co-payments for generic drugs, $35.00 co-payments for drugs on the preferred drug list, and $55.00 co-payments for nonpreferred drugs;

(IV) out-of-pocket maximums of $3,500.00 for an individual and $7,000.00 for family for in-network services and $5,500.00 for an individual and $10,500.00 for a family for out-of-network services; and

(V) a waiver of the deductible and other cost-sharing payments for preventive care.

(2) Catamount Health shall provide a chronic care management program that has criteria substantially similar to the chronic care management program established in section 1903a of Title 33 and shall share the data on enrollees, to the extent allowable under federal law, with the secretary of administration or designee in order to inform the health care reform initiatives under section 2222a of Title 3.

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

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

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

(6) A health care facility or health care provider who agrees to participate in a Catamount Health network that provides services for a Catamount Health insured shall not balance bill the insured by charging the insured amounts in addition to the reimbursement provided for by the plan's participating provider agreement.

(7) The commissioner shall adjust periodically the deductible and out-of-pocket maximums for the Catamount Health HSA plan in accordance with federal Department of the Treasury and Internal Revenue Service guidance on contribution levels for health savings accounts.

(d)(1) A carrier shall guarantee acceptance of any uninsured individual for any Catamount Health plan offered by the carrier. A carrier shall also

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

(2)(A) An individual with income less than or equal to 300 percent of the federal poverty level who is eligible for an employer-sponsored insurance plan may purchase a Catamount Health ISD plan if:

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

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

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

(B) Decisions by the agency of human services regarding whether an individual's employer-sponsored plan is an approved employer-sponsored plan under section 1974 of Title 33 and decisions by the agency of human services regarding whether enrolling the individual in an approved employer-sponsored plan is cost-effective under section 1974 of Title 33 are matters fully within the discretion of the agency of human services. On appeal pursuant to section 3091 of Title 3, the human services board may overturn the agency's decision only if it is arbitrary or unreasonable.

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

(B) An individual ~~who has been enrolled in~~ whose most recent health care coverage was Medicaid, VHAP, Dr. Dynasaur, ~~or~~ any other health benefit plan authorized under Title XIX or Title XX of the Social Security Act, or Catamount Health shall not be subject to a 12-month waiting period before becoming eligible for Catamount Health.

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

(5) Catamount Health policyholders may change enrollment to a different Catamount Health plan or carrier only during the 30-day period leading up to and including their anniversary date.

(6) If a Catamount Health policyholder terminates coverage and reenrolls in Catamount Health within 12 months of termination, the individual must reenroll at the same Catamount Health benefit level in which he or she was previously enrolled. Reenrollment in Catamount Health shall establish a new contract year and anniversary date for the policyholder.

* * *

(j)(1) A carrier offering Catamount Health shall use a community rating method acceptable to the commissioner for determining premiums for Catamount Health plans. Catamount Health plans shall constitute a separate market and shall be rated as a distinct pool, separate from other individual or group insurance products. The Catamount Health ISD plan and the Catamount Health HSA plan shall be community-rated as one risk pool, and premiums shall be adjusted to reflect benefit differences. For Catamount Health, the following risk classification factors are prohibited from use in rating individuals and their dependents:

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

~~(2)~~(B) geographic area rating;

~~(3)~~(C) industry rating;

~~(4)~~(D) medical underwriting and screening;

~~(5)~~(E) experience rating;

~~(6)~~(F) tier rating; or

~~(7)~~(G) durational rating.

(2) The commissioner shall adopt rules to permit a carrier to establish rewards, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a policyholder to programs of health promotion and disease prevention. The incentives shall comply with the health promotion and disease prevention program rules adopted by the commissioner pursuant to subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

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

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

(2) Carriers shall not sell the Catamount Health ISD plan or the Catamount Health HSA plan prior to November 1, 2009. Carriers shall submit filings for rates and forms for approval on or before September 1, 2009.

(3) Upon a Catamount Health policyholder's first anniversary date following November 1, 2009, each policyholder who chooses to renew coverage in Catamount Health shall choose to enroll in either the Catamount Health ISD plan or in one of the Catamount Health HSA plans.

(4) Carriers shall develop and file for approval with the commissioner consumer education materials concerning health savings accounts prior to sale of the Catamount Health HSA plan.

(5) Carriers shall assist applicants enrolling in the Catamount Health HSA plan with establishing a health savings account.

* * *

Sec. 2. 33 V.S.A. § 1973(e)(4) is amended to read:

(4) Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in subdivision ~~4080f(a)(9)~~ 4080f(a)(12) of Title 8, the individual shall not be eligible for the Vermont health access plan for the 12-month period following the date of enrollment in Catamount Health.

Sec. 3. 33 V.S.A. § 1974 is amended to read:

§ 1974. EMPLOYER-SPONSORED INSURANCE; PREMIUM ASSISTANCE

* * *

(b) VHAP-eligible premium assistance.

* * *

(6) Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in subdivision ~~4080f(a)(9)~~ 4080f(a)(12) of Title 8, the individual shall not be eligible for premium assistance for the 12-month period following the date of enrollment in Catamount Health.

(c) Uninsured individuals; premium assistance.

* * *

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

services covered by the Vermont health access plan that are related to evidence-based guidelines for ongoing prevention and clinical management of the chronic condition specified in the blueprint for health in section 702 of Title 18. Notwithstanding any other provision of law, when an individual is enrolled in Catamount Health solely under the high deductible standard outlined in subdivision ~~4080f(a)(9)~~ 4080f(a)(12) of Title 8, the individual shall not be eligible for premium assistance for the 12-month period following the date of enrollment in Catamount Health.

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

(A) covered benefits to be substantially similar, as determined by the agency, to the benefits covered under Catamount Health, including an annual deductible no greater than the deductible applicable to the individual's income level under the Catamount Health ISD plan; and

(B)(i) until January 1, 2009 or when statewide participation in the Vermont blueprint for health is achieved, appropriate coverage of chronic conditions in a manner consistent with statewide participation by health

insurers in the Vermont blueprint for health, and in accordance with the standards established in section 702 of Title 18;

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

(5) The agency shall determine whether it is cost-effective to the state to require the individual to purchase the approved employer-sponsored insurance plan with premium assistance under this subsection instead of Catamount Health established in section 4080f of Title 8 with assistance under subchapter 3a of chapter 19 of this title. If providing the individual with assistance to purchase the Catamount Health ISD plan is more cost-effective to the state than providing the individual with premium assistance to purchase the individual's approved employer-sponsored plan, the state shall provide the individual the option of purchasing the Catamount Health ISD plan with assistance for that product. An individual may purchase the Catamount Health ISD plan and receive Catamount Health assistance until the approved employer-sponsored plan has an open enrollment period, but the individual shall be required to enroll in the approved employer-sponsored plan in order to continue to receive any assistance. The agency shall not consider the medical history, medical conditions, or claims history of any individual for whom cost-effectiveness is being evaluated.

* * *

(j) The premium contributions for individuals shall be as follows:

(1) Monthly premiums for each individual who is eligible for ~~the Vermont health access plan~~ premium assistance under subsection (b) of this section shall be the same as charged in the Vermont health access plan.

(2) Monthly premiums for each individual who is not eligible for the Vermont health access plan shall be~~:~~

~~(A) Income less than or equal to 175 percent of FPL: $60.00 per month.~~

~~(B) Income greater than 175 percent and less than or equal to 200 percent of FPL: $65.00 per month.~~

~~(C) Income greater than 200 percent and less than or equal to 225 percent of FPL: $110.00 per month.~~

~~(D) Income greater than 225 percent and less than or equal to 250 percent of FPL: $135.00 per month.~~

~~(E) Income greater than 250 percent and less than or equal to 275 percent of FPL: $160.00 per month.~~

~~(F) Income greater than 275 percent and less than or equal to 300 percent of FPL: $185.00 per month~~ the same as the premiums established in subdivision 1984(c)(1) of this section.

Sec. 4. 33 V.S.A. § 1982 is amended to read:

§ 1982. DEFINITIONS

As used in this subchapter:

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

* * *

Sec. 5. 33 V.S.A. § 1984 is amended to read:

§ 1984. INDIVIDUAL CONTRIBUTIONS

(a) The agency shall provide assistance to individuals eligible under this subchapter to purchase a Catamount Health ISD plan. For the lowest cost Catamount Health ISD plan, the amount of the assistance shall be the difference between the premium for the lowest cost Catamount Health ISD plan for the individual's income range and the individual's contribution as defined in subdivision (c)(1) of this section. For Catamount Health ISD plans other than the lowest cost plan, the assistance shall be the difference between the premium for the lowest cost Catamount Health ISD plan and the individual's contribution as set out in subdivision (c)(1) of this section.

(b) Subject to amendment in the fiscal year 2008 budget, the agency of administration or designee shall establish individual and family contribution amounts for Catamount Health under this subchapter for the first year as established in this section and shall index the contributions in future years to the overall growth in spending per enrollee in Catamount Health as established in section 4080f of Title 8. The agency shall establish family contributions by

income bracket based on the individual contribution amounts and the average family size. In fiscal year ~~2008~~ 2010, the individual's contribution shall be as established in subsection (c) of this section.

(c)(1) For the lowest cost Catamount Health ISD plan in each income range, an individual's contribution shall be:

(A) Income less than or equal to 175 percent of FPL: $60.00 per month.

(B) Income greater than 175 percent and less than or equal to 200 percent of FPL: $65.00 per month.

(C) Income greater than 200 percent and less than or equal to 225 percent of FPL: $110.00 per month.

(D) Income greater than 225 percent and less than or equal to 250 percent of FPL: $135.00 per month.

(E) Income greater than 250 percent and less than or equal to 275 percent of FPL: $160.00 per month.

(F) Income greater than 275 percent and less than or equal to 300 percent of FPL: $185.00 per month.

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

(2) For plans other than the lowest cost Catamount Health ISD plan, an individual's contribution shall be the sum of:

(A) the applicable contribution as set out in subdivision (1) of this subsection; and

(B) the difference between the premium for the lowest cost Catamount Health ISD plan for the individual's income range and the premium for the Catamount Health ISD plan in which the individual is enrolled.