House Calendar

Thursday, May 05, 2011

121st DAY OF THE BIENNIAL SESSION

House Convenes at 9:00 A.M.

TABLE OF CONTENTS

Page No.

ORDERS OF THE DAY

ACTION CALENDAR

Action Postponed Until May 5, 2011

Third Reading

S. 78

An act relating to the advancement of cellular, broadband, and other technology infrastructure in Vermont

NEW BUSINESS

Third Reading

H. 97

An act relating to early childhood educators

S. 15

An act relating to insurance coverage for midwifery services and home births

Amendment to be offered by Rep. Donahue of Northfield to S. 15

further amended in Sec. 2, 18 V.S.A. chapter 30, in § 1554(a), following "opinions", by striking out "shall be confidential and" and by striking out "inspection or review under subchapter 3 of chapter 5 of Title 1 or to"

Amendment to be offered by Rep. Donahue of Northfield to S. 15

further amended by inserting a new Sec. 9 to read:

Sec. 9. PROFESSIONAL REGULATION

The office of professional regulation and the board of medical practice shall collaborate to determine which of the two agencies is most appropriate to regulate the practice and licensure of midwives pursuant to 26 V.S.A. chapter 85. No later than January 15, 2012, the director of the office of professional regulation and the executive director of the board of medical practice shall report their joint recommendation to the house committees on human services and on government operations and to the senate committees on health and welfare and on government operations.

and by redesignating the existing Sec. 9 to be Sec. 10

S. 17

An act relating to licensing a nonprofit organization to dispense marijuana for therapeutic purposes

Favorable with amendment

S. 74

An act relating to the transferring of the animal spaying and neutering program to the department of health

Rep. Evans of Essex, for the Committee on Government Operations**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 20 V.S.A § 3815 is amended to read:

§ 3815. DOG, CAT, AND WOLF-HYBRID SPAYING AND NEUTERING PROGRAM

(a) The ~~agency of agriculture, food and markets shall establish by rule a process by which a qualified organization~~ agency of human services shall administer a dog, cat, and wolf-hybrid spaying and neutering program providing reduced-cost spaying and neutering services and presurgical immunization for dogs, cats, and wolf-hybrids owned or cared for by low income individuals. The agency shall implement the program through an agreement with a qualified organization consistent with the applicable administrative rules.

(b) The program shall reimburse veterinarians who voluntarily consent to spay or neuter dogs, cats, and wolf-hybrids under the auspices of the program. The reimbursement shall be less any co-payment by the owner of a dog, cat, or wolf-hybrid for the cost of each spaying or neutering procedure.

(c) ~~The agency of agriculture, food and markets is authorized to promulgate an emergency administrative rule by August 1, 2009, the purpose of which shall be that only a dog, cat, or wolf-hybrid acquired for no compensation shall be eligible for funding from the animal spaying and neutering program established under this section. The rule shall provide consideration for the financial ability of the funding applicant to pay for the requested service. For the purposes of this subsection, a nominal fee or donation required for adoption of a dog, cat, or wolf-hybrid shall not constitute compensation paid for the animal~~ The secretary of human services may adopt and amend rules pursuant to chapter 25 of Title 3 to enable the agency to carry out the purposes of this act.

Sec. 2. 20 V.S.A. § 3816 is amended to read:

§ 3816. ANIMAL SPAYING AND NEUTERING FUND; CREATION

(a) There is created, pursuant to subchapter 5 of chapter 7 of Title 32, in the ~~agency of agriculture, food and markets~~ agency of human services the dog, cat,

and wolf-hybrid spaying and neutering special fund to finance the costs of the dog, cat, and wolf-hybrid spaying and neutering program established in section 3815 of this title.

(b) Revenue for the fund shall be derived from:

(1) The ~~$2.00~~ surcharge payment paid to a municipality pursuant to subdivision 3581(c)(1) of this title.

(2) Gifts from private donors.

(3) Any appropriation which the general assembly makes to the fund.

(c) Interest earned on the fund shall be retained in the fund.

(d) The ~~agency may offset the cost of administering the dog, cat, and wolf-hybrid spaying and neutering program from the fund created in subsection (a) of this section in accordance with the provisions of section 10 of Title 6~~ agency of human services shall use the revenue in the fund created in subsection (a) of this section for administering the dog, cat, and wolf-hybrid spaying and neutering program.

Sec. 3. ADMINISTRATIVE RULE APPLICABILITY

The agency of human services shall administer the dog, cat, and wolf-hybrid spaying and neutering program established in 20 V.S.A. § 3815 pursuant to the applicable administrative rule which became effective on July 1, 2010 until the rule is amended to reflect the transfer of the jurisdiction of the program to the agency of human services.

Sec. 4. EFFECTIVE DATE

This act shall take effect on July 1, 2011.

and that after passage the title of the bill be amended to read: "An act relating to the transferring of the animal spaying and neutering program to the agency of human services"

(Committee vote: 9-0-2)

(For text see Senate Journal 4/19 - 4/20/11)

Amendment to be offered by Rep. Bartholomew of Hartland to S. 74

In Sec. 1, 20 V.S.A. § 3815(c), in the final sentence following the words "The secretary of human services" by inserting the phrase ", in consultation with the state veterinarian or designee,"

S. 96

An act relating to technical corrections to the workers' compensation statutes

Rep. Kitzmiller of Montpelier, for the Committee on Commerce and Economic Development**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds that it is important to ensure that an injured worker's medical records and personal information are kept secure and that health care providers, workers' compensation insurers, and the department of labor adopt practices that are consistent with relevant state and federal statutes regarding medical and personal privacy.

Sec. 2. 21 V.S.A. § 641 is amended to read:

§ 641. VOCATIONAL REHABILITATION

* * *

(c) Any vocational rehabilitation plan for a claimant presented to the employer shall be deemed valid if the employer was provided an opportunity to participate in the development of the plan and has made no objections or changes within 21 days after submission. A vocational rehabilitation counselor shall provide the employer with a written invitation to participate in plan development, including the date, time, and place to provide an opportunity to participate in the development of the plan, with a copy to the department. The participation in the development of the plan may be conducted by telephone. The written notice shall be evidence of the opportunity to participate in plan development and shall be appended to the proposed plan.

* * *

Sec. 3. 21 V.S.A. § 640b is added to read:

§ 640b. REQUEST FOR PREAUTHORIZATION TO DETERMINE IF PROPOSED TREATMENT IS NECESSARY

(a) Within 14 days of receiving a request for preauthorization for a proposed medical treatment and medical evidence supporting the requested treatment, a workers' compensation insurer shall:

(1) authorize the treatment and notify the health care provider, the injured worker, and the department; or

(2)(A) deny the treatment because the entire claim is disputed and the commissioner has not issued an interim order to pay benefits; or

(B) deny the treatment if, based on a preponderance of credible medical evidence specifically addressing the proposed treatment, it is unreasonable or unnecessary. The insurer shall notify the health care provider, the injured worker, and the department of the decision to deny treatment; or

(3) notify the health care provider, the injured worker, and the department that the insurer has scheduled an examination of the employee or ordered a medical record review pursuant to section 655 of this title. Based on the examination or review, the insurer shall authorize or deny the treatment and notify the department and the injured worker of the decision within 45 days of a request for preauthorization. The commissioner may in his or her sole discretion grant a 10-day extension to the insurer to authorize or deny treatment, and such an extension shall not be subject to appeal.

(b) If the insurer fails to authorize or deny the treatment pursuant to subsection (a) of this section within 14 days of receiving a request, the claimant or health care provider may request that the department issue an order authorizing treatment. After receipt of the request, the department shall issue an interim order within five days after notice to the insurer, and five days in which to respond, absent evidence that the entire claim is disputed. Upon request of a party, the commissioner shall notify the parties that the treatment has been authorized by operation of law.

(c) If the insurer denies the preauthorization of the treatment pursuant to subdivision (a)(2) or (3) of this section, the commissioner may on his or her own initiative or upon a request by the claimant issue an order authorizing the treatment if he or she finds that the evidence shows that the treatment is reasonable, necessary, and related to the work injury.

Sec. 4. 21 V.S.A. § 655a is added to read:

§ 655a. RELEASE OF RELEVANT MEDICAL RECORDS BY HEALTH CARE PROVIDERS; DEPARTMENT TO OVERSEE RELEASE AND USE OF RELEVANT MEDICAL INFORMATION

(a) Health care providers examining or attending the examination of an injured worker pursuant to this chapter shall provide relevant medical records and reports as requested by the injured worker, the employer, or the department regarding the diagnosis, condition, or treatment of the worker, permanent impairment, or any restrictions or limitations on the worker's ability to work upon receiving a written medical release authorization from the injured worker. The authorization shall be on a form approved by the department. If

the relevance of any medical information is disputed, the department shall determine whether the requested medical information is relevant.

(b) Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

(c) An injured worker shall only be obligated to sign a medical record release authorization approved by the department.

(d) Any medical information received by the employer or the insurance carrier that is found not to be relevant to the claim may not be used to deny or limit a claim. The commissioner may order that specific disclosure requests be denied or rescinded and may make such other interim orders as are appropriate.

(e) Any medical information received in conjunction with a claim shall be used only for the purpose of advancing or defending a claim relating to the injury or of investigating a claim of false representation or of ensuring compliance with the workers' compensation statutes and rules.

Sec. 5. 21 V.S.A. § 692 is amended to read:

§ 692. PENALTIES; FAILURE TO INSURE; STOP WORK ORDERS

(a) Failure to insure. If after a hearing under section 688 of this title, the commissioner determines that an employer has failed to comply with the provisions of section 687 of this title, the employer shall be assessed an administrative penalty of not more than $100.00 for every day for the first seven days the employer neglected to secure liability and not more than $150.00 for every day thereafter.

* * *

Sec. 6. Sec. 32 of No. 54 of the Acts of 2009 is amended to read:

Sec. 32. WORKERS' COMPENSATION; STATE CONTRACTS; COMPLIANCE WITH DAVIS-BACON

(a) The agencies of administration and transportation shall establish procedures to assure that state contracting procedures and contracts are designed to minimize the incidents of miscoding of employees in NCCI job

codes and misclassification of the status of workers as independent contractors rather than employees by state contractors on projects with a total project cost of more than $250,000.00 by requiring those contractors to provide, at a minimum, all the following:

* * *

(3) For construction and transportation projects over $250,000.00, a payroll process by which during every pay period the contractor collects from the subcontractors or independent contractors a list of all workers who were on the jobsite during the pay period, the work performed by those workers on the jobsite, and a daily census of the jobsite. This information, including confirmation that contractors, subcontractors, and independent contractors have the appropriate workers' compensation coverage for all workers at the job site, and similar information for the subcontractors regarding their subcontractors shall also be provided to the department of labor and to the department of banking, insurance, securities, and health care administration, upon request, and shall be available to the public.

* * *

(c) The agencies shall assure that any state contract funded in whole or in part with American Recovery and Reinvestment Act of 2009 (ARRA) monies or any project for which the state granted, allocated, or awarded ARRA monies shall comply with the payment of Davis-Bacon wages when required by ARRA. However, in the event the applicable Davis-Bacon wages in any county have not been updated in the previous three years, the minimum state required wage for a state contract subject to Davis-Bacon wages under ARRA shall be that of the Vermont county that has most recently updated its applicable Davis-Bacon wages, provided this provision does not result in the loss of ARRA funds and is not otherwise contrary to federal law. In the event that the most recently updated Davis-Bacon wages cannot be determined due to the simultaneous updating by two or more counties, the agencies may select the minimum state-required wage for a state contract subject to Davis-Bacon wages under ARRA from among those counties.

Sec. 7. 21 V.S.A. § 1314 is amended to read:

§ 1314. REPORTS AND RECORDS; SEPARATION INFORMATION; DETERMINATION OF ELIGIBILITY; FAILURE TO REPORT EMPLOYMENT INFORMATION; DISCLOSURE OF INFORMATION TO OTHER STATE AGENCIES TO INVESTIGATE MISCLASSIFICATION OR MISCODING

* * *

(d)(1) Except as otherwise provided in this chapter, information obtained from any employing unit or individual in the administration of this chapter, and determinations as to the benefit rights of any individual shall be held confidential and shall not be disclosed or open to public inspection in any manner revealing the individual's or employing unit's identity, nor be admissible in evidence in any action or proceeding other than one arising out of this chapter, or to support or facilitate an investigation by a public agency identified in subdivision (e)(1) of this section.

(2) An individual or his or her duly authorized agent may be supplied with information from those records to the extent necessary for the proper presentation of his or her claims for benefits or to inform him or her of his or her existing or prospective rights to benefits; an employing unit may be furnished with such information as may be deemed proper, within the discretion of the commissioner, to enable it to fully discharge its obligations and safeguard its rights under this chapter.

~~(2)~~(3) Automatic data processing services and systems and programming services within the department of labor shall be the responsibility and under the direct control of the commissioner in the administration of this chapter and chapter 15 of this title.

~~(3)~~(4) Notwithstanding the provisions in subdivision (2) of this section, the department of labor shall, at the request of the agency of administration, perform such services for other departments and agencies of the state as are within the capacity of its data processing equipment and personnel, provided that such services can be accomplished without undue interference with the designated work of the department of labor

(e)(1) Subject to such restrictions as the board may by regulation prescribe, information from unemployment insurance records may be made available to any public officer or public agency of this or any other state or the federal government dealing with the administration or regulation of relief, public assistance, unemployment compensation, a system of public employment offices, wages and hours of employment, workers' compensation, misclassification or miscoding of workers, occupational safety and health, or a public works program for purposes appropriate to the necessary operation of those offices or agencies. The commissioner may also make information available to colleges, universities, and public agencies of the state for use in connection with research projects of a public service nature, and to the Vermont economic progress council with regard to the administration of subchapter 11E of chapter 151 of Title 32; but no person associated with those institutions or agencies may disclose that information in any manner which

would reveal the identity of any individual or employing unit from or concerning whom the information was obtained by the commissioner.

* * *

Sec. 8. 21 V.S.A. § 1453 is amended to read:

§ 1453. APPROVAL OR REJECTION; RESUBMISSION

The commissioner shall approve or reject a plan in writing within ~~15~~ 30 days of its receipt, and in the case of rejection shall state the reasons therefor. The reasons for rejection shall be final and nonappealable, but the employer shall be allowed to submit another plan for approval.

Sec. 9. REPORT

The department of labor shall review and assess information relating to workers' compensation medical information and records to determine whether the scope of information contained in the medical records exceeds that relating only to a work-related injury and whether nonrelevant medical information is being sent to the department without redaction. The department shall report its findings and any recommendations to the house committee on commerce and economic development and the senate committee on economic development, housing and general affairs by January 15, 2012.

Sec. 10. EFFECTIVE DATES

This section and Secs. 5, 6, 7, 8, and 9 of this act shall take effect on passage. The remaining sections shall take effect on July 1, 2011.

and that after passage the title of the bill be amended to read: "An act relating to the workers' compensation and unemployment compensation statutes"

(Committee vote: 9-0-2)

(No Senate Amendments)

S. 104

An act relating to modifications to the ban on gifts by manufacturers of prescribed products

Rep. Till of Jericho, for the Committee on Health Care**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 18 V.S.A. § 4631a is amended to read:

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

(1) "Allowable expenditures" means:

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

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

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

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

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

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

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

(C) For a bona fide clinical trial:

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

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

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

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

(i) gross compensation;

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

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

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

(F) Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally recognized discovery for which the health care provider holds an ownership right.

(G) The payment of the reasonable expenses of an individual related to the interview of the individual by a manufacturer of prescribed products in connection with a bona fide employment opportunity or for health care services on behalf of an employee of the manufacturer.

(H) Other research paid at fair market value, as long as the manufacturer on behalf of which the survey or other research is conducted is unaware of the identity of the health care provider receiving expenditures related to the research.

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

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

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

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

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

(B) in providing health care, either:

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

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

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

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

(5) "Gift" means:

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

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

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

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

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

(7)(A) "Health care professional" means:

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

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

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

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

(8) "Health care provider" means a health care professional, hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to dispense or purchase for distribution prescribed products

in this state. The term does not include a hospital foundation that is organized as a nonprofit entity separate from a hospital.

(9) "Manufacturer" means a pharmaceutical, biological product, or medical device manufacturer or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repacking, distributing, or labeling of prescribed products. The term does not include a wholesale distributor of biological products, a retailer, or a pharmacist licensed under chapter 36 of Title 26. The term also does not include a manufacturer whose only prescribed products are classified as Class I by the U.S. Food and Drug Administration, are exempt from pre-market notification under Section 510(k) of the federal Food, Drug and Cosmetic Act, and are sold over-the-counter without a prescription.

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

(11) "Pharmaceutical manufacturer" means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, whether directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs. The term does not include a wholesale distributor of prescription drugs, a retailer, or a pharmacist licensed under chapter 36 of Title 26.

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

(13) "Sample" means a unit of a prescription drug, biological product, or medical device that is not intended to be sold and is intended to promote the sale of the drug, product, or device. The term includes starter packs and coupons or other vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price. The term does not include prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.

(14) "Significant educational, scientific, or policy-making conference or seminar" means an educational, scientific, or policy-making conference or seminar that:

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

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

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

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

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

(B) The loan of a medical device for a short-term trial period, not to exceed ~~90~~ 120 days, to permit evaluation of a medical device by a health care provider or patient.

(C) The provision of reasonable quantities of medical device demonstration or evaluation units to a health care provider to assess the appropriate use and function of the product and determine whether and when to use or recommend the product in the future.

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

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

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

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

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

(I) ~~The provision of free prescription drugs to or on behalf of an individual through a prescription drug manufacturer's patient assistance program.~~ Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.

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

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

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

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

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

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

(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees and may impose on a manufacturer that violates this section a civil penalty of no more than $10,000.00 per violation. Each unlawful gift shall constitute a separate violation.

Sec. 2. 18 V.S.A. § 4632 is amended to read:

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

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

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

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

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

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

(iv) interview or health care expenses as described in subdivision 4631a(a)(1)(G) of this title; ~~and~~

(v) coffee or other snacks or refreshments at a booth at a conference or seminar; and

(vi) loans of medical devices for short-term trial periods pursuant to subdivision 4631a(b)(2)(B) of this title, provided the loan results in the purchase, lease, or other comparable arrangement of the medical device after issuance of a certificate of need pursuant to chapter 221, subchapter 5 of this title.

(B) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year:

(i) if the manufacturer is reporting other allowable expenditures or permitted gifts pursuant to subdivision (a)(1)(A) of this section, the product, dosage, number of units, and recipient information of over-the-counter drugs, nonprescription medical devices, and items of nonprescription durable medical equipment provided to a health care provider for free distribution to patients pursuant to subdivision 4631a(b)(2)(A) of this title; provided that any public reporting of such information shall not include information that allows for the identification of individual recipients of samples or connects individual recipients with the monetary value of the samples provided.

(ii) for each research activity described in subdivision 4631a(a)(1)(H) of this title, the number of health care providers participating in the research, the total amount paid to the entity conducting the research, and, if a product is distributed as part of the research, the product name, dosage, and number of units distributed.

(iii) the product, dosage, and number of units of prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program, reported separately for products distributed to individuals residing in Vermont and for products distributed to health care providers.

(C) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year the value, nature, purpose, and recipient information of any allowable expenditure or gift to an academic institution, to a nonprofit hospital foundation, or to a professional, educational, or patient organization representing or serving health care providers or consumers located in or providing services in Vermont, except:

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

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

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

(2)(A)(i) Subject to the provisions of subdivision (B) of this subdivision (a)(2) and to the extent allowed under federal law, annually on or before April 1 of each year beginning in 2012, each manufacturer of prescribed products shall disclose to the office of the attorney general all ~~free~~ samples of prescribed products provided to health care providers during the preceding calendar year, identifying for each sample the product, recipient, number of units, and dosage.

(ii) The office of the attorney general may contract with academic researchers to release to such researchers data relating to manufacturer distribution of ~~free~~ samples, subject to confidentiality provisions and without including the names or license numbers of individual recipients, for analysis and aggregated public reporting.

(iii) Any public reporting of manufacturer distribution of ~~free~~ samples shall not include information that allows for the identification of

individual recipients of samples or connects individual recipients with the monetary value of the samples provided.

(B) Subdivision (A) of this subdivision (a)(2) shall not apply to samples of prescription drugs required to be reported under Sec. 6004 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, if ~~as of January 1, 2011,~~ the office of the attorney general ~~has determined~~ determines that the U.S. Department of Health and Human Services will collect and report state- and recipient-specific information regarding manufacturer distribution of ~~free~~ samples of such prescription drugs.

(3) Annually on ~~July~~ January 1, each manufacturer of prescribed products also shall disclose to the office of the attorney general the name and address of the individual responsible for the manufacturer's compliance with the provisions of this section.

(4) Disclosure shall be made on a form and in a manner prescribed by the office of the attorney general and shall require manufacturers of prescribed products to report each allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title including:

(A) except as otherwise provided in ~~subdivision~~ subdivisions (a)(1)(B) and (a)(2) of this section, the value, nature, and purpose of each allowable expenditure, and gift permitted under subdivision 4631a(b)(2) of this title according to specific categories identified by the office of the attorney general;

(B) the name of the recipient;

(C) the recipient's address;

(D) the recipient's institutional affiliation;

(E) prescribed product or products being marketed, if any; and

(F) the recipient's state board number or, in the case of an institution, foundation, or organization, the federal tax identification number or the identification number assigned by the attorney general.

(5) The office of the attorney general shall report annually on the disclosures made under this section to the general assembly and the governor on or before ~~April 1~~ October 1. The report shall include:

(A) Information on allowable expenditures and permitted gifts required to be disclosed under this section, which shall be presented in both aggregate form and by selected types of health care providers or individual health care providers, as prioritized each year by the office. In accordance

with subdivisions (1)(B) and (2)(A) of this subsection, information on samples of prescribed products and of over-the-counter drugs, nonprescription medical devices, and items of nonprescription durable medical equipment shall be presented in aggregate form.

(B) Information on violations and enforcement actions brought pursuant to this section and section 4631a of this title.

(6) After issuance of the report required by subdivision (5) of this subsection and except as otherwise provided in ~~subdivision~~ subdivisions (1)(B)(i) and (2)(A)~~(i)~~ of this subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

(7) The department of Vermont health access shall examine the data available from the office of the attorney general for relevant expenditures and determine whether and to what extent prescribing patterns by health care providers of prescribed products reimbursed by Medicaid, VHAP, Dr. Dynasaur, VermontRx, and VPharm may reflect manufacturer influence. The department may select the data most relevant to its analysis. The department shall report its analysis annually to the general assembly and the governor on or before ~~October 1~~ March 1.

(b)(1) ~~Annually on July 1~~ Beginning January 1, 2013 and annually thereafter, the office of the attorney general shall collect a $500.00 fee from each manufacturer of prescribed products filing annual disclosures of expenditures greater than zero described in subsection (a) of this section.

(2) Fees collected under this section shall fund collection and analysis of information on activities related to the marketing of prescribed products under section 4631a of this title and under this section. The fees shall be collected in a special fund assigned to the office.

(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer of prescribed products that fails to disclose as required by subsection (a) of this section a civil penalty of no more than $10,000.00 per violation. Each unlawful failure to disclose shall constitute a separate violation.

(d) The terms used in this section shall have the same meanings as they do in section 4631a of this title.

Sec. 3. REPORTING FEES

(a) Notwithstanding the provisions of 18 V.S.A. § 4632(b)(1), on July 1, 2011, the office of the attorney general shall collect a $500.00 fee from each

manufacturer of prescribed products filing annual disclosures of expenditures greater than zero described in 18 V.S.A. § 4632(a) for the fiscal year ending June 30, 2011.

(b) Notwithstanding the provisions of 18 V.S.A. § 4632(b)(1), on January 1, 2012, the office of the attorney general shall collect a $250.00 fee from each manufacturer of prescribed products filing disclosures of expenditures greater than zero described in 18 V.S.A. § 4632(a) for the six-month period from July 1, 2011 through December 31, 2011.

Sec. 4. ELECTRONIC PRIOR AUTHORIZATION

The commissioner of Vermont health access and the Vermont information technology leaders (VITL), in collaboration with health insurers, prescribers, representatives of the independent pharmacy community, and other interested parties, shall evaluate the use of electronic means for requesting and granting prior authorization for prescription drugs. No later than January 15, 2012, the commissioner and VITL shall report their findings to the senate committee on health and welfare and the house committee on health care and make recommendations for processes to develop standards for electronic prior authorizations.

Sec. 5. EFFECTIVE DATES

This act shall take effect on July 1, 2011, except that, in Sec. 2, the amendments to 18 V.S.A. § 4632(a)(1)(B) shall take effect on January 1, 2012.

(Committee vote: 7-3-1)

(For text see Senate Journal 4/20 -4/21/11)

Rep. Clarkson of Woodstock, for the Committee on **Ways and Means,** recommends the bill ought to pass when amended as recommended by the Committee on **Health Care.**

(Committee Vote: 11-0-0)

Senate Proposal of Amendment

H. 201

An act relating to hospice and palliative care

The Senate proposes to the House to amend the bill as follows

First: By striking out the Sec. 3 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 3 to read as follows:

Sec. 3. REQUEST FOR A WAIVER

By no later than July 1, 2012, the agency of human services shall include as a part of its application request for a demonstration project from the Centers for Medicare and Medicaid Services to integrate care for dual eligible individuals the additional proposal of allowing the state to provide for an "enhanced hospice access" benefit, whereby the definition of "terminal illness" is expanded from six months' life expectancy to that of 12 months and participants may access hospice without being required to first discontinue curative therapy. Also, by no later than July 1, 2013, the agency of human services shall submit a Global Commitment Medicaid waiver amendment to provide funding for the same enhanced hospice access benefit.

Second: In Sec. 4, subsection (c), by striking out the following: "Assembly of Home Health Agencies, Inc." and inserting in lieu thereof the following: Vermont Assembly of Home Health and Hospice Agencies

Third: By striking out Sec. 7 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 7 to read as follows:

Sec. 7. 26 V.S.A. § 1400 is amended to read:

§ 1400. RENEWAL OF LICENSE; CONTINUING MEDICAL EDUCATION

(a) Every person licensed to practice medicine ~~and surgery~~ by the board shall apply biennially for the renewal of his or her license. ~~One~~ At least one month prior to the date on which renewal is required, the board shall send to each licensee a license renewal application form and notice of the date on which the existing license will expire. On or before the renewal date, the licensee shall file an application for license renewal and pay the required fee. The board shall register the applicant and issue the renewal license. Within one month following the date renewal is required, the board shall pay the license renewal fees into the medical practice board special fund ~~and shall file a list of licensees with the department of health~~.

(b) A licensee applying for renewal of an active license to practice medicine shall have completed continuing medical education which shall meet minimum criteria as established by rule, by the board, by August 31, 2012 and which shall be in effect for the renewal of licenses to practice medicine expiring after August 31, 2014. The board shall require a minimum of ten hours of continuing medical education by rule. The training provided by the continuing medical education shall be designed to ensure that the licensee has updated his or her knowledge and skills in his or her own specialties and also has kept abreast of advances in other fields for which patient referrals may be appropriate. The board shall require evidence of current professional competence in recognizing the need for timely appropriate consultations and

referrals to ensure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

(c) A licensee applying for renewal of an active license to practice medicine shall have practiced medicine within the last three years as defined in section 1311 of this title or have complied with the requirements for updating knowledge and skills as defined by board rules.

(d) A licensee shall demonstrate that the requirements for licensure are met.

(e) A licensee shall promptly provide the board with new or changed information pertinent to the information in his or her license and license renewal applications at the time he or she becomes aware of the new or changed information.

~~(b)~~(f) A person who practices medicine ~~and surgery~~ and who fails to renew his or her license in accordance with the provisions of this section shall be deemed an illegal practitioner and shall forfeit the right to so practice or to hold himself or herself out as a person licensed to practice medicine ~~and surgery~~ in the state until reinstated by the board, but nevertheless a ~~person who was licensed to practice medicine and surgery at the time of his induction, call on reserve commission or enlistment into the armed forces of the United States, shall be entitled to practice medicine and surgery during the time of his service with the armed forces of the United States and for 60 days after separation from such service~~ physician while on extended active duty in the uniformed services of the United States or as a member of the national guard, state guard, or reserve component who is licensed as a physician at the time of an activation or deployment shall receive an extension of licensure up to 90 days following the physician's return from activation or deployment, provided the physician notifies the board of his or her activation or deployment prior to the expiration of the current license and certifies that the circumstances of the activation or deployment impede good faith efforts to make timely application for renewal of the license.

~~(c)~~(g) Any person who allows a license to lapse by failing to renew the same in accordance with the provisions of this section may be reinstated by the board by payment of the renewal fee and the late renewal penalty, and if applicable, by completion of the continuing medical education requirement as established in subsection (b) of this section and any other requirements for licensure as required by this section and board rule.

Fourth: In Sec. 8, after the following "set forth in 26 V.S.A." by striking out the following: "§ 1400(b)(1) and (2), in the field of field of palliative care,

hospice, end-of-life care, and management of chronic pain" and inserting in lieu thereof the following: § 1400(b)

Fifth: In Sec. 10, 18 V.S.A. § 9708, by striking subsection (f) in its entirety. And by relettering the remaining subsections in Sec. 10 to be alphabetically correct

Sixth: In Sec. 10, 18 V.S.A. § 9708, by striking relettered subsection (g) in its entirety and inserting in lieu thereof a new subsection (g) to read as follows:

~~(b)~~(g) A clinician who issues a DNR order ~~may~~ shall authorize issuance of a DNR identification to the ~~principal~~ patient. Uniform minimum requirements for DNR identification shall be determined by rule by the department of health no later than March 1, 2012.

Seventh: In Sec. 10, 18 V.S.A. § 9708, by inserting a new subsection to be lettered subsection (i) to read as follows:

(i) A DNR/COLST order executed prior to July 1, 2011 shall be a valid order if the document complies with the statutory requirements in effect at the time the document was executed or with the provisions of this chapter.

And by relettering the remaining subsections in Sec. 10 to be alphabetically correct.

Eighth: By inserting a new section to be numbered Sec. 11 to read as follows:

* * * STUDY ON DNR/COLST ORDER INFORMED CONSENT * * *

SEC. 11. STUDY ON DNR/COLST ORDER INFORMED CONSENT

(a) The DNR/COLST order informed consent committee is created and shall be convened by the commissioner of health to study criteria to be used for rules concerning individuals who are giving informed consent for a DNR/COLST order issued pursuant to 18 V.S.A. § 9708(b), but who are not the patient, the patient's agent, or the patient's guardian.

(b) The committee shall consist of the following members or their designees:

(1) The commissioners of health; Vermont health access; and disabilities, aging, and independent living;

(2) one representative each from the Vermont Medical Society, the Vermont Ethics Network, the Vermont Association of Hospitals and Health Systems, Vermont Program for Quality in Health Care, the Hospice and Palliative Care Council of Vermont, the Vermont Center for Independent

Living, Vermont Area Agencies on Aging, Vermont Assembly of Home Health and Hospice Agencies, and the Vermont Health Care Association;

(3) the long term care ombudsman; and

(4) the state health care ombudsman.

(c) The committee shall make recommendations on the criteria to be used for rules concerning individuals who are giving informed consent for a DNR/COLST order to be issued pursuant to 18 V.S.A. § 9708(b), but who are not the patient, the patient's agent, or the patient's guardian. The committee's recommendations shall include:

(1) which individual or individuals who are not the patient, the patient's agent, or the patient's guardian, but who shall be a family member of the patient or a person with a known close relationship to the patient, are permitted to give informed consent for a DNR/COLST order;

(2) how decisions regarding who is the appropriate person to be giving informed consent for a DNR/COLST order are to be made, which shall include at a minimum the protection of a patient's own wishes in the same manner as set forth in 18 V.S.A. § 9711,

(3) the use of a hospital's internal ethics protocols when there is a disagreement over who is the appropriate person to give informed consent for a DNR/COLST order; and

(4) an examination of the relationship between the wishes expressed in an advance directive and the DNR/COLST order.

(d) The committee shall report by December 1, 2011 to the Vermont health access oversight committee, the chair of the house committee on human services, and the chair of the senate committee on health and welfare on its findings and recommendations.

And by renumbering all remaining sections to be numerically correct.

Ninth: In renumbered Sec. 12, 18 V.S.A. § 9709, subsection (c), by striking out subdivision (5) in its entirety and inserting in lieu thereof new subdivisions (5) and (6) to read as follows:

(5) Upon transfer or discharge ~~from the~~ to another facility, a copy of any advance directive, DNR order, ~~and clinician order for life sustaining treatment is~~ or COLST order shall be transmitted with the principal ~~or, if~~ or patient. If the transfer is to a health care facility or residential care facility, ~~is~~ any advance directive, DNR order, or COLST order shall be promptly transmitted to the subsequent facility, unless the sending facility has confirmed that the receiving facility has a copy of ~~any~~ the advance directive, DNR order, or ~~clinician order for life sustaining treatment~~ COLST order.

(6) For a patient for whom DNR/COLST orders are documented in a facility-specific manner, any DNR/COLST orders to be continued upon discharge, during transport, or in another setting shall be documented on the Vermont DNR/COLST form issued pursuant to 18 V.S.A. § 9708(b) or on the form as prescribed by the patient's state of residence.

Tenth: By inserting a new section to be numbered Sec. 13 to read as follows:

Sec. 13. 18 V.S.A. § 9713 is amended to read:

§ 9713. IMMUNITY

(a) No individual acting as an agent or guardian shall be subjected to criminal or civil liability for making a decision in good faith pursuant to the terms of an advance directive, or DNA order, or COLST order and the provisions of this chapter.

(b)(1) No health care provider, health care facility, residential care facility, or any other person acting for or under such person's control shall, if the provider or facility has complied with the provisions of this chapter, be subject to civil or criminal liability for:

(A) providing or withholding ~~health care~~ treatment or services in good faith pursuant to the direction of a principal or patient, the provisions of an advance directive, a DNA order, a COLST order, a DNR identification ~~of the principal~~, the consent of a principal or patient with capacity or of the principal's or patient's agent or guardian, or a decision or objection of a principal or patient; or

(B) relying in good faith on a suspended or revoked advance directive, suspended or revoked DNR order, or suspended or revoked COLST order, unless the provider or facility knew or should have known of the suspension or revocation.

(2) No funeral director, crematory operator, cemetery official, procurement organization, or any other person acting for or under such person's control, shall, if the director, operator, official, or organization has complied with the provisions of this chapter, be subject to civil or criminal liability for providing or withholding its services in good faith pursuant to the provisions of an advance directive, whether or not the advance directive has been suspended or revoked.

(3) Nothing in this subsection shall be construed to establish immunity for the failure to follow standards of professional conduct and to exercise due care in the provision of services.

(c) No employee shall be subjected to an adverse employment decision or evaluation for:

(1) providing or withholding ~~health care~~ treatment or services in good faith pursuant to the direction of a principal or patient, the provisions of an advance directive, a DNR order, a COLST order, a DNR identification ~~of the principal~~, the consent of the ~~principal's~~ principal or patient with capacity or principals or patient's agent or guardian, a decision or objection of a principal or patient, or the provisions of this chapter. This subdivision shall not be construed to establish a defense for the failure to follow standards of professional conduct and to exercise due care in the provision of services;

(2) relying on an amended, suspended, or revoked advance directive, unless the employee knew or should have known of the amendment, suspension or revocation; or

(3) providing notice to the employer of a moral or other conflict pursuant to subdivision 9707(b)(3) of this title, so long as the employee has provided ongoing health care until a new employee or provider has been found to provide the services.

And by renumbering all remaining sections to be numerically correct.

Eleventh: In renumbered Sec. 15, after the following: "This act shall take effect on passage" by inserting the following: , except for Sec. 7, 26 V.S.A. § 1400(c), which shall take effect 60 days after the adoption of the maintenance of licensure rule for physicians

(For text see House Journal March 18 and 24, 2011)

Committee of Conference Report

H. 202

An act relating to a universal and unified health system

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

The Committee of Conference to which were referred the disagreeing votes of the two Houses upon House Bill entitled:

H. 202 An act relating to a universal and unified health system

Respectfully reports that it has met and considered the same and recommends that the Senate recede from its proposals of amendment and that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. INTENT

(a) It is the intent of the general assembly to create Green Mountain Care to contain costs and to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage. It is the intent of the general assembly to achieve health care reform through the coordinated efforts of an independent board, state government, and the citizens of Vermont, with input from health care professionals, businesses, and members of the public.

(b) It is also the intent of the general assembly to maximize the receipt of federal funds, including those available pursuant to 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 to create a reasonable plan to implement Green Mountain Care as set forth in this act.

Sec. 1a. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(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, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

(5) Every Vermonter should be able to choose his or her health care providers.

(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.

(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.

(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.

(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.

(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.

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

(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.

(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.

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

Sec 1b. 3 V.S.A. § 2222a is amended to read:

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

(a) The ~~secretary~~ director of health care reform in the agency of administration shall be responsible for the coordination of health care system

reform ~~initiatives~~ efforts among executive branch agencies, departments, and offices, and for coordinating with the Green Mountain Care board established in 18 V.S.A. chapter 220.

(b) The ~~secretary~~ director 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 coordinated, timely, equitable, patient-centered, and evidence-based, and that seeks to inform and improve the quality and affordability of patient care and public health, contain costs, and attract and retain well-paying jobs in this state.

(c) Vermont's health care system reform ~~initiatives~~ efforts 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 V.S.A. chapter 13, 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 V.S.A. chapter 219.

(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~~ The 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 universal 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 services to encourage quality and efficiency in the delivery of health care as set forth in 18 V.S.A. chapter 220.

(10) ~~The uniform hospital uncompensated car policies.~~ A strategic approach to workforce needs set forth in 18 V.S.A. chapter 222, including retraining programs for workers displaced through increased efficiency and reduced administration in the health care system and ensuring an adequate health care workforce to provide access to health care for all Vermonters.

(11) A plan for public financing of health care coverage 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~~ director of health care reform 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.

* * * Road Map to a Universal and a Unified Health System * * *

Sec. 2. STRATEGIC PLAN; UNIVERSAL AND UNIFIED HEALTH SYSTEM

(a) Vermont must begin to plan now for health care reform, including simplified administration processes, payment reform, and delivery reform, in order to have a publicly financed program of universal and unified health care operational after the occurrence of specific events, including the receipt of a waiver from the federal Exchange requirement from the U.S. Department of Health and Human Services. A waiver will be available in 2017 under the provisions of existing law in the Patient Protection and Affordable Care Act (Public Law 111-148) ("Affordable Care Act"), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and may be available in 2014 under the provisions of two bills, H.R. 844 and S.248, introduced in the 112th Congress. In order to begin the planning efforts, the director of health care reform in the agency of administration shall

establish a strategic plan, which shall include time lines and allocations of the responsibilities associated with health care system reform, to further the containment of health care costs, to further Vermont's existing health care system reform efforts as described in 3 V.S.A. § 2222a and to further the following:

(1) As provided in Sec. 4 of this act, 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 33 V.S.A. chapter 18, subchapter 1; under Medicaid; under Medicare; by employers that choose to participate; and to state employees and municipal employees, including teachers. In the event of a modification to the Affordable Care Act by congressional, judicial, or federal administrative action which prohibits implementation of the health benefit exchange; eliminates federal funds available to individuals, employees, or employers; or eliminates the waiver under Section 1332 of the Affordable Care Act, the director of health care reform shall continue, and adjust as appropriate, the planning and cost-containment activities provided in this act related to Green Mountain Care and to creation of a unified, simplified administration system for health insurers offering health benefit plans, including identifying the financing impacts of such a modification on the state and its effects on the activities proposed in this act.

(2)(A) As provided in Sec. 4 of this act, no later than November 1, 2013, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling individuals and small employers 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 Green Mountain Care.

(B) No later than February 15, 2012, the director of health care reform or designee shall provide the house committee on health care and the senate committees on finance and on health and welfare the following information related to the Vermont health benefit exchange, to the extent available:

(i) a list of the federal health benefits required under the Affordable Care Act as defined in 33 V.S.A. chapter 18, subchapter 1, including covered services and cost-sharing;

(ii) a comparison of the federal health benefits with the Vermont health insurance benefit requirements provided for in 8 V.S.A. chapter 108;

(iii) information relating to the silver, gold, and platinum benefit levels of qualified health benefit plans that may be available in the Vermont health benefit exchange;

(iv) a draft of qualified health benefit plan choices that may be available in the Vermont health benefit exchange;

(v) in collaboration with the three insurers with the largest number of lives, premium estimates for draft plan choices described in subdivision (iv) of this subdivision (B); and

(vi) the status of related tax credits, including small employer tax credits, and of cost-sharing subsidies.

(C) The director shall deliver to the general assembly by January 15, 2015 a report including:

(i) the qualified health benefit plans available in and outside the exchange, current and projected premiums, and enrollment data;

(ii) recommendations for any statutory changes needed to improve the functioning of the exchange, including those needed to reduce premiums and administrative costs for qualified health benefit plans and others the director determines are necessary to achieve cost-effectiveness; and

(iii) Vermont's efforts to obtain a waiver from the exchange requirement under Section 1332 of the Affordable Care Act.

(3) As provided in Sec. 4 of this act, no later than November 1, 2016, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling large employers for coverage beginning January 1, 2017.

(4) The director shall supervise and oversee, as appropriate, the planning efforts, reports of which are due on January 15, 2012, as provided in Secs. 8 and 10 through 13 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 director 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 health care professionals, and for covering the uninsured and underinsured through Medicaid and the Vermont health benefit exchange.

(6) The director, in collaboration with the agency of human services, shall obtain waivers, exemptions, agreements, legislation, or a combination thereof to ensure that, to the extent possible under federal law, 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, the number of Medicare-eligible individuals, and other factors that may be advantageous to Vermont and that do 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.

(7) No later than January 15, 2012, the secretary of administration or designee shall submit to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary a proposal for potential improvement or reforms to the medical malpractice system for Vermont. The proposal shall be designed to address any findings of defensive medicine, reduce health care costs and medical errors, and protect patients' rights, and shall include the secretary's or designee's consideration of a no-fault system and of confidential pre-suit mediation. In designing the proposal, the secretary or designee shall consider the findings and recommendations contained in the majority and minority reports of the medical malpractice study committee established by Sec. 292 of No. 122 of the Acts of the 2003 Adj. Sess. (2004).

(b) The Green Mountain Care board established in 18 V.S.A. chapter 220, in collaboration with the director of health care reform in the agency of administration, shall develop a work plan for the board, which may include any necessary processes for implementation of the board's duties, a time line for implementation of the board's duties, and a plan for ensuring sufficient staff to implement the board's duties. The work plan shall be provided to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.

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

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

CHAPTER 220. GREEN MOUNTAIN CARE BOARD

Subchapter 1. Green Mountain Care Board

§ 9371. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(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, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

(5) Every Vermonter should be able to choose his or her health care providers.

(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.

(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.

(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.

(9) Vermont's health delivery system must seek continuous

improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.

(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.

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

(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.

(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.

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

§ 9372. PURPOSE

It is the intent of the general assembly to create an independent board to promote the general good of the state by:

(1) improving the health of the population;

(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;

(3) enhancing the patient and health care professional experience of care;

(4) recruiting and retaining high-quality health care professionals; and

(5) achieving administrative simplification in health care financing and delivery.

§ 9373. DEFINITIONS

As used in this chapter:

(1) "Board" means the Green Mountain Care board established in this chapter.

(2) "Chronic care" means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care.

(3) "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 licensed health care practitioners and their patients, and a plan of care emphasizing prevention of complications, utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(4) "Global payment" means a payment from a health insurer, Medicaid, Medicare, or other payer for the health services of a defined population of patients for a defined period of time. Such payments may be adjusted to account for the population's underlying risk factors, including severity of illness and socioeconomic factors that may influence the cost of health care for the population.

(5) "Green Mountain Care" means the public–private universal health care program designed to provide health benefits through a simplified, uniform, single administrative system pursuant to 33 V.S.A. chapter 18, subchapter 2.

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

(7) "Health care system" means the local, state, regional, or national system of delivering health services, including administrative costs, capital expenditures, preventive care and wellness services.

(8) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of a health benefit plan offered by a public or a private entity. The term does not include Medicaid, the Vermont health access plan, or any other state health care assistance program financed in whole or in part through a federal program.

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

(10) "Integrated delivery system" means a group of health care professionals, associated either through employment by a single entity or through a contractual arrangement, that provides health services for a defined population of patients and is compensated through a global payment.

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

(12) "Payment reform" means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

(13) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have 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.

(14) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

§ 9374. BOARD MEMBERSHIP; AUTHORITY

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair and all of the members shall be state employees and shall be exempt from the state classified system. The chair shall receive compensation equal to that of a superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the chair.

(2) The chair and the members of the board shall be nominated by the Green Mountain Care board nominating committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a superior judge. The governor shall not appoint a nominee who was denied confirmation by the senate within the past six years.

(b)(1) The initial term of the chair shall be seven years, and the term of the chair shall be six years thereafter.

(2) The term of each member other than the chair shall be six years, except that of the members first appointed, one each shall serve a term of three years, four years, five years, and six years.

(3) Subject to the nomination and appointment process, a member may serve more than one term.

(4) Members of the board may be removed only for cause. The board shall adopt rules pursuant to 3 V.S.A. chapter 25 to define the basis and process for removal.

(c)(1) No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.

(2) No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member, individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.

(3) The prohibitions contained in subdivisions (1) and (2) of this subsection shall not be construed to prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

(A) being an insurance policyholder or from receiving health services on the same terms as are available to the public generally;

(B) owning a stock, bond, or other security in an entity subject to supervision or regulation by the board that is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the board member chooses the stock, bond, or security; or

(C) receiving retirement benefits through a defined benefit plan from an entity subject to supervision or regulation by the board.

(4) No board member shall, during his or her term or terms on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board.

(5) No board member may appear before the board or any other state agency on behalf of a person subject to supervision or regulation by the board for a period of one year following his or her last day as a member of the Green Mountain Care board.

(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.

(e)(1) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. Members of such advisory group who are not state employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

(f) In carrying out its duties pursuant to this chapter, the board shall seek the advice of the state health care ombudsman established in 8 V.S.A. § 4089w. The state health care ombudsman shall advise the board regarding the policies, procedures, and rules established pursuant to this chapter. The ombudsman shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the board in order to protect patients' and consumers' interests.

§ 9375. DUTIES

(a) The board shall execute its duties consistent with the principles expressed in 18 V.S.A. § 9371.

(b) The board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in chapter 13, subchapter 2 of this title are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the board's proposed methodologies to the house committee on health care and the senate committee on health and welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of state government to engage in additional cost-containment activities to the extent permitted by state and federal law.

(2) Review and approve Vermont's statewide health information technology plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the state to achieve the principles expressed in section 9371 of this title.

(3) Review and approve the health care workforce development strategic plan created in chapter 222 of this title.

(4) Review the health resource allocation plan created in chapter 221 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business days of receipt of such recommendations and taking into consideration the requirements in the underlying statutes, changes in health

care delivery, changes in payment methods and amounts, and other issues at the discretion of the board, on:

(A) any insurance rate increases pursuant to 8 V.S.A. chapter 107, beginning January 1, 2012;

(B) hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012; and

(C) certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning July 1, 2012.

(7) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

(8) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

(C) in consultation with the department of health and the director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

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

(E) for determining the adequacy of the supply and distribution of health care resources in this state;

(F) to address access to and quality of mental health and substance abuse services; and

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

(c) The board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the agency of human services, and define the Green

Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the agency of human services shall present a report on the benefit package proposal to the house committee on health care and the senate committee on health and welfare. The report shall describe the covered services to be included in the Green Mountain Care benefit package and any cost-sharing requirements. If the general assembly is not in session at the time that the agency makes its recommendations, the agency shall send its report electronically or by first class mail to each member of the house committee on health care and the senate committee on health and welfare.

(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the board comports with the principles expressed in section 9371 of this title.

(e) All reports prepared by the board shall be available to the public and shall be posted on the board's website.

§ 9376. PAYMENT AMOUNTS; METHODS

(a) It is the intent of the general assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient

health services that are in the public interest. It is also the intent of the general assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

(b)(1) The board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the state, and the need for health care professionals in particular areas of the state, particularly in underserved geographic or practice shortage areas.

(2) Nothing in this subsection shall be construed to limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection from a patient without health insurance or other coverage for the service or services received.

(c) The board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the board determines such payments to be appropriate.

(d) To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.

§ 9377. PAYMENT REFORM; PILOTS

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that

payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for payment and delivery system reform, including setting the overall policy goals for the pilot projects established in chapter 13, subchapter 2 of this title.

(2) The director of payment reform in the department of Vermont health access shall develop and implement the payment reform pilot projects in accordance with policies established by the board, and the board shall evaluate the effectiveness of such pilot projects in order to inform the payment and delivery system reform.

(3) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, 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 and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(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 consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

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

(E) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(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, the inclusion of home health services and long-term care services as part of capitated payments.

(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 board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

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

§ 9378. PUBLIC PROCESS

The Green Mountain Care board shall provide a process for soliciting public input. The process may include receiving written comments on proposed new or amended rules or holding public hearings or both.

§ 9379. AGENCY COOPERATION

The secretary of administration shall ensure that, in accordance with state and federal privacy laws, the Green Mountain Care 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.

§ 9380. RULES

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

§ 9381. APPEALS

(a) The Green Mountain Care board shall adopt procedures for administrative appeals of its actions, orders, or other determinations. Such procedures shall provide for the issuance of a final order and the creation of a record sufficient to serve as the basis for judicial review pursuant to subsection (b) of this section.

(b) Any person aggrieved by a final action, order, or other determination of the Green Mountain Care board may, upon exhaustion of all administrative appeals available pursuant to subsection (a) of this section, appeal to the supreme court pursuant to the Vermont Rules of Appellate Procedure.

Subchapter 2. Green Mountain Care Board Nominating Committee

§ 9390. GREEN MOUNTAIN CARE BOARD NOMINATING COMMITTEE CREATED; COMPOSITION

(a) A Green Mountain Care board nominating committee is created for the nomination of the chair and members of the Green Mountain Care board.

(b)(1) The committee shall consist of nine members who shall be selected as follows:

(A) Two members appointed by the governor.

(B) Two members of the senate, who shall not be members of the same party, to be appointed by the committee on committees.

(C) Two members of the house of representatives, who shall not be members of the same party, to be appointed by the speaker of the house of representatives.

(D) One member each to be appointed by the governor, the president pro tempore of the senate, and the speaker of the house, with knowledge of or expertise in health care policy, health care delivery, or health care financing, to complement that of the remaining members of the committee.

(2) The members of the committee shall serve for terms of two years and may serve for no more than three consecutive terms. All appointments shall be made between January 1 and February 1 of each odd-numbered year, except to fill a vacancy. Members shall serve until their successors are appointed.

(3) The members shall elect their own chair who shall serve for a term of two years.

(c) For committee meetings held when the general assembly is not in session, the legislative members of the Green Mountain Care board nominating committee shall be entitled to per diem compensation and reimbursement of expenses in accordance with the provisions of 2 V.S.A. § 406. Committee

members who are not legislators shall be entitled to per diem compensation and reimbursement of expenses on the same basis as that applicable to the legislative members, and their compensation and reimbursements shall be paid out of the budget of the Green Mountain Care board.

(d) The Green Mountain Care board nominating committee shall use the qualifications described in section 9392 of this title for the nomination of candidates for the chair and members of the Green Mountain Care board. The nominating committee shall adopt procedures for a nomination process based on the rules adopted by the judicial nominating board, and shall make such procedures available to the public.

(e) A quorum of the committee shall consist of five members.

(f) The board is authorized to use the staff and services of appropriate state agencies and departments as necessary to conduct investigations of applicants.

§ 9391. NOMINATION AND APPOINTMENT PROCESS

(a) Whenever a vacancy occurs on the Green Mountain Care board, or when an incumbent does not declare that he or she will be a candidate to succeed himself or herself, the Green Mountain Care board nominating committee shall select for consideration by the committee, by majority vote, provided that a quorum is present, from the applications for membership on the Green Mountain Care board as many candidates as it deems qualified for the position or positions to be filled. The committee shall base its determinations on the qualifications set forth in section 9392 of this section.

(b) The committee shall submit to the governor the names of the persons it deems qualified to be appointed to fill the position or positions.

(c) The governor shall make an appointment to the Green Mountain Care board from the list of qualified candidates submitted pursuant to subsection (b) of this section. The appointment shall be subject to the consent of the senate.

(d) All proceedings of the committee, including the names of candidates considered by the committee and information about any candidate submitted by any source, shall be confidential.

§ 9392. QUALIFICATIONS FOR NOMINEES

The Green Mountain Care board nominating committee shall assess candidates using the following criteria:

(1) commitment to the principles expressed in section 9371 of this title.

(2) knowledge of or expertise in health care policy, health care delivery, or health care financing, and openness to alternative approaches to health care.

(3) possession of desirable personal characteristics, including integrity, impartiality, health, empathy, experience, diligence, neutrality, administrative and communication skills, social consciousness, public service, and regard for the public good.

(4) knowledge, expertise, and characteristics that complement those of the remaining members of the board.

(5) impartiality and the ability to remain free from undue influence by a personal, business, or professional relationship with any person subject to supervision or regulation by the board.

Sec. 3a. 8 V.S.A. § 4089w(b) is amended to read:

(b) The health care ombudsman office shall:

* * *

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations, and policies relating to patients and health insurance consumers, including the activities and policies of the Green Mountain Care board established in 18 V.S.A. chapter 220, and recommend changes it deems necessary.

* * *

Sec. 3b. GREEN MOUNTAIN CARE BOARD AND EXCHANGE POSITIONS

(a) On July 1, 2011, five exempt positions are created on the Green Mountain Care board, including:

(1) one chair, Green Mountain Care board; and

(2) four members, Green Mountain Care board.

(b)(1) On or before January 1, 2012, up to nine positions and appropriate amounts for personal services and operating expenses shall be transferred from the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

(2) One exempt attorney position shall be transferred from the administrative division in the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

(c) On July 1, 2011, one classified administrative assistant position is created for the Green Mountain Care board.

(d) On or after November 1, 2011, one exempt deputy commissioner position is created in the department of Vermont health access to support the

functions provided for in Sec. 4 of this act establishing 33 V.S.A. chapter 18, subchapter 1. The salary and benefits for this position shall be funded from federal funds provided to establish the Vermont health benefit exchange.

(e) On July 1, 2011, one exempt position, director of health care reform, is created in the agency of administration.

* * *

Sec. 3c. 18 V.S.A. chapter 13 is amended to read:

CHAPTER 13. CHRONIC CARE INFRASTRUCTURE AND PREVENTION MEASURES

§ 701. DEFINITIONS

For the purposes of this chapter:

(1) "Blueprint for Health" or "Blueprint" means the state's program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.

(2) "Board" means the Green Mountain Care board established in chapter 220 of this title.

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

~~(3)~~(4) "Chronic care information system" means the electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.

~~(4)~~(5) "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 licensed health care practitioners and their patients, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical,

humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(6) "Global payment" means a payment from a health insurer, Medicaid, Medicare, or other payer for the health services of a defined population of patients for a defined period of time. Such payments may be adjusted to account for the population's underlying risk factors, including severity of illness and socioeconomic factors that may influence the cost of health care for the population.

~~(5)~~(7) "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)~~(8) "Health benefit plan" shall have the same meaning as in 8 V.S.A. § 4088h.

~~(7)~~(9) "Health insurer" shall have the same meaning as in section 9402 of this title.

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

~~(8)~~(11) "Hospital" shall have the same meaning as in section 9456 of this title.

(12) "Integrated delivery system" means a group of health care professionals, associated either through employment by a single entity or through a contractual arrangement, that provides health services for a defined population of patients and is compensated through a global payment.

(13) "Payment reform" means modifying the method of payment from a fee for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies, for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

(14) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have 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.

(15) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

Subchapter 1. Blueprint for Health

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

* * *

Subchapter 2. Payment Reform

§ 721. PURPOSE

It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

§ 722. PILOT PROJECTS

(a) The Green Mountain Care board shall be responsible for payment reform and delivery system reform, including setting the overall policy goals for the pilot projects as provided in this subchapter. The director of payment reform in the department of Vermont health access shall develop and implement the payment reform pilot projects consistent with policies established by the board and the board shall evaluate the effectiveness of the pilot projects in order to inform the payment and delivery system reform. Whenever health insurers are involved, the director and the Green Mountain Care board shall collaborate with the commissioner of banking, insurance, securities, and health care administration.

(b) The director of payment reform 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, the state health care ombudsman, and state and local governments to advise the director in developing and

implementing the pilot projects and the Green Mountain Care board in setting overall policy goals.

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

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

(2) 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 and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(3) 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 consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(4) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(5) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(d) In addition to the objectives identified in subsection (c) of this section, the design and implementation of payment reform pilot projects may consider:

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

(2) with input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(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.

(f) The Green Mountain Care board shall ensure that payment reform pilot projects are consistent with the board's overall efforts to control the rate of growth in health care costs while maintaining or improving health care quality.

§ 723. HEALTH INSURER PARTICIPATION

(a)(1) 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 providing incentives, fees, or payment methods, 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.

(2) 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.

(b) 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.

§ 724. ANTITRUST PROTECTION

To the extent required to avoid federal antitrust violations, the director 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 director shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the director determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

§ 725. ADMINISTRATION; RULES

(a) The director of payment reform shall apply for grant funding, if available, for the design and implementation evaluation of the pilot projects described in this section.

(b) The agency of human services may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the provisions of this chapter.

(c) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.

Sec. 3d. 18 V.S.A. § 4631a is amended to read:

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(5) "Gift" means:

(A) Anything of value provided for free to a health care provider ~~for free~~ or to a member of the Green Mountain Care board established in chapter 220 of this title; or

(B) Except as otherwise provided in subdivision (a)(1)(A)(ii) of this section, any payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title, unless:

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

(ii) the health care provider or board member reimburses the cost at fair market value.

* * *

(b)(1) It is unlawful for any manufacturer of a prescribed product or any wholesale distributor of medical devices, or any agent thereof, to offer or give any gift to a health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title.

* * *

Sec. 3e. 18 V.S.A. § 4632 is amended to read:

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

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

(A) any allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title to any health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title, except:

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

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

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

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

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

* * *

(5) The office of the attorney general shall report annually on the disclosures made under this section to the general assembly and the governor on or before April 1. The report shall include:

(A) Information on allowable expenditures and gifts required to be disclosed under this section, which shall ~~be presented in both~~ present information in aggregate form; ~~and~~ by selected types of health care providers or individual health care providers, as prioritized each year by the office; and showing the amounts expended on the Green Mountain Care board established in chapter 220 of this title.

(B) Information on violations and enforcement actions brought pursuant to this section and section 4631a of this title.

(6) After issuance of the report required by subdivision (5) of this

subsection and except as otherwise provided in subdivision (2)(A)(i) of this subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

* * *

* * * Public–Private Universal Health Care System * * *

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

CHAPTER 18. PUBLIC–PRIVATE UNIVERSAL HEALTH CARE 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 Green Mountain Care.

(b) The purpose of the Vermont health benefit exchange is to facilitate the purchase of affordable, qualified health benefit 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 contain costs; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

(c) Nothing in this chapter shall be construed to reduce, diminish, or otherwise infringe upon the benefits provided to eligible individuals under Medicare.

§ 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) "Commissioner" means the commissioner of the department of Vermont health access.

(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 an employer that:

(A) 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

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

(6) "Qualified entity" means an entity with experience in individual and group health insurance, benefit administration, or other experience relevant to health benefit program eligibility, enrollment, or support.

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

(8) "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 an immigrant lawfully present 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 committee 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 3 V.S.A. chapter 53.

(b)(1)(A) The Vermont health benefit exchange shall provide qualified individuals and qualified employers with qualified health benefit plans, including the multistate plans required by the Affordable Care Act, 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 any 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) to individuals and employers who are not qualified individuals 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, including teachers.

(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 21 V.S.A. chapter 9 (workers' compensation).

(c)(1) The Vermont health benefit exchange may determine an appropriate method to provide a unified, simplified administration system for health insurers offering qualified health benefit plans. The exchange may include

claims administration, benefit management, billing, or other components in the unified system and may achieve simplification by contracting with a single entity for administration and management of all qualified health benefit plans, by licensing or requiring the use of particular software, by requiring health insurers to conform to a standard set of systems and rules, or by another method determined by the commissioner.

(2) The Vermont health benefit exchange may offer certain services, such as wellness programs and services designed to simplify administrative processes, to health insurers offering plans outside the exchange, to workers' compensation insurers, to employers, and to other entities.

(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

[Reserved.]

§ 1805. DUTIES AND RESPONSIBILITIES

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

(1) Offering 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 qualified 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, as well as any other public health benefit program.

(3) Creating and maintaining consumer assistance tools, including a website through which enrollees and prospective enrollees of qualified health benefit plans may obtain standardized comparative information on such plans, a toll-free telephone hotline to respond to requests for assistance, and interactive online communication tools, in a manner that complies with the Americans with Disabilities Act.

(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 benefit plan offered through the Vermont health benefit exchange and determining each qualified health benefit 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 secretary of the U.S. Department 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 U.S. Department 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 benefit 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 secretary of the U.S. Department 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 secretary of the U.S. Department 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 benefit 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 U.S. Department of 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 the Vermont health benefit exchange.

(12) Consistent with federal law, crediting the amount of any free choice voucher provided pursuant to Section 10108 of the Affordable Care Act 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 and health care professionals with satisfaction surveys and other mechanisms for evaluating the performance of qualified health benefit plans and informing the commissioner of Vermont health access and the commissioner of banking, insurance, securities, and health care administration of such performance.

(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 committee established in section 402 of this title to obtain information and advice as necessary to fulfill the duties outlined in this subchapter.

(16) Referring consumers to the office of health care ombudsman for assistance with grievances, appeals, and other issues involving the Vermont health benefit exchange.

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

(a) Prior to contracting with a health insurer to offer a qualified health benefit plan, the 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. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.

(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 secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

(B) Notwithstanding subdivision (1)(A) of this subsection, a health insurer or a stand-alone dental insurer, including a nonprofit dental service corporation, may offer a plan that provides only limited dental benefits, either separately or in conjunction with a qualified health benefit plan, if it 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.

(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 cost-sharing requirements specified by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

(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 deductible requirements specified by the secretary

of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

(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, appropriate services to enable access for underserved individuals or populations, accreditation, quality improvement, and information on quality measures for health benefit plan performance, as provided in Section 1311 of the Affordable Care Act and any more restrictive requirements provided by 8 V.S.A. chapter 107;

(2) quality and wellness standards, including a requirement for joint quality improvement activities with other plans, as specified in rule by the secretary of human services, after consultation with the commissioners of health and of banking, insurance, securities, and health care administration and with the advisory committee 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 health insurer offering a qualified health benefit plan shall use the uniform enrollment forms and descriptions of coverage provided by the commissioner of Vermont health access and the commissioner of banking, insurance, securities, and health care administration.

(e)(1) A health insurer offering 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 benefit plan at the silver level and at least one qualified health benefit plan at the gold level that meet the requirements of Section 1302 of the Affordable Care Act and any additional requirements specified by the secretary of human services by rule. In addition, a health insurer may choose to offer one or more qualified health benefit plans at the platinum level that meet the requirements of Section 1302 of the Affordable Care Act and any additional requirements specified by the secretary of human services by rule.

(C) Charge the same premium rate for a health benefit 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 commissioner of Vermont health access or by the commissioner of banking, insurance, securities, and health care administration. The commissioner of banking, insurance, securities, and health care administration shall define, by rule, the acceptable time frame for provision of information in accordance with this subdivision.

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

(2) A health insurer offering a qualified health benefit plan shall comply with all other insurance requirements for health insurers as provided in 8 V.S.A. chapter 107 and as specified by rule by the commissioner of banking, insurance, securities, and health care administration.

(f) Consistent with Section 1311(e)(1)(B) of the Affordable Care Act, 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 for treatments necessary to prevent patients' deaths in circumstances the Vermont health benefit exchange determines are inappropriate or too costly.

§ 1807. NAVIGATORS

(a)(1) 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.

(2) The Vermont health benefit exchange shall ensure that navigators are available to provide assistance in person or through interactive technology

to individuals in all regions of the state in a manner that complies with the Americans with Disabilities Act.

(3) Consistent with Section 1311(i)(4) of the Affordable Care Act, health insurers shall not serve as navigators, and no navigator shall receive any compensation from a health insurer in connection with enrolling individuals or employees in qualified health benefit plans.

(b) Navigators shall have the following duties:

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

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

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

(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, other public health benefit programs, 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, any examination of the properties and records of the Vermont health benefit exchange, or any 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 AND SATISFACTION SURVEYS

(a) The Vermont health benefit exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, as well as 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.

(b) The Vermont health benefit exchange shall publish the deidentified results of the satisfaction surveys and other evaluation mechanisms required pursuant to subdivision 1805(13) of this title on a website intended to enable consumers to compare the qualified health benefit plans offered through the exchange.

§ 1810. RULES

The secretary of human services may adopt rules pursuant to 3 V.S.A. chapter 25 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, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless and equitable manner regardless of income, assets, health status, or availability of other health coverage. Green Mountain Care shall contain costs by:

(1) providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits;

(2) establishing innovative payment mechanisms to health care professionals, such as global payments;

(3) encouraging the management of health services through the Blueprint for Health; and

(4) reducing unnecessary administrative expenditures.

§ 1822. IMPLEMENTATION; WAIVER

(a) Green Mountain Care shall be implemented 90 days following the last

to occur of:

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

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

(3) Approval by the Green Mountain Care board of the initial Green Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

(4) Enactment of the appropriations for the initial Green Mountain Care benefit package proposed by the Green Mountain Care board pursuant to 18 V.S.A. § 9375.

(5) A determination by the Green Mountain Care Board that each of the following conditions will be met:

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

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.

(C) The financing for Green Mountain Care is sustainable.

(D) Administrative expenses will be reduced.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.

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

(b) As soon as allowed 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.

§ 1823. DEFINITIONS

For purposes of this subchapter:

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

(2) "Board" means the Green Mountain Care board established in 18 V.S.A. chapter 220.

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

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

(5) "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 licensed health care practitioners and their patients, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

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

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

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

(9) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have 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.

(10) "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 family planning, prenatal care, and mental health and substance abuse treatment.

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

(12) "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. An individual shall not be considered to be a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state.

(13) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

§ 1824. ELIGIBILITY

(a)(1) Upon implementation, all Vermont residents shall be eligible for Green Mountain Care, regardless of whether an employer offers health insurance for which they are eligible. The agency shall establish standards by rule for proof and verification of residency.

(2)(A) Except as otherwise provided in subdivision (C) of this subdivision (2), if an individual is determined to be eligible for Green Mountain Care based on information later found to be false, the agency shall make reasonable efforts to recover from the individual the amounts expended for his or her care. In addition, if the individual knowingly provided the false information, he or she shall be assessed an administrative penalty of not more than $5,000.00.

(B) The agency shall include information on the Green Mountain Care application to provide notice to applicants of the penalty for knowingly providing false information as established in subdivision (2)(A) of this subsection.

(C) An individual determined to be eligible for Green Mountain Care whose health services are paid in whole or in part by Medicaid funds who commits fraud shall be subject to the provisions of chapter 1, subchapter V of this title in lieu of the administrative penalty described in subdivision (A) of this subdivision (2).

(D) Nothing in this section shall be construed to limit or restrict prosecutions under any applicable provision of law.

(3)(A) Except as otherwise provided in this section, a person who is not a Vermont resident shall not be eligible for Green Mountain Care.

(B) Except as otherwise provided in subdivision (C) of this subdivision (3), an individual covered under Green Mountain Care shall inform the agency within 60 days of becoming a resident of another state. An individual who obtains or attempts to obtain health services through Green Mountain Care more than 60 days after becoming a resident of another state shall reimburse the agency for the amounts expended for his or her care and shall be assessed an administrative penalty of not more than $1,000.00 for a first violation and not more than $2,000.00 for any subsequent violation.

(C) An individual whose health services are paid in whole or in part by Medicaid funds who obtains or attempts to obtain health services through Green Mountain Care more than 60 days after becoming a resident of another state shall be subject to the provisions of chapter 1, subchapter V of this title in lieu of the administrative penalty described in subdivision (B) of this subdivision (3).

(D) Nothing in this section shall be construed to limit or restrict prosecutions under any applicable provision of law.

(b) The agency shall establish a procedure to enroll residents in Green Mountain Care.

(c)(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, Medicare, CHIP, or other federal 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.

(3) If an individual presumed eligible for Green Mountain Care pursuant to subdivision (1) of this subsection is later determined not to be eligible for the program, the agency shall make reasonable efforts to recover from the individual the amounts expended for his or her care.

(d) The agency shall adopt rules pursuant to 3 V.S.A. chapter 25 to ensure that Vermont residents who are temporarily out of the state and who intend to return and reside in Vermont remain eligible for Green Mountain Care while outside Vermont.

(e) 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 and shall adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this subsection.

§ 1825. HEALTH BENEFITS

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

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

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

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

(B) The Green Mountain Care board shall consider whether to include long-term care benefits in the Green Mountain Care benefit package.

(5) Green Mountain Care shall not limit coverage of preexisting conditions.

(6) The Green Mountain Care board shall approve the benefit package and present it to the general assembly as part of its recommendations for the Green Mountain Care budget.

(b)(1)(A) For individuals eligible for Medicaid or CHIP, the benefit package shall include the benefits required by federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

(B) Upon implementation of Green Mountain Care, the benefit package for individuals eligible for Medicaid or CHIP shall also include any optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc for which these individuals are eligible on January 1, 2014. Beginning with the

second year of Green Mountain Care and going forward, the Green Mountain Care board may, consistent with federal law, modify these optional benefits, as long as at all times the benefit package for these individuals contains at least the benefits described in subdivision (A) of this subdivision (b)(1).

(2) For children eligible for benefits paid for with Medicaid funds, the benefit package 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 the benefits provided to these individuals under federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

§ 1826. BLUEPRINT FOR HEALTH

(a) It is the intent of the general assembly that within five years following the implementation of Green Mountain Care, each individual enrolled in Green Mountain Care will have a primary health care professional who is involved with the Blueprint for Health established in 18 V.S.A. chapter 13.

(b) Consistent with the provisions of 18 V.S.A. chapter 13, if an individual enrolled in Green Mountain Care does not have a medical home through the Blueprint for Health, the individual may choose a primary health care professional who is not participating in the Blueprint to serve as the individual's primary care point of contact.

(c) 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 or primary care point of contact for the patient. The agency shall approve a specialist as a patient's medical home or primary care point of contact on a case-by-case basis and only for a patient who receives the majority of his or her health care from that specialist.

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

§ 1827. ADMINISTRATION; ENROLLMENT

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

(2) The agency shall ensure that entities awarded contracts pursuant to this subsection do not have a financial incentive to restrict individuals' access to health services. The agency may establish performance measures that provide incentives for contractors to provide timely, accurate, transparent, and

courteous services to individuals enrolled in Green Mountain Care and to health care professionals.

(3) When considering contract bids pursuant to this subsection, the agency shall consider the interests of the state relating to the economy, the location of the entity, and the need to maintain and create jobs in Vermont. The agency may utilize an econometric model to evaluate the net costs of each contract bid.

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

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

(d) Except for cost-sharing, 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, including private health insurance, retiree health benefits, or federal health benefit plans offered by the Veterans' Administration, by the military, or to federal employees.

(g) The agency may seek a waiver under Section 1115 of the Social Security Act to include Medicaid and under Section 2107(e)(2)(A) of the Social Security Act to include 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.

(i) Green Mountain Care shall maintain a robust and adequate network of health care professionals located in Vermont or regularly serving Vermont residents, including mental health and substance abuse professionals. The

agency shall contract with outside entities as needed to allow for the appropriate portability of coverage under Green Mountain Care for Vermont residents who are temporarily out of the state.

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

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

(l) The agency, in collaboration with the department of banking, insurance, securities, and health care administration, shall monitor the extent to which residents of other states move to Vermont for the purpose of receiving health services and the impact, positive or negative, of any such migration on Vermont's health care system and on the state's economy, and make appropriate recommendations to the general assembly based on its findings.

§ 1828. BUDGET PROPOSAL

The Green Mountain Care board, in collaboration with the agencies of administration and of human services, shall be responsible for developing each year a three-year Green Mountain Care budget for proposal to the general assembly and to the governor, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

§ 1829. 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 Green Mountain Care.

(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 32 V.S.A. chapter 7, subchapter 5, 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:

(1) the administration and delivery of health services covered by Green Mountain Care as provided in this subchapter; and

(2) expenses related to the duties and operation of the Green Mountain Care board pursuant to 18 V.S.A. chapter 220.

§ 1830. COLLECTIVE BARGAINING RIGHTS

Nothing in this subchapter shall be construed to limit the ability of collective bargaining units to negotiate for coverage of health services pursuant to 3 V.S.A. § 904 or any other provision of law.

§ 1831. PUBLIC PROCESS

The agency of human services shall provide a process for soliciting public input on the Green Mountain Care benefit package on an ongoing basis, including a mechanism by which members of the public may request inclusion of particular benefits or services. The process may include receiving written comments on proposed new or amended rules or holding public hearings or both.

§ 1832. RULEMAKING

The secretary of human services may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this subchapter. When establishing rules relating to the Green Mountain Care benefit package, the secretary shall ensure that the rules are consistent with the benefit package defined by the Green Mountain Care board pursuant to section 1825 of this title and to 18 V.S.A. chapter 220.

Sec. 4a. HOUSEHOLD HEALTH INSURANCE SURVEY

The department of banking, insurance, securities, and health care administration shall include questions on its household health insurance survey that enable the department to determine the extent to which residents of other states move to Vermont for the purpose of receiving health services. The department shall provide its findings to the agency of human services to enable the agency to monitor migration into the state as required in 33 V.S.A. § 1827.

Sec. 4b. EXCHANGE IMPLEMENTATION

(a) The commissioner of Vermont health access shall make a reasonable

effort to maintain contracts with at least two health insurers to provide qualified health benefit plans, in addition to the multistate plans required by the Affordable Care Act, in the Vermont health benefit exchange in 2014 if at least two health insurers are interested in participating and meet the requirements of 33 V.S.A. § 1806; provided that the commissioner shall not be required to solicit participation by insurers outside the state in order to contract with two insurers.

(b) Nothing in this section shall be construed to require the commissioner to contract with a health insurer to provide a plan that does not meet the requirements specified in 33 V.S.A. chapter 18, subchapter 1.

Sec. 4c. HEALTH COVERAGE FINDINGS AND STUDY

(a) The general assembly finds that:

(1) Federal law requires certain health care providers to provide emergency treatment to all individuals, regardless of immigration status.

(2) Federal law prohibits coverage of undocumented immigrants through Medicaid and through the Vermont health benefit exchange. Federal funds would not be available to cover undocumented immigrants through Green Mountain Care.

(3) Federal law requires that employers provide health insurance coverage for certain immigrants working seasonally in Vermont. Dairy workers, however, are not included in this category because they are year-round workers.

(4) Some employers of undocumented immigrants pay employment taxes for these workers, and these workers do not derive health care benefits from the government.

(b) No later than January 15, 2013, the Green Mountain Care board shall examine and report to the general assembly on:

(1) The potential costs of services provided to undocumented immigrants by health care professionals if these immigrants are not covered through Green Mountain Care, including any increased costs of care delayed due to the lack of coverage for primary care; and

(2) The potential costs of providing coverage for health services to undocumented immigrants through Green Mountain Care, including any state funds necessary to fund the services.

(c) The secretary of administration or designee shall work with Vermont's congressional delegation to:

(1) provide a mechanism for legal status under federal immigration law for nonseasonal farm workers; and

(2) clarify any impacts of covering or not covering undocumented immigrants through Green Mountain Care on the receipt of a waiver under section 1332 of the Affordable Care Act.

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

After March 15, 2012 but not later than July 1, 2013, 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. No later than January 15, 2012, the secretary shall provide to the house committees on health care and on human services and the senate committee on health and welfare a plan for transferring the positions and funds.

* * * Consumer and Health Care Professional Advisory Committee * * *

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

§ 402. MEDICAID AND EXCHANGE ADVISORY COMMITTEE

(a) A Medicaid and exchange advisory committee 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, and Medicaid-funded programs, consistent with the requirements of federal law.

(b)(1) The commissioner of Vermont health access shall appoint members of the advisory committee established by this section, who shall serve staggered three-year terms. The total membership of the advisory committee shall be 22 members. The commissioner may remove members of the committee who fail to attend three consecutive meetings and may appoint

replacements. The commissioner may reappoint members to serve more than one term.

(2)(A) The commissioner of Vermont health access shall appoint one representative of health insurers licensed to do business in Vermont to serve on the advisory committee. The commissioner of health shall also serve on the advisory committee.

(B) Of the remaining members of the advisory committee, one-quarter of the members shall be from each of the following constituencies:

(i) beneficiaries of Medicaid or Medicaid-funded programs.

(ii) individuals, self-employed individuals, and representatives of small businesses eligible for or enrolled in the Vermont health benefit exchange.

(iii) advocates for consumer organizations.

(iv) health care professionals and representatives from a broad range of health care professionals.

(3) Members whose participation is not supported through their employment or association shall receive per diem compensation pursuant to 32 V.S.A. § 1010 and reimbursement of travel expenses. In addition, members who are eligible for Medicaid or who are enrolled in a qualified health benefit plan in the Vermont health benefit exchange and whose income does not exceed 300 percent of the federal poverty level shall also receive reimbursement of expenses, including costs of child care, personal assistance services, and any other service necessary for participation in the advisory committee and approved by the commissioner.

(c)(1) The advisory committee shall have an opportunity to review and comment on 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 3 V.S.A. chapter 25 and on waiver or waiver amendment applications prior to submission to the Centers for Medicare and Medicaid Services.

(2) 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, health care professional reimbursement rates, funding outlook, financing options, and possible budget recommendations.

(d)(1) The advisory committee shall make policy recommendations on proposals of the department of Vermont health access to the department, the Green Mountain Care board, 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 the members of each of the legislative committees of jurisdiction and to the Green Mountain Care board.

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

(e) The commissioner shall convene the advisory committee at least 10 times during each calendar year. If at least one-third of the members of the advisory committee so choose, the members may convene up to four additional meetings per calendar year on their own initiative by sending a request to the commissioner. The department shall provide the committee with staffing and independent technical assistance as needed to enable it to make effective recommendations.

(f) A majority of the members of the committee shall constitute a quorum, and all action shall be taken upon a majority vote of the members present and voting.

Sec. 8. INTEGRATION PLAN

(a) No later than January 15, 2012, the secretary of administration or designee shall present a factual report and make recommendations to the house committee on health care and the senate committees on health and welfare and on finance 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 33 V.S.A. chapter 18, including:

(A) Whether it is advisable 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 comprehensive and affordable for this population.

(B)(i) 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.

(ii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, and for employees, of defining a small employer for purposes of the Vermont health benefit exchange for the period from January 1, 2014 through December 31, 2015 as an employer with up to 50 employees or as an employer with up to 100 employees, including an analysis of the impacts of the definition on teachers, municipal employees, and associations. For purposes of the analysis pursuant to this subdivision, "employer" means all for-profit entities, nonprofit entities, public entities, and individuals who are self-employed.

(iii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing qualified health benefit plans to be sold to individuals and small groups both inside and outside the Vermont health benefit exchange.

(iv) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing nonqualified health benefit plans that comply with the provisions of the Affordable Care Act to be sold to individuals and small groups outside the exchange.

(C) In consultation with the Green Mountain Care 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 for evidence-based health services with proven effectiveness.

(D) The impact of the availability of supplemental insurance plans on offerings in the small and individual group markets.

(E) The potential for purchasing prescription drugs in Green Mountain Care through Medicaid, the 340B drug pricing program, or another bulk purchasing mechanism.

(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.

(3) How to enable parents to make coverage under Green Mountain Care available to an adult child up to age 26 who would not otherwise be eligible for coverage under the program, including a recommendation on the amount of and mechanism for collecting a financial contribution for such coverage and information on the difference in costs to the system between allowing all adult children up to age 26 to be eligible and limiting eligibility to adult children attending a college or university.

(4) whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state's exposure to financial risk in the operation of Green Mountain Care; if so, how to accomplish such implementation; and the impact, if any, on the state's bond rating.

(5) How to fully align the administration of Medicaid, Medicare, Dr. Dynasaur, the Catamount Health premium assistance program, the Vermont health access program, and other public or private health benefit programs in order to simplify the administrative aspects of health care delivery. In his or her recommendations, the secretary or designee shall estimate the cost-savings associated with such administrative simplification and identify any federal waivers or other agreements needed to accomplish the purposes of this subdivision (5).

(b) The commissioner of labor, in consultation with the commissioner of Vermont health access, the commissioner of banking, insurance, securities, and health care administration, and interested stakeholders, shall evaluate the feasibility of integrating or aligning Vermont's workers' compensation system with Green Mountain Care, including providing any covered services in addition to those in the Green Mountain Care benefit package that may be appropriate for injuries arising out of and in the course of employment. No later than January 15, 2012, the commissioner of labor shall report the results of the evaluation and, if integration or alignment has been found to be feasible, make recommendations on how to achieve it.

(c) The commissioner of Vermont health access, in consultation with the commissioner of banking, insurance, securities, and health care administration; the commissioner of taxes; and the commissioner of motor vehicles shall review the requirements for maintaining minimum essential coverage under Section 1501 of the Affordable Care Act, including the enforcement mechanisms provided in that act. No later than January 15, 2012, the commissioner of Vermont health access shall recommend to the house committee on health care and the senate committees on finance and on health

and welfare any additional enforcement mechanisms necessary to ensure that most, if not all, Vermonters will obtain sufficient health benefit coverage.

Sec. 9. FINANCING PLANS

(a) The secretary of administration or designee shall recommend two plans for sustainable financing 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 universal health care system. The secretary shall recommend whether nonresidents employed by Vermont businesses should be eligible for Green Mountain Care and solutions to other cross-border issues.

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

(1) all 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 and consistency with the principles of equity expressed in 18 V.S.A. § 9371;

(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, including the circumstances under which a particular tax change may result in the potential for double payments, such as premiums and tax obligations;

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

(C) for a transitional period, while the tax system and health care cost structure are changing;

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

(6) anticipated federal funds that may be used for health services and how to maximize the amount of federal funding available for this purpose;

(7) the amounts required to maintain existing state insurance benefit requirements and other appropriate considerations in order to determine the state contribution toward federal premium tax credits available in the Vermont health benefit exchange pursuant to the Affordable Care Act;

(8) additional funds needed to support recruitment and retention programs for high-quality health care professionals in order to address the shortage of primary care professionals and other specialty care professionals in this state;

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

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

(11) how to maximize the flow of federal funds to the state for individuals eligible for Medicare, such as enrolling eligible individuals in Medicare and paying or supplementing the cost-sharing requirements on their behalf;

(12) the use of financial or other incentives to encourage healthy lifestyles and patient self-management for individuals enrolled in Green Mountain Care;

(13) preserving retirement health benefits while enabling retirees to participate in Green Mountain Care;

(14) the implications of Green Mountain Care on funds set aside to pay for future retiree health benefits; and

(15) changes in federal health funding through reduced payments to health care professionals or through limitations or restrictions on the availability of grant funding or federal matching funds available to states through the Medicaid program.

(c) In developing the financing plan for Green Mountain Care, the secretary of administration or designee shall consult with interested stakeholders, including health care professionals, employers, and members of the public, to determine the potential impact of various financing sources on Vermont

businesses and on the state's economy and economic climate. No later than February 1, 2012, the secretary or designee shall report his or her findings on the impact on businesses and the economy and any related recommendations to the house committees on health care and on commerce and to the senate committees on health and welfare, on finance and on economic development, housing and general affairs.

(d) In addition to the consultation required by subsection (c) of this section, in developing the financing plan for Green Mountain Care, the secretary of administration or designee shall solicit input from interested stakeholders, including health care professionals, employers, and members of the public and shall provide opportunities for public engagement in the design of the financing plan.

(e) The secretary of administration or designee shall consider strategies to address individuals who receive health coverage through the Veterans Administration, TRICARE, the Federal Employees Health Benefits Program, the government of a foreign nation, or from another federal governmental or foreign source.

Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

(a) The secretary of administration or designee, in consultation with the Green Mountain Care 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 universal health care 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 funding sources available for such development. The health information technology plan or design and implementation plan shall also include 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 shall include 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

(a) 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 Green Mountain Care 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 a plan to institute a public health impact assessment 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, how to coordinate quality assurance 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, using standards and algorithms such as those developed by the National Committee for Quality Assurance.

(4) How to reorganize and consolidate health care-related functions in agencies and departments across state government in order to ensure integrated and efficient administration of all of Vermont's health care programs and initiatives.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall review the hospital budget review process provided in 18 V.S.A. chapter 221, subchapter 7, and

the certificate of need process provided in 18 V.S.A. chapter 221, subchapter 5 and recommend to the house committee on health care and the senate committee on health and welfare statutory modifications needed to enable the participation of the Green Mountain Care board as set forth in 18 V.S.A. § 9375.

Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

No later than March 15, 2012, the Green Mountain Care board established in 18 V.S.A. chapter 220, 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. 12a. 18 V.S.A. chapter 222 is added to read:

CHAPTER 222. ACCESS TO HEALTH CARE PROFESSIONALS

§ 9491. HEALTH CARE WORKFORCE; STRATEGIC PLAN

(a) The director of health care reform in the agency of administration shall oversee the development of a current health care workforce development strategic plan that continues efforts to ensure that Vermont has the health care workforce necessary to provide care to all Vermont residents. The director of health care reform may designate an entity responsible for convening meetings and for preparing the draft strategic plan. The Green Mountain Care board established in chapter 220 of this title shall review the draft strategic plan and shall approve the final plan and any subsequent modifications.

(b) The director or designee shall collaborate with the area health education centers, the workforce development council established in 10 V.S.A. § 541, the prekindergarten-16 council established in 16 V.S.A. § 2905, the department of labor, the department of health, the department of Vermont health access and other interested parties, to develop and maintain the plan. The director of health care reform shall ensure that the strategic plan includes recommendations on how to develop Vermont's health care workforce, including:

(1) the current capacity and capacity issues of the health care workforce and delivery system in Vermont, including the shortages of health care professionals, specialty practice areas that regularly face shortages of qualified health care professionals, issues with geographic access to services, and unmet health care needs of Vermonters.

(2) the resources needed to ensure that the health care workforce and the delivery system are able to provide sufficient access to services given demographic factors in the population and in the workforce as well as other factors, and able to participate fully in health care reform initiatives, including how to ensure that all Vermont residents have a medical home through the Blueprint for Health pursuant to chapter 13 of this title and how to transition to electronic medical records; and

(3) how state government, universities and colleges, the state's educational system, entities providing education and training programs related to the health care workforce, and others may develop the resources in the health care workforce and delivery system to educate, recruit, and retain health care professionals to achieve Vermont's health care reform principles and purposes.

(4) review data on the extent to which individual health care professionals begin and cease to practice in their applicable fields in Vermont.

(5) identify factors which either hinder or assist in recruitment or retention of health care professionals, including an examination of the processes for prior authorizations, and make recommendations for further improving recruitment and retention efforts.

(6) assess the availability of state and federal funds for health care workforce development.

(c) Beginning January 15, 2013, the director or designee shall provide the strategic plan approved by the Green Mountain Care board to the general assembly and shall provide periodic updates on modifications as necessary.

Sec. 13. WORKFORCE ISSUES

(a)(1) Currently, Vermont has a shortage of primary care professionals, and many practices are closed to new patients. It also experiences periodic and geographic shortages of specialty care professionals necessary to ensure that Vermonters have reasonable access to a broad range of health services within the state. 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, including specific recommendations to modify scopes of practice to enable health care professionals to perform to the fullest extent of their professional competence.

(b) The director of health care reform or designee, in collaboration with the department of labor, and the agency of human services, the prekindergarten-16 council established in 16 V.S.A. § 2905, the workforce development council, and other interested parties, shall 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. 13a. PRIOR AUTHORIZATIONS

The Green Mountain Care board shall consider:

(1) compensating health care providers for the completion of requests for prior authorization; and

(2) exempting from prior authorization requirements for specific services in Green Mountain Care those health care professionals whose prior authorization requests are routinely granted for those services.

* * * Cost Estimates * * *

Sec. 14. COST ESTIMATES; MEETINGS

(a) No later than April 21, 2011, the legislative joint fiscal office and the department of banking, insurance, securities, and health care administration shall provide to the house committee on health care and the senate committee on health and welfare an initial, draft estimate of the costs of Vermont's current health care system compared to the costs of a reformed health care system upon implementation of Green Mountain Care and the additional provisions of this act. To the extent possible, the estimates shall be based on the department of banking, insurance, securities, and health care

administration's expenditure report and additional data available in the multi-payer database established in 18 V.S.A. § 9410.

(b) The legislative joint fiscal office and the department of banking, insurance, securities, and health care administration shall report their final estimates of the costs described in subsection (a) of this section to the committees of jurisdiction no later than November 1, 2011.

(c) The house committee on health care and the senate committee on health and welfare may meet while the legislature is not in session to receive updates on reports and work in progress related to the provisions of this act. To the extent practicable, such meetings shall coincide with scheduled meetings of the joint fiscal committee.

* * * Rate Review * * *

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

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy 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 days after having been filed, or in the case of a request for a rate increase, until a decision by the Green Mountain Care board as provided herein, unless the commissioner shall sooner give his or her written approval thereto. Prior to approving a rate increase, the commissioner shall seek approval for such rate increase from the Green Mountain Care board established in 18 V.S.A. chapter 220, which shall approve or disapprove the rate increase within 10 business days. The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board.

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this state. 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~~ 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.~~

(3) 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.

(b) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file a summary applicable to the cumulative rate increase. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, and any other information required by the commissioner. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

(c)(1) The commissioner shall provide information to the public on the department's website about the public availability of the filings and summaries required under this section.

(2) Beginning no later than January 1, 2012, the commissioner shall post the filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the department's website within five days of filing. The department shall provide an electronic mechanism for the public to comment on proposed rate increases over five percent. The public shall have 21 days from the posting of the summaries and filings to provide public comment. The department shall review and consider the public comments prior to the expiration of the review period pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for their consideration in approving any rate increases.

(d)(1) The following provisions of this section shall not apply to policies for specific disease, accident, injury, hospital indemnity, dental care, disability income, or other limited benefit coverage, but shall apply to long-term care policies:

(A) the requirement in subdivision (a)(1) for the Green Mountain Care board's approval for any rate increase;

(B) the review standards in subdivision (a)(2) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and

(C) subsections (b) and (c) of this section.

(2) The exemptions from the provisions described in subdivisions (1)(A) through (C) of this subsection shall also apply to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred.

Sec. 15a. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate, or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 15b. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the commissioner for his or her approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the commissioner of a nonrefundable fee of $50.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15c. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the commissioner of banking, insurance, securities, and health care administration under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts

and rates originally filed with such commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by such commissioner. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the commissioner of a nonrefundable fee of $50.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15d. 8 V.S.A. § 5104(a) is amended to read:

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The commissioner may request and shall receive any information that is needed to determine whether to approve the policy form or rate. In addition to any other information requested, the commissioner shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including but not limited to Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section 4062 of this title.

(2) The commissioner shall refuse to approve the form of evidence of coverage, filing or rate if it contains any provision which is unjust, unfair, inequitable, misleading or contrary to the law of the state or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

* * * Health Benefit Information * * *

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

§ 2004. HEALTH BENEFIT COSTS

(a) Employers shall provide their employees with an annual statement indicating:

(1) the total monthly premium cost paid for any employer-sponsored health benefit plan;

(2) the employer's share and the employee's share of the total monthly premium; and

(3) any amount the employer contributes toward the employee's cost-sharing requirement or other out-of-pocket expenses.

(b) Notwithstanding the provisions of subsection (a) of this section, an employer who reports the cost of coverage under an employer-sponsored health benefit plan as required by 26 U.S.C. § 6051(a)(14) shall be deemed to be in full compliance with the requirements of this section.

Sec. 16a. 33 V.S.A. § 1901(g) is added to read:

(g) The department of Vermont health access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the state's share and the beneficiary's share of such cost.

* * * Consumer Protection * * *

Sec. 17. REVIEW OF BAN ON DISCRETIONARY CLAUSES

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting a National Association of Insurance Commissioners (NAIC) model act prohibiting insurers from using discretionary clauses in their health benefit contracts. The purpose of the NAIC model act is to prohibit insurance clauses that purport to reserve discretion to the insurer to interpret the terms of the policy, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare on the advantages and disadvantages of Vermont adopting the NAIC model act.

* * * Single Formulary * * *

Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

No later than January 15, 2012, the department of Vermont health access, after consultation with health insurers, third-party administrators, and the drug utilization and review board, shall provide recommendations to the house committee on health care and the senate committee on health and welfare regarding:

(1) A single prescription drug formulary to be used by all payers of health services which allows for some variations for Medicaid due to the availability of rebates and discounts and which allows health care professionals prescribing drugs purchased pursuant to Section 340B of the Public Health Service Act to use the 340B formulary. The recommendations shall address the feasibility of requesting a waiver from Medicare Part D in order to ensure Medicare participation in the formulary, as well as the feasibility of enabling all prescription drugs purchased by or on behalf of Vermont residents to be purchased through the Medicaid program or pursuant to the 340B drug pricing program.

(2) A single mechanism for negotiating rebates and discounts across payers using a single formulary, and the advantages and disadvantages of using a single formulary to achieve uniformity of coverage.

(3) A uniform set of drug management rules aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management. The standards for pharmacy benefit management shall address timely decisions, access to clinical peers, access to evidence-based rationales, exemption processes, and tracking and reporting data on prescriber satisfaction.

* * * Repeal of Public Oversight Commission * * *

Sec. 19. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

(15) ~~"Public oversight commission" means the commission established in section 9407 of this title.~~

~~(16)~~ "Unified health care budget" means the budget established in accordance with section 9406 of this title.

~~(17)~~(16) "State health plan" means the plan developed under section 9405 of this title.

Sec. 20. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION PLAN

* * *

(b) On or before July 1, 2005, the commissioner, in consultation with the secretary of human services, shall submit to the governor a four-year health

resource allocation plan. The plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

* * *

(2) In the preparation of the plan, the commissioner shall assemble an advisory committee of no fewer than nine nor more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, payers, third-party payers, and consumer representatives~~, and up to three members of the public oversight commission~~. The advisory committee shall review drafts and provide recommendations to the commissioner during the development of the plan. Upon adoption of the plan, the advisory committee shall be dissolved.

(3) The commissioner, with the advisory committee, shall conduct at least five public hearings, in different regions of the state, on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the commissioner shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the commissioner shall publish in the manner prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place and period during which to direct written comments to the commissioner. In addition, the commissioner may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(4) The commissioner shall develop a mechanism for receiving ongoing public comment regarding the plan and for revising it every four years or as needed. ~~The public oversight commission shall recommend revisions to the plan at least every four years and at any other time it determines revisions are warranted.~~

* * *

Sec. 21. 18 V.S.A. § 9405a is amended to read:

§ 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

Each hospital shall have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Needs identified through the process shall be integrated with the hospital's long-term planning ~~and shall be described as a component of its four-year capital expenditure projections provided to the public oversight commission under subdivision 9407(b)(2) of this title~~. The process shall be updated as necessary to continue

to be consistent with such planning and capital expenditure projections, and identified needs shall be summarized in the hospital's community report.

Sec. 22. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The commissioner, in consultation with representatives from ~~the public oversight commission,~~ hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules establishing a standard format for community reports, as well as the contents, which shall include:

* * *

(c) The community reports shall be provided to the ~~public oversight commission and the~~ commissioner. The commissioner shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators.

Sec. 23. 18 V.S.A. § 9433(c) is amended to read:

(c) The commissioner shall consult with hospitals, nursing homes and professional associations and societies, ~~the public oversight commission,~~ the secretary of human services, and other interested parties in matters of policy affecting the administration of this subchapter.

Sec. 24. 18 V.S.A. § 9440 is amended to read:

§ 9440. PROCEDURES

* * *

(c) The application process shall be as follows:

* * *

(4) Within 90 days of receipt of an application, the commissioner shall notify the applicant that the application contains all necessary information required and is complete, or that the application review period is complete notwithstanding the absence of necessary information. The commissioner may extend the 90-day application review period for an additional 60 days, or for a period of time in excess of 150 days with the consent of the applicant. The time during which the applicant is responding to the commissioner's notice that additional information is required shall not be included within the maximum review period permitted under this subsection. The ~~public oversight commission may recommend, or the~~ commissioner may determine that the

certificate of need application shall be denied if the applicant has failed to provide all necessary information required to review the application.

* * *

(d) The review process shall be as follows:

(1) The ~~public oversight commission~~ commissioner shall review:

(A) The application materials provided by the applicant.

(B) ~~The assessment of the applicant's materials provided by the department.~~

~~(C)~~ Any information, evidence, or arguments raised by interested parties or amicus curiae, and any other public input.

(2) The ~~public oversight commission~~ department shall hold a public hearing during the course of a review.

(3) ~~The public oversight commission shall make a written findings and a recommendation to the commissioner in favor of or against each application. A record shall be maintained of all information reviewed in connection with each application.~~

~~(4) A review shall be completed and the~~ The commissioner shall make a final decision within 120 days after the date of notification under subdivision (c)(4) of this section. Whenever it is not practicable to complete a review within 120 days, the commissioner may extend the review period up to an additional 30 days. Any review period may be extended with the written consent of the applicant and all other applicants in the case of a review cycle process.

~~(5)~~(4) After reviewing each application ~~and after considering the recommendations of the public oversight commission~~, the commissioner shall make a decision either to issue or to deny the application for a certificate of need. The decision shall be in the form of an approval in whole or in part, or an approval subject to such conditions as the commissioner may impose in furtherance of the purposes of this subchapter, or a denial. In granting a partial approval or a conditional approval the commissioner shall not mandate a new health care project not proposed by the applicant or mandate the deletion of any existing service. Any partial approval or conditional approval must be directly within the scope of the project proposed by the applicant and the criteria used in reviewing the application.

~~(6)(A)~~(5) If the commissioner proposes to render a final decision denying an application in whole or in part, or approving a contested application, the commissioner shall serve the parties with notice of a proposed

decision containing proposed findings of fact and conclusions of law, and shall provide the parties an opportunity to file exceptions and present briefs and oral argument to the commissioner. The commissioner may also permit the parties to present additional evidence.

~~(B) If the commissioner's proposed decision is contrary to the recommendation of the public oversight commission:~~

~~(i) the notice of proposed decision shall contain findings of fact and conclusions of law demonstrating that the commissioner fully considered all the findings and conclusions of the public oversight commission and explaining why his or her proposed decision is contrary to the recommendation of the public oversight commission and necessary to further the policies and purposes of this subchapter; and~~

~~(ii) the commissioner shall permit the parties to present additional evidence.~~

~~(7)~~(6) Notice of the final decision shall be sent to the applicant, competing applicants, and interested parties. The final decision shall include written findings and conclusions stating the basis of the decision.

~~(8)~~(7) The commissioner shall establish rules governing the compilation of the record used by ~~the public oversight commission and~~ the commissioner in connection with decisions made on applications filed and certificates issued under this subchapter.

(e) The commissioner shall adopt rules governing procedures for the expeditious processing of applications for replacement, repair, rebuilding, or reequipping of any part of a health care facility or health maintenance organization destroyed or damaged as the result of fire, storm, flood, act of God, or civil disturbance, or any other circumstances beyond the control of the applicant where the commissioner finds that the circumstances require action in less time than normally required for review. If the nature of the emergency requires it, an application under this subsection may be reviewed by the commissioner only, without notice and opportunity for public hearing or intervention by any party.

(f) Any applicant, competing applicant, or interested party aggrieved by a final decision of the commissioner under this section may appeal the decision to the supreme court. ~~If the commissioner's decision is contrary to the recommendation of the public oversight commission, the standard of review on appeal shall require that the commissioner's decision be supported by a preponderance of the evidence in the record.~~

* * *

Sec. 25. 18 V.S.A. § 9440a is amended to read:

§ 9440a. APPLICATIONS, INFORMATION, AND TESTIMONY; OATH REQUIRED

(a) Each application filed under this subchapter, any written information required or permitted to be submitted in connection with an application or with the monitoring of an order, decision, or certificate issued by the commissioner, and any testimony taken before the ~~public oversight commission, the~~ commissioner~~,~~ or a hearing officer appointed by the commissioner shall be submitted or taken under oath. The form and manner of the submission shall be prescribed by the commissioner. The authority granted to the commissioner under this section is in addition to any other authority granted to the commissioner under law.

(b) Each application shall be filed by the applicant's chief executive officer under oath, as provided by subsection (a) of this section. The commissioner may direct that information submitted with the application be submitted under oath by persons with personal knowledge of such information.

(c) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

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

(h)(1) If a hospital violates a provision of this section, the commissioner may maintain an action in the superior court of the county in which the hospital is located to enjoin, restrain or prevent such violation.

* * *

(3)(A) The commissioner shall require the officers and directors of a hospital to file under oath, on a form and in a manner prescribed by the commissioner, any information designated by the commissioner and required pursuant to this subchapter. The authority granted to the commissioner under this subsection is in addition to any other authority granted to the commissioner under law.

(B) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner ~~or to the public oversight commission~~ or to a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the

commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

* * * Conforming Revisions * * *

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, and treatment of ~~alcoholics and alcoholic rehabilitation~~ substance abuse.

(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) Seek 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, which may include providing assistance to employers for wellness program grants, encouraging employers to promote employee engagement in healthy behaviors, and encouraging the appropriate use of the health care system.

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 Green Mountain Care 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~~ June 30, 2011.

Sec. 30. Sec. 14 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 14. PAYMENT REFORM; PILOTS

* * *

(4)~~(A)~~ No later than February 1, 2011, the director of payment reform shall provide a strategic plan for the pilot projects to the house committee on

health care and the senate committee on health and welfare. The strategic plan shall provide:

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

~~(ii)~~(B) An ongoing program evaluation and improvement protocol.

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

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

Sec. 31. GREEN MOUNTAIN CARE BOARD NOMINATIONS; APPOINTMENTS

(a) Notwithstanding the provisions of 18 V.S.A. § 9390(b)(2), no later than June 1, 2011, the governor, the speaker of the house of representatives, and the president pro tempore of the senate shall appoint the members of the Green Mountain Care board nominating committee. The members shall serve until their replacements are appointed pursuant to 18 V.S.A. § 9390 between January 1, 2013 and February 1, 2013.

(b) The governor shall appoint the members of the Green Mountain Care board pursuant to the process set forth in 18 V.S.A. chapter 220, subchapter 2, to begin employment no earlier than October 1, 2011. In making the initial appointments to the board, the governor shall ensure that the skills and qualifications of the board members complement those of the other members of the board.

Sec. 32. REPEAL

(a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective July 1, 2012.

(b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective July 1, 2011.

Sec. 33. APPROPRIATIONS

(a) In fiscal year 2012, the sum of $703,693.00 in general funds and $321,231.00 in federal funds is appropriated to the Green Mountain Care board to carry out its functions.

(b) In fiscal year 2012, the sum of $25,000.00 is appropriated from the general fund to the secretary of administration for the medical malpractice proposal pursuant to Sec. 2(e) of this act.

(c) In fiscal year 2012, the sum of $138,000.00 is appropriated from the general fund to the agency of administration for salary and benefits for the director of health care reform.

Sec. 33a. COMPENSATION

For fiscal year 2012, the salary for the chair of the Green Mountain Care board shall be $116,688.00.

Sec. 34. EFFECTIVE DATES

(a) Secs. 1 (intent), 1a (principles), and 2 (strategic plan); 3 (18 V.S.A. chapter 220, subchapter 2 "Green Mountain Care board nominating committee"); 8 (integration plan), and 9 (financing plans); 10 (HIT); 11 (health planning); 12 (regulatory process); 13 (workforce); 14 (cost estimates); 17 (discretionary clauses); 18 (single formulary); 26 (department of health); 28 (ACA grants); 29 (primary care workforce committee); 30 (approval of pilot projects); and 31 (initial Green Mountain Care board nominating committee appointments) of this act and this section shall take effect on passage.

(b) Sec. 1b (agency of administration), and Secs. 3, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Care board), 3a (health care ombudsman), 3b (positions), 3c (payment reform), 3d and 3e (manufacturers of prescribed products), 4c (health care coverage study), 5 (DVHA), 6 (Health care eligibility), 12a (health care workforce strategic plan); 13a (prior authorizations), 19–25a and 32 (repeal of public oversight commission), 33 (appropriations), and 33a (compensation) shall take effect on July 1, 2011.

(c)(1) Secs. 4 (Vermont health benefit exchange; Green Mountain Care), 4a (household health insurance survey), and 4b (exchange implementation) shall take effect on July 1, 2011.

(2) 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.

(3) Green Mountain Care shall be implemented as set forth in 33 V.S.A. § 1822.

(d) Sec. 7, 3 V.S.A. § 402 (Medicaid and exchange advisory board), shall take effect on July 1, 2012.

(e) Secs. 15-15d (rate review) shall take effect on January 1, 2012 and shall apply to all filings on and after January 1, 2012.

(f) Sec. 27 (VHCURES) shall take effect on October 1, 2011.

(g) Secs. 16 (health benefit information) and 16a (Medicaid program costs) shall take effect on January 1, 2012, and the reporting requirement shall apply to each calendar year, beginning with 2012.

CLAIRE D. AYER
KEVIN J. MULLIN
SALLY G. FOX
Committee on the part of the Senate

MARK LARSON
MICHAEL FISHER
SARAH L. COPELAND-HANZAS
Committee on the part of the House

Action Under Rule 52

H.R. 12

House resolution urging the adoption of state and federal measures to create an effective price support system for Vermont Northeast Marketing Area dairy farmers

(For text see House Journal 5/4/11)

NOTICE CALENDAR

Favorable with Amendment

H. 272

An act relating to maintenance of private roads

Rep. Kupersmith of South Burlington, for the Committee on **Commerce and Economic Development,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. LEGISLATIVE FINDINGS AND INTENT

The general assembly finds that:

(1) Fannie Mae (the Federal National Mortgage Association) is both a major purchaser of residential mortgage loans on the secondary market and an organization that sets the standards for the underwriting and legal requirements for loans sold on the secondary market.

(2) The current Fannie Mae appraisal form contains a section for the appraiser to comment on off-site improvements—including private streets—and to indicate whether the improvements are publicly or privately maintained. If a property is located on a community-owned or privately owned and maintained street, Fannie Mae requires a legally enforceable agreement or covenant for maintenance of the street.

(3) On January 31, 2008, Fannie Mae issued Announcement 08-01, which specifies that Fannie Mae will permit the delivery of mortgage loans for properties for which there is no such maintenance agreement or covenant, provided that the property is located in a state that has statutory provisions defining the responsibilities of property owners for the maintenance and repair of private streets. Prior to this act, Vermont had no such statutory provisions.

(4) Since the mortgage crisis, Fannie Mae has become stricter in its underwriting standards and in enforcing the private street maintenance agreement requirement. Because the ability to sell mortgages to Fannie Mae on the secondary market is critical to most mortgage lenders, this has delayed mortgage closings and created uncertainty for Vermont homeowners throughout the state.

(5) When a conflict arises among persons who share a private road but lack an express agreement concerning the maintenance of that road, the Vermont supreme court has applied common law equitable principles to apportion the cost of maintaining the private road. In the reported decision *Hubbard v. Bolieau*, 144 Vt. 373 (1984), the supreme court held that "when several persons enjoy a common benefit, all must contribute rateably to the discharge of the burdens incident to the existence of the benefit."

(6) Vermonters have a long history of working together to share the costs of maintaining private roads. Nothing in this act is intended to disturb the many working arrangements that exist between neighbors in Vermont. Instead, this act codifies a standard drawn from established principles of Vermont law, and the act will apply to resolve conflicts regarding maintenance of private roads only in the absence of a legally enforceable agreement. The term "rateably" as used in this act follows the existing common law standard, and continues to give courts the flexibility to examine the facts and circumstances of each case.

(7) This act will facilitate the sales of real property, promote the availability of secondary mortgage market financing, and reduce uncertainty for Vermont homeowners.

Sec. 2. 19 V.S.A. chapter 27 is added to read:

CHAPTER 27. PRIVATE ROADS

§ 2701. DEFINITIONS

As used in this chapter:

(1) "Maintenance" includes activities related to the upkeep of a private road in its usual condition or that are necessary to allow safe passage. "Maintenance" shall not be construed to include an expansion of the private road.

(2) "Private road" means a road or street other than a highway as defined in subdivision 1(12) of this title that is owned by one or more persons and used by more than one owner or holder of a recorded easement as a means of access to one or more parcels of land.

§ 2702. PRIVATE ROAD MAINTENANCE

In the absence of a legally enforceable agreement—including obligations established by covenants and requirements contained in deeds, state and local permits, and land development and subdivision bylaws—regarding the allocation of costs for the maintenance of a private road, the owners of property that utilize a private road for access and the holders of recorded easements with a right to use a private road for access shall contribute rateably to the payment of the expenses for maintenance of the private road on account of the common benefit enjoyed by each owner and easement holder.

§ 2703. ENFORCEMENT

If an owner or easement holder fails to pay after demand his or her rateable share of maintenance costs as required under section 2702 of this chapter, an owner or easement holder who suffers damage as a result may bring an action in the civil division of a superior court where the private road is located for damages or injunctive relief or both.

Sec. 3. EFFECTIVE DATE

This act shall take effect on July 1, 2011.

(Committee Vote: 10-1-0)

S. 67

An act relating to the open meeting law

Rep. Martin of Wolcott, for the Committee on Government Operations**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 1 V.S.A. § 310 is amended to read:

§ 310. DEFINITIONS

As used in this subchapter:

(1) "Deliberations" means weighing, examining, and discussing the reasons for and against an act or decision, but expressly excludes the taking of evidence and the arguments of parties.

(2) "Meeting" means a gathering of a quorum of the members of a public body for the purpose of discussing the business of the public body or for the purpose of taking action. "Meeting" shall not mean written correspondence or an electronic communication, including e-mail, telephone, or teleconferencing, between members of a public body for the purpose of scheduling a meeting, organizing an agenda, or distributing materials to discuss at a meeting, provided that such a written correspondence or such an electronic communication that results in written or recorded information shall be available for inspection and copying under the public records act as set forth in chapter 5, subchapter 4 of this title.

(3) "Public body" means any board, council, or commission of the state or one or more of its political subdivisions, any board, council, or commission of any agency, authority, or instrumentality of the state or one or more of its political subdivisions, or any committee of any of the foregoing boards, councils or commissions, except that "public body" does not include councils or similar groups established by the governor for the sole purpose of advising the governor with respect to policy.

(4) "Publicly announced" means that notice is given to an editor, publisher, or news director of a newspaper or radio station serving the area of the state in which the public body has jurisdiction, and to any ~~editor, publisher, or news director~~ person who has requested under subdivision 312(c)(5) of this title to be notified of special meetings.

(5) "Quasi-judicial proceeding" means a proceeding which is:

(A) a contested case under the Vermont Administrative Procedure Act; or

(B) a case in which the legal rights of one or more persons who are granted party status are adjudicated, which is conducted in such a way that all parties have opportunity to present evidence and to cross-examine witnesses presented by other parties, which results in a written decision, and the result of which is appealable by a party to a higher authority.

Sec. 2. 1 V.S.A. § 312 is amended to read:

§ 312. RIGHT TO ATTEND MEETINGS OF PUBLIC AGENCIES

(a)(1) All meetings of a public body are declared to be open to the public at all times, except as provided in section 313 of this title. No resolution, rule,

regulation, appointment, or formal action shall be considered binding except as taken or made at such open meeting, except as provided under ~~section 313(a)(2)~~ subdivision 313(b)(1) of this title. ~~A meeting may be conducted by audio conference or other electronic means, as long as the provisions of this subchapter are met.~~ A meeting of a public body is subject to the public accommodation requirements of 9 V.S.A. chapter 139. A public body shall electronically record ~~by audio tape,~~ all public hearings held to provide a forum for public comment on a proposed rule, pursuant to 3 V.S.A. § 840. The public shall have access to copies of ~~such tapes~~ electronic recordings as described in section 316 of this title.

(2) One or more of the members of a public body may participate in a meeting by electronic or other means of communication provided that:

(A) At least 24 hours prior to the meeting, the public body shall publicly announce the meeting, and a municipal public body shall post notice of the meeting in or near the municipal clerk's office and in at least two other public places in the municipality.

(B) The public announcement and posted notice of the meeting shall identify:

(i) at least one physical location where a member of the public can attend and participate in the meeting; or

(ii) an electronic or other means by which the public can access the meeting from a remote location.

(C) Each member participating by electronic or other means of communication shall:

(i) identify himself or herself when the meeting is convened;

(ii) be audible to the public at the physical location identified in subdivision (2)(B)(i) of this subsection and to those members of the public participating by the electronic or other means identified in subdivision (2)(B)(ii) of this subsection; and

(iii) be able to simultaneously hear each member and speak to each member during the meeting.

(D) The public body meets all other requirements of this subchapter in holding a meeting.

(E) A vote of the public body shall be taken by roll call.

(3) Written correspondence and electronic communications may be distributed among members of a public body, provided that such

communications shall not be used to circumvent the spirit or the requirements of this subchapter.

(b)(1) Minutes shall be taken of all meetings of public bodies. The minutes shall cover all topics and motions that arise at the meeting and give a true indication of the business of the meeting. Minutes shall include at least the following minimal information:

(A) All members of the public body present;

(B) All other active participants in the meeting;

(C) All motions, proposals, and resolutions made, offered, and considered, and what disposition is made of same; and

(D) The results of any votes, with a record of the individual vote of each member if a roll call is taken.

(2) Minutes of all public meetings shall be matters of public record, shall be kept by the clerk or secretary of the public body, and shall be available for inspection by any person and for purchase of copies at cost upon request after five days from the date of any meeting.

(c)(1) The time and place of all regular meetings subject to this section shall be clearly designated by statute, charter, regulation, ordinance, bylaw, resolution, or other determining authority of the public body, and this information shall be available to any person upon request. The time and place of all public hearings and meetings scheduled by all executive branch state agencies, departments, boards, or commissions shall be available to the public as required under 3 V.S.A. § 2222(c).

(2) The time, place, and purpose of a special meeting subject to this section shall be publicly announced at least 24 hours before the meeting. Municipal public bodies shall post notices of special meetings in or near the municipal clerk's office and in at least two other public places in the municipality, at least 24 hours before the meeting. In addition, notice shall be given, either orally or in writing, to each member of the public body at least 24 hours before the meeting, except that a member may waive notice of a special meeting.

(3) Emergency meetings may be held without public announcement, without posting of notices and without 24-hour notice to members, provided some public notice thereof is given as soon as possible before any such meeting. Emergency meetings may be held only when necessary to respond to an unforeseen occurrence or condition requiring immediate attention by the public body.

(4) Any adjourned meeting shall be considered a new meeting, unless the time and place for the adjourned meeting is announced before the meeting adjourns.

(5) An editor, publisher, or news director of any newspaper, radio station, or television station serving the area of the state in which the public body has jurisdiction may request in writing that a public body notify the editor, publisher, or news director of special meetings of the public body. The request shall apply only to the calendar year in which it is made, unless made in December, in which case it shall apply also to the following year.

(d) ~~The~~ At least 24 hours prior to a meeting, the agenda for a regular or special meeting shall be:

(1) posted to a website, if one exists, that the public body maintains or designates as the official website of the body;

(2) posted by a municipal public body in or near the municipal office and in at least two other public places in the municipality;

(3) made available to the news media or concerned persons prior to the meeting upon specific request; and

(4) adjustments to the agenda of a public body may be made as the first act of business at a public meeting.

(e) Nothing in this section or in section 313 of this title shall be construed as extending to the judicial branch of the government of Vermont or of any part of the same or to the public service board; nor shall it extend to the deliberations of any public body in connection with a quasi-judicial proceeding; nor shall anything in this section be construed to require the making public of any proceedings, records, or acts which are specifically made confidential by the laws of the United States of America or of this state.

(f) A written decision issued by a public body in connection with a quasi-judicial proceeding need not be adopted at an open meeting if the decision will be a public record.

(g) The provisions of this subchapter shall not apply to site inspections for the purpose of assessing damage or making tax assessments or abatements, clerical work, or work assignments of staff or other personnel. Routine, day-to-day administrative matters that do not require action by the public body, may be conducted outside a duly warned meeting, provided that no money is appropriated, expended, or encumbered.

(h) At an open meeting the public shall be given a reasonable opportunity to express its opinion on matters considered by the public body during the meeting as long as order is maintained. Public comment shall be subject to

reasonable rules established by the chairperson. This subsection shall not apply to quasi-judicial proceedings.

(i) Nothing in this section shall be construed to prohibit the parole board from meeting at correctional facilities with attendance at the meeting subject to rules regarding access and security established by the superintendent of the facility.

Sec. 3. 1 V.S.A. § 313 is amended to read:

§ 313. EXECUTIVE SESSIONS

(a) No public body described in section 312 of this title may hold an executive session from which the public is excluded, except by the affirmative vote of two-thirds of its members present in the case of any public body of state government or of a majority of its members present in the case of any public body of a municipality or other political subdivision. A motion to go into executive session shall indicate the nature of the business of the executive session, and no other matter may be considered in the executive session. Such vote shall be taken in the course of an open meeting and the result of the vote recorded in the minutes. No formal or binding action shall be taken in executive session except for actions relating to the securing of real estate options under subdivision ~~(2)~~ (b)(1) of this ~~subsection~~ section. Minutes of an executive session need not be taken, but if they are, shall not be made public subject to subsection 312(b) of this title. ~~A public body may not hold an executive session except to consider one or more of the following:~~

~~(1) Contracts, labor relations agreements with employees, arbitration, mediation, grievances, civil actions, or prosecutions by the state, where premature general public knowledge would clearly place the state, municipality, other public body, or person involved at a substantial disadvantage;~~

(b) A public body may hold an executive session only for one or more of the following purposes:

~~(2) The negotiating or securing of~~ (1) To negotiate or secure real estate purchase options;

~~(3)~~(2) ~~The~~ To consider the appointment or employment or evaluation of a public officer or employee, including discussion, interview, and evaluation of the merits of a candidate for public office or employment, provided that a final decision to hire or appoint a public officer or employee shall be made in an open meeting;

~~(4)~~(3) ~~A~~ To conduct a disciplinary or dismissal action against a public officer or employee; but nothing in this subsection shall be construed to impair

the right of such officer or employee to a public hearing if formal charges are brought;

~~(5)~~(4) ~~A~~ To consider a clear and imminent peril to the public safety;

~~(6)~~(5) ~~Discussion or consideration of~~ To discuss or consider records or documents ~~excepted~~ exempted from the access to public records provisions of ~~subsection~~ section 317~~(b)~~ of this title. Discussion or consideration of the ~~excepted~~ record or document shall not itself permit an extension of the executive session to the general subject to which the record or document pertains;

~~(7)~~(6) ~~The~~ To consider academic records or suspension or discipline of students;

~~(8)~~(7) ~~Testimony~~ To take or hear testimony from a person in a parole proceeding conducted by the parole board if public disclosure of the identity of the person could result in physical or other harm to the person;

~~(9)~~(8) ~~Information~~ 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, considered pursuant to 33 V.S.A. §§ 1998(f)(2) and 2002(c);

(9) To discuss or consider municipal or school security or emergency response measures, the disclosure of which could jeopardize public safety;

(10) Where the public body determines that premature general public knowledge would place the public body or a person involved at a substantial disadvantage for one or more of the following purposes:

(A) To consider or negotiate of contracts;

(B) To consider or negotiate labor relations agreements with employees;

(C) To conduct arbitration or mediation;

(D) To hear grievances, other than tax grievances; or

(E) To meet with an attorney to discuss pending litigation to which the public body is a party to civil actions or prosecutions.

~~(b)~~(c) Attendance in executive session shall be limited to members of the public body, and, in the discretion of the public body, its staff, clerical assistants and legal counsel, and persons who are subjects of the discussion or whose information is needed.

~~(c)~~(d) The senate and house of representatives, in exercising the power to make their own rules conferred by Chapter II of the Vermont Constitution, shall be governed by the provisions of this section in regulating the admission of the public as provided in Chapter II, § 8 of the Constitution.

Sec. 4. 1 V.S.A. § 314 is amended to read:

§ 314. PENALTY AND ENFORCEMENT

(a) A person who is a member of a public body and who knowingly and intentionally violates the provisions of this subchapter, a person who knowingly and intentionally violates the provisions of this subchapter on behalf or at the behest of a public body, or a person who knowingly and intentionally participates in the wrongful exclusion of any person or persons from any meeting for which provision is herein made, shall be guilty of a misdemeanor and shall be fined not more than $500.00.

(b) The attorney general or any person aggrieved by a violation of the provisions of this subchapter may apply to the civil division of the superior court in the county in which the violation has taken place for appropriate injunctive relief or for a declaratory judgment. Except as to cases the court considers of greater importance, proceedings before the civil division of the superior court, as authorized by this section and appeals therefrom, take precedence on the docket over all cases and shall be assigned for hearing and trial or for argument at the earliest practicable date and expedited in every way.

(c) After receipt by the public body of written notice that alleges a specific violation of this subchapter and that requests a specific cure of such violation, the public body may cure the violation, subject to the following:

(1) Upon receipt of written notice of an alleged violation of this subchapter, the public body shall have 21 calendar days to respond publicly to the alleged violation and:

(A) Acknowledge the violation of this subchapter and state an intent to cure the violation; or

(B) State that the public body has determined that no violation has occurred and that no cure is necessary.

(2) Failure of a public body to respond to a notice of alleged violation within 21 days of receipt of notice under subdivision (1) of this subsection shall be treated as a denial of the violation for purposes of enforcement of the requirements of this subchapter.

(3) Following a public body's acknowledgment of a violation under subdivision (1)(A) of this subsection, the public body shall have 14 calendar

days to cure the violation by declaring as void an action or actions taken at or resulting from a meeting in violation of this subchapter.

(4) A public body that cures a violation of this subchapter under this subsection shall not be subject to an assessment of attorney's fees and litigation costs under subsection (d) of this section.

(d) The court shall assess against a public body found to have violated the requirements of this subchapter reasonable attorney's fees and other litigation costs reasonably incurred in any case under this subchapter in which the complainant has substantially prevailed, unless the court finds that:

(1) The public body had a reasonable basis in fact and law for its position; and

(2) The public body acted in good faith. In determining whether a public body acted in good faith, the court shall consider, among other factors, whether the public body responded to a notice of an alleged violation of this subchapter in a timely manner under subsection (c) of this section.

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2011.

(Committee vote: 10-0-1)

(For text see Senate Journal 3/16 - 3/24/11)

Favorable

H. 460

An act relating to amending the charter of the city of Barre

Rep. Townsend of Randolph, for the Committee on **Government Operations,** recommends the bill ought to pass.

(Committee Vote: 9-0-2)

Senate Proposal of Amendment

H. 428

An act relating to requiring supervisory unions to perform common duties

The Senate proposes to the House to amend the bill by adding a new section to be numbered Sec. 2a to read as follows:

Sec. 2a. PUTNEY EDUCATION PROPERTY TAX LIABILITY

Notwithstanding 32 V.S.A. § 5402(c), the commissioner of education shall use the corrected education grand list values provided by the town of Putney to

the department of taxes after March 15, 2011 to calculate Putney's fiscal year 2012 education property tax liability.

(For text see House Journal 3/10 - 3/11/11)

J.R.H. 19

Joint resolution supporting the administration's efforts to examine and provide recommendations for improving and increasing the effectiveness of Vermont's state and municipal environmental protection process

The Senate proposes to the House to amend the resolution by striking all after the title and inserting in lieu thereof the following:

Whereas, our environment is the sum of everything around us, our beautiful mountains and valleys, our streams and lakes, the air we breathe and the winter's snow and summer's green grass, and

Whereas, to date, Vermont has managed to preserve many aspects of the state's environment, but this protective process could be administered more effectively and with greater certainty and transparency, and

Whereas, since 1970, Vermont's system of state and municipal environmental and land use regulation has grown and changed, resulting in overlapping laws and programs under the administrative jurisdiction of multiple state offices that do not always share the same regulatory objectives or coordinate in an optimal fashion, and

Whereas, the state of Vermont and local municipalities should be encouraging appropriate development at specific locations, and

Whereas, for example, attempts to effectively enforce water quality standards in Lake Champlain, promote a settlement pattern of compact urban and village centers surrounded by a rural, working landscape, and reduce greenhouse gas emissions have not resulted in achieving compliance with statutory goals and not infrequently have resulted in contentious disputes and litigation, and

Whereas, project developers and citizens concerned about projects often voice complaints expressing confusion about the specific permits required for a given project and objecting that the regulatory process can be expensive, daunting, and time-consuming and that it needs to be predictable, and

Whereas, Vermont must ensure that its permitting process appropriately utilizes the benefits of new technology to improve efficiency while simultaneously achieving protection of the natural environment, and

Whereas, Governor Shumlin has directed the chair of the natural resources board and the secretary of natural resources to review Vermont's

environmental and land use permitting system and to provide recommendations for improving the system and increasing its effectiveness, and

Whereas, the General Assembly continues to propose policies that improve environmental permitting and ensure that development protects Vermont's working landscape and natural environment, now therefore be it

Resolved by the Senate and House of Representatives:

That the General Assembly supports the administration's efforts to examine and provide recommendations for improving and increasing the effectiveness of Vermont's environmental protection process, and be it further

Resolved: That the General Assembly requests that the chair of the natural resources board and the secretary of natural resources, in consultation with other state permitting officials including representatives of the agencies of agriculture, food and markets, commerce and community development, transportation, and the environmental division of superior court, and municipal permitting officials, and invite public input through public meetings, the use of the Internet, and other forms of outreach, and be it further

Resolved: That the General Assembly requests that the chair of the natural resources board and the secretary of natural resources regularly meet and consult with the chairs of the House and Senate Committees on Natural Resources and Energy and the House Committee on Fish, Wildlife and Water Resources during this review process, and be it further

Resolved: That the General Assembly requests that the chair of the natural resources board and the secretary of natural resources develop recommendations intended to maintain standards assuring the environmental quality so important to Vermonters while making Vermont's land use and environmental permit process more efficient, more effective, more user-friendly, more open, more predictable, better coordinated, and quicker for applicants and citizens, and be it further

Resolved: That the General Assembly requests the chair of the natural resources board and the secretary of natural resources to report to the chairs of the House and Senate Committees on Natural Resources and Energy and the House Committee on Fish, Wildlife and Water Resources by January 15, 2012 with recommendations to meet the intent of this resolution, and be it further

Resolved: That the Secretary of State be directed to send a copy of this resolution to the chair of the natural resources board and the secretary of natural resources.

(For text see House Journal 4/28/11)

Senate Proposal of Amendment to House Proposal of Amendment

S. 77

An act relating to water testing of private wells

The Senate concurs in the House proposal of amendment, with further proposal of amendment in Sec. 4, 27 V.S.A. § 616, by striking out subsection (b) in its entirety and by relettering the remaining subsection to be alphabetically correct.

(For House Proposal of Amendment see House Journal 5/2/11 Page 1791-1794; 5/3/11 Page 1862)

S. 108

An act relating to effective strategies to reduce criminal recidivism

The Senate concurs in the House proposal of amendment with the following proposal of amendment thereto:

First: By adding a new section to be numbered Sec. 1 to read as follows:

Sec. 1. SHORT TITLE

This act may be referred to and cited as "The War on Recidivism Act."

And by renumbering the existing Sec. 1 to be Sec. 1a.

Second: In Sec. 3a, in 28 V.S.A. § 808a(c)(1), by striking out the last sentence, and in 28 V.S.A. § 808b, by striking out the last two sentences in subsection (b) and by striking subsection (e) in its entirety, and in 28 V.S.A. § 808c(a)(2), by striking out the last sentence

Third: By adding a new section to be numbered Sec. 3c to read as follows:

Sec. 3c. 28 V.S.A. §§ 808a–808d are amended to read:

§ 808a. TREATMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on treatment furlough to participate in such programs administered by the department in the community that reduce the offender's risk to reoffend or that provide reparation to the community in the form of supervised work activities.

(b) Provided the approval of the sentencing judge is first obtained, the department may place on treatment furlough an offender who has not yet served the minimum term of the sentence, who, in the department's determination, needs residential treatment services not available in a correctional facility. The services may include treatment for substance abuse

or personal violence or any other condition that the department has determined should be addressed in order to reduce the offender's risk to reoffend or cause harm to himself or herself or to others in the facility. The offender shall be released only to a hospital or residential treatment facility that provides services to the general population. The state's share of the cost of placement in such a facility, net of any private or federal participation, shall be paid pursuant to memoranda of agreement between and within state agencies reflective of their shared responsibilities to maximize the efficient and effective use of state resources. In the event that a memorandum of agreement cannot be reached, the secretary of administration shall make a final determination as to the manner in which costs will be allocated.

~~(c)(1) Except as provided in subdivision (2) of this subsection, the department, in its own discretion, may place on treatment furlough an offender who has not yet served the minimum term of his or her sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism.~~

~~(2) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(c) and boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323 shall be considered eligible misdemeanors for the sole purpose of subdivision (1) of this subsection.~~

§ 808b. HOME CONFINEMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on home confinement furlough that restricts the defendant to a preapproved place of residence continuously, except for authorized absences. Home confinement furlough shall be enforced by appropriate means of supervision, including electronic monitoring and other conditions such as limitations on alcohol, visitors, and access to firearms imposed by the court, the department, or both.

~~(b) The department, in its own discretion, may place on home confinement furlough an offender who has not yet served the minimum term of the sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism.~~

(c) A home confinement furlough shall not exceed a total of 180 days and shall require the defendant:

(1) to remain at a preapproved residence at all times except for scheduled and preapproved absences for work, school, treatment, attorney appointments, court appearances, and other obligations as the court may order; or

(2) to remain at a preapproved residence 24 hours a day on lock-down status except for medical appointments and court appearances.

(d) In determining whether a home confinement furlough sentence is appropriate and whether a place of residence is suitable for such a sentence, all of the following shall be considered:

(1) The nature of the offense with which the defendant was charged and the nature of the offense of which the defendant was convicted.

(2) The defendant's criminal history record, history of violence, medical and mental health needs, history of supervision, and risk of flight.

(3) Any risk or undue burden to other persons who reside at the proposed residence or risk to third parties or to public safety that may result from such placement.

§ 808c. REINTEGRATION FURLOUGH

(a)~~(1)~~ To prepare for reentry into the community, an offender sentenced to incarceration may be furloughed to the community up to 180 days prior to completion of the minimum sentence, at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (c) of this section. ~~Except as provided in subdivision (2) of this subsection, an~~ An offender sentenced to a minimum term of fewer than 365 days shall not be eligible for furlough under this subdivision until the offender has served at least one-half of his or her minimum term of incarceration.

~~(2) An offender sentenced to a minimum term of fewer than 365 days for an eligible misdemeanor as defined in section 808d of this title shall be eligible for furlough under this subdivision, provided the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism.~~

(b) Except as provided in subsection (d) of this section, an offender sentenced to incarceration is eligible to earn five days toward reintegration furlough, to be applied prior to the expiration of the offender's minimum term, for each month served in the correctional facility during which the offender has

complied with the case plan prepared pursuant to subsection 1(b) of this title and has obeyed all rules and regulations of the facility. Days shall be awarded only if the commissioner determines, in his or her sole discretion, that they have been earned in accordance with rules adopted by the department pursuant to subsection (c) of this section and shall in no event be awarded automatically. The commissioner's determination shall be final. Days earned under this subsection may be awarded in addition to the reintegration furlough authorized in subsection (a) of this section. The commissioner shall have the discretion to determine the frequency with which calculations under this subsection shall be made provided they are made at least as frequently as every six months.

(c) The commissioner may authorize reintegration furlough under subsections (a) and (b) of this section only if the days are awarded in accordance with rules adopted pursuant to chapter 25 of Title 3 designed to do the following:

(1) Evaluate factors such as risk of reoffense, history of violent behavior, history of compliance with community supervision, compliance with the case plan, progress in treatment programs designed to reduce criminal risk, and obedience to rules and regulations of the facility.

(2) Ensure adequate departmental supervision of the offender when furloughed into the community.

(d) The commissioner may not award days toward reintegration furlough under subsection (b) of this section if the offender is sentenced to a minimum term of incarceration in excess of five years or is incarcerated for a conviction of one or more of the following crimes:

(1) Arson causing death as defined in 13 V.S.A. § 501;

(2) Assault and robbery with a dangerous weapon as defined in 13 V.S.A. § 608(b);

(3) Assault and robbery causing bodily injury as defined in 13 V.S.A. § 608(c);

(4) Aggravated assault as defined in 13 V.S.A. § 1024;

(5) Murder as defined in 13 V.S.A. § 2301;

(6) Manslaughter as defined in 13 V.S.A. § 2304;

(7) Kidnapping as defined in 13 V.S.A. § 2405;

(8) Unlawful restraint as defined in 13 V.S.A. §§ 2406 and 2407;

(9) Maiming as defined in 13 V.S.A. § 2701;

(10) Sexual assault as defined in 13 V.S.A. § 3252(a)(1) or (2);

(11) Aggravated sexual assault as defined in 13 V.S.A. § 3253;

(12) Burglary into an occupied dwelling as defined in 13 V.S.A. § 1201(c); or

(13) Lewd or lascivious conduct with a child as defined in 13 V.S.A. § 2602.

(e) An offender incarcerated for driving while under the influence of alcohol under 23 V.S.A. § 1210(d) or (e) may be furloughed to the community up to 180 days prior to completion of the minimum sentence at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (d) of this section, provided that an offender sentenced to a minimum term of fewer than 270 days shall not be eligible for furlough under this subsection until the offender has served at least 90 days of his or her minimum term of incarceration and provided that the commissioner uses electronic equipment to monitor the offender's location and blood alcohol level continually, or other equipment such as an alcohol ignition interlock system, or both.

(f) Prior to release under this section, the department shall screen and, if appropriate, assess each felony drug and property offender for substance abuse treatment needs using an assessment tool designed to assess the suitability of a broad range of treatment services, and it shall use the results of this assessment in preparing a reentry plan. The department shall attempt to identify all necessary services in the reentry plan and work with the offender to make connections to necessary services prior to release so that the offender can begin receiving services immediately upon release.

~~§ 808d. DEFINITION; ELIGIBLE MISDEMEANOR; FURLOUGH AT THE DISCRETION OF THE DEPARTMENT~~

~~For purposes of sections 808a–808c of this title, "eligible misdemeanor" means a misdemeanor crime that is not one of the following crimes:~~

~~(1) Cruelty to animals involving death or torture as defined in 13 V.S.A. § 352(1) and (2).~~

~~(2) Simple assault as defined in 13 V.S.A. § 1023(a)(1).~~

~~(3) Simple assault with a deadly weapon as defined in 13 V.S.A. § 1023(a)(2).~~

~~(4) Simple assault of a law enforcement officer, firefighter, emergency medical personnel member, or health care worker while he or she is performing a lawful duty as defined in 13 V.S.A. § 1023(a)(1).~~

~~(5) Reckless endangerment as defined in 13 V.S.A. § 1025.~~

~~(6) Simple assault of a correctional officer as defined in 13 V.S.A. § 1028a(a)(1).~~

~~(7) Simple assault of a correctional officer as defined in 13 V.S.A. § 1028a(b).~~

~~(8) Violation of an abuse prevention order, first offense, as defined in 13 V.S.A. § 1030.~~

~~(9) Stalking as defined in 13 V.S.A. § 1062.~~

~~(10) Domestic assault as defined in 13 V.S.A. § 1042.~~

~~(11) Cruelty to children over 10 years of age by one over 16 years of age as defined in 13 V.S.A. § 1304.~~

~~(12) Cruelty by a person having custody of another as defined in 13 V.S.A. § 1305.~~

~~(13) Abuse, neglect, or exploitation of a vulnerable adult as provided in 13 V.S.A. §§ 1376-1381.~~

~~(14) Hate-motivated crime as defined in 13 V.S.A. § 1455 or burning of a cross or other religious symbol as defined in 13 V.S.A. § 1456.~~

~~(15) Voyeurism as defined in 13 V.S.A. § 2605.~~

~~(16) Prohibited acts as defined in 13 V.S.A. § 2632.~~

~~(17) Obscenity as defined in chapter 63 of Title 13.~~

~~(18) Possession of child pornography as defined in 13 V.S.A. § 2827.~~

~~(19) Possession of a dangerous or deadly weapon in a school bus or school building as defined in 13 V.S.A. § 4004(a).~~

~~(20) Possession of a dangerous or deadly weapon on school property with intent to injure as defined in 13 V.S.A. § 4004(b).~~

~~(21) Possession of a firearm in court as defined in 13 V.S.A. § 4016(b)(1).~~

~~(22) Possession of a dangerous or deadly weapon in court as defined in 13 V.S.A. § 4016(b)(2).~~

~~(23) Failure to comply with the sex offender registry as defined in 13 V.S.A. § 5409.~~

~~(24) Careless or negligent operation of a motor vehicle resulting in serious bodily injury or death as defined in 23 V.S.A. § 1091(b).~~

~~(25) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(c).~~

~~(26) Boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323.~~

Fourth: In Sec. 4(b) , by adding a new subdivision (1) to read as follows:

(1) a former member of either the house committee on judiciary or the senate committee on judiciary appointed jointly by the speaker of the house and the senate committee on committees;

And by renumbering the existing subdivisions to be numerically correct.

Fifth: By striking out Sec. 6 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 6 to read as follows:

Sec. 6. PLACE-BASED STRATEGIES TO REDUCE RECIDIVISM

Some Vermont communities have a disproportionate number of residents who have been through the correctional system. Corrections and law enforcement officials are increasingly interested in sharing information that can lead to more effective resource allocation and coordination to reduce recidivism in communities with a high number of persons under the supervision of the department of corrections. Therefore, the department of corrections shall work with the Vermont League of Cities and Towns, the association of the chiefs of police, and other local law enforcement agencies to develop strategies that coordinate services provided by state, local, and nonprofit entities to persons in the custody of the commissioner of corrections and that enhance public safety. The department shall keep the joint committee on corrections oversight, the senate and house committees on judiciary, and the house committee on corrections and institutions informed of the groups' efforts on this matter.

Sixth: By striking out Sec. 10 in its entirety and inserting in lieu thereof a new Sec. 10 to read as follows:

Sec. 10. RECIDIVISM REDUCTION STUDY, EVALUATION OF WORK CAMPS; VERMONT CENTER FOR JUSTICE RESEARCH

(a) Research suggests that short, swift, and certain sanctions may be effective at reducing recidivism among certain groups of offenders. Programs that employ strategies such as those of Georgia's Probation Options Management (POM) and Hawaii's Opportunity Probation with Enforcement (HOPE) have shown reduced rates of recidivism, drug use, missed appointments with probation officers, and probation revocations for program participants versus rates for control group participants. The general assembly and representatives of all statewide criminal justice agencies have been working to develop an innovative pilot project to reduce recidivism based on such a model, but more information is needed to ascertain how these principles

can be applied in Vermont to achieve clearly stated goals set forth by the joint committee on corrections oversight with respect to reductions in recidivism.

(b) The Vermont center for justice research has been engaged in discussions with stakeholders regarding the employment of strategies used in POM and HOPE and specializes in collecting and analyzing criminal and juvenile justice information and providing technical assistance to state and local criminal justice agencies.

(c) The center shall evaluate innovative programs and initiatives, including local programs and prison-based initiatives, best practices, and contemporary research regarding assessments of programmatic alternatives and pilot projects relating to reducing recidivism in the criminal justice system. The center's research shall focus on evidence-based initiatives related to swift and sure delivery of sanctions and effective interventions for offenders. The center shall make its recommendations to the senate and house committees on judiciary and the joint committee on corrections oversight by December 1, 2011.

Seventh: By striking out Sec. 11 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 11 to read as follows:

Sec. 11. DEPARTMENT OF CORRECTIONS; REDUCTION IN ADMINISTRATIVE BURDEN ON PROBATION AND PAROLE OFFICERS

(a) The general assembly finds that the current burden of administrative paperwork on probation and parole officers impedes their ability to supervise offenders in the community. Additionally, some paperwork, such as the offender responsibility plan, has diverged from its laudable original purpose and become unnecessarily time-consuming for staff and of little value to offenders. Rather than spending time in the field, visiting offenders at home, and checking on employment and housing, officers are forced to spend an inordinate amount of time at their desks filling out paperwork.

(b) To improve community supervision by getting more probation and parole officers out on the streets, the department of corrections shall undertake a review of the administrative burden placed on field officers and shall reduce paperwork handled by these officers by 50 percent as of July 1, 2012. In its efforts, the department shall strongly consider the use of technology to assist field officers and the efficiency of providing portable devices so that officers would not need to leave the field to file reports. The department shall report to the joint committee on corrections oversight by November 1, 2011 regarding its progress in achieving the goal of a 50-percent reduction in paperwork, and shall continue to keep the joint committee, the senate and house committees on

judiciary, and the house committee on corrections and institutions informed of their efforts on this matter.

Eighth: By adding a new section to be numbered Sec. 11a to read as follows:

Sec. 11a. 28 V.S.A. § 122 is added to read:

§ 122. CONTRACTING FOR PROGRAMMING AND SERVICES

For the purpose of securing programming and services for offenders, the department of corrections shall publicly advertise or invite three or more bids. The contract for any such programming and services shall be awarded to one of the three lowest responsible bidders, conforming to specification, with consideration being given to the time required for provision of services, the purpose for which it is required, competency and responsibility of bidder, and his or her ability to render satisfactory services; but the commissioner with the approval of the secretary of human services shall have the right to reject any and all bids and to invite other bids.

Ninth: By striking out Sec. 13 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 13 to read as follows:

Sec. 13. EFFECTIVE DATES

(a) Sec. 2 of this act shall take effect on passage.

(b) Sec. 3c shall take effect on April 1, 2013.

(c) The remainder of the act shall take effect on July 1, 2011.

(For House Proposal of Amendment see House Journal April 28, 2011)

Amendment to be offered by Rep. Emmons of Springfield to S. 108

Rep. Emmons of Springfield moves that the House concur in the Senate proposal of amendment in the first, and fourth through ninth instances of amendment and be further amended by adding a Sec. 3c to read as follows:

Sec. 3c. 28 V.S.A. §§ 808a–808c are amended to read:

§ 808a. TREATMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on treatment furlough to participate in such programs administered by the department in the community that reduce the offender's risk to reoffend or that provide reparation to the community in the form of supervised work activities.

(b) Provided the approval of the sentencing judge is first obtained, the department may place on treatment furlough an offender who has not yet

served the minimum term of the sentence, who, in the department's determination, needs residential treatment services not available in a correctional facility. The services may include treatment for substance abuse or personal violence or any other condition that the department has determined should be addressed in order to reduce the offender's risk to reoffend or cause harm to himself or herself or to others in the facility. The offender shall be released only to a hospital or residential treatment facility that provides services to the general population. The state's share of the cost of placement in such a facility, net of any private or federal participation, shall be paid pursuant to memoranda of agreement between and within state agencies reflective of their shared responsibilities to maximize the efficient and effective use of state resources. In the event that a memorandum of agreement cannot be reached, the secretary of administration shall make a final determination as to the manner in which costs will be allocated.

(c)(1) Except as provided in subdivision (2) of this subsection, the department, in its own discretion, may place on treatment furlough an offender who has not yet served the minimum term of his or her sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism. ~~An offender shall not be eligible for treatment furlough under this subdivision, if, at the time of sentencing, the court makes written findings that treatment furlough is not likely to ensure public safety or victim safety, or is not likely to reduce the risk of recidivism for the offender.~~

(2) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(c) and boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323 shall be considered eligible misdemeanors for the sole purpose of subdivision (1) of this subsection.

§ 808b. HOME CONFINEMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on home confinement furlough that restricts the defendant to a preapproved place of residence continuously, except for authorized absences. Home confinement furlough shall be enforced by appropriate means of supervision, including electronic monitoring and other conditions such as limitations on alcohol, visitors, and access to firearms imposed by the court, the department, or both.

(b) The department, in its own discretion, may place on home confinement furlough an offender who has not yet served the minimum term of the sentence

for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism. ~~An offender shall not be eligible for home confinement furlough under this subsection, if, at the time of sentencing, the court makes written findings that home confinement furlough is not likely to ensure public safety or victim safety, or is not likely to reduce the risk of recidivism for the offender, or the criteria for a home confinement furlough set forth in this section have not been met. Such a finding shall be set forth as a condition on the mittimus.~~

(c) A home confinement furlough shall not exceed a total of 180 days and shall require the defendant:

(1) to remain at a preapproved residence at all times except for scheduled and preapproved absences for work, school, treatment, attorney appointments, court appearances, and other obligations as the court may order; or

(2) to remain at a preapproved residence 24 hours a day on lock-down status except for medical appointments and court appearances.

(d) In determining whether a home confinement furlough sentence is appropriate and whether a place of residence is suitable for such a sentence, all of the following shall be considered:

(1) The nature of the offense with which the defendant was charged and the nature of the offense of which the defendant was convicted.

(2) The defendant's criminal history record, history of violence, medical and mental health needs, history of supervision, and risk of flight.

(3) Any risk or undue burden to other persons who reside at the proposed residence or risk to third parties or to public safety that may result from such placement.

~~(e) At the request of the department, the court may vacate a condition of a mittimus prohibiting home confinement issued under subsection (b) of this section, based upon a showing of changed circumstances by the department.~~

§ 808c. REINTEGRATION FURLOUGH

(a)(1) To prepare for reentry into the community, an offender sentenced to incarceration may be furloughed to the community up to 180 days prior to completion of the minimum sentence, at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (c) of this section. Except as provided in subdivision (2) of this subsection, an offender sentenced

to a minimum term of fewer than 365 days shall not be eligible for furlough under this subdivision until the offender has served at least one-half of his or her minimum term of incarceration.

(2) An offender sentenced to a minimum term of fewer than 365 days for an eligible misdemeanor as defined in section 808d of this title shall be eligible for furlough under this subdivision, provided the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism. ~~An offender shall not be eligible for a reintegration furlough under this subdivision if, at the time of sentencing, the court makes written findings that it is not likely to ensure public safety or victim safety, or is not likely to reduce the risk of recidivism for the offender.~~

(b) Except as provided in subsection (d) of this section, an offender sentenced to incarceration is eligible to earn five days toward reintegration furlough, to be applied prior to the expiration of the offender's minimum term, for each month served in the correctional facility during which the offender has complied with the case plan prepared pursuant to subsection 1(b) of this title and has obeyed all rules and regulations of the facility. Days shall be awarded only if the commissioner determines, in his or her sole discretion, that they have been earned in accordance with rules adopted by the department pursuant to subsection (c) of this section and shall in no event be awarded automatically. The commissioner's determination shall be final. Days earned under this subsection may be awarded in addition to the reintegration furlough authorized in subsection (a) of this section. The commissioner shall have the discretion to determine the frequency with which calculations under this subsection shall be made provided they are made at least as frequently as every six months.

(c) The commissioner may authorize reintegration furlough under subsections (a) and (b) of this section only if the days are awarded in accordance with rules adopted pursuant to chapter 25 of Title 3 designed to do the following:

(1) Evaluate factors such as risk of reoffense, history of violent behavior, history of compliance with community supervision, compliance with the case plan, progress in treatment programs designed to reduce criminal risk, and obedience to rules and regulations of the facility.

(2) Ensure adequate departmental supervision of the offender when furloughed into the community.

(d) The commissioner may not award days toward reintegration furlough under subsection (b) of this section if the offender is sentenced to a minimum

term of incarceration in excess of five years or is incarcerated for a conviction of one or more of the following crimes:

(1) Arson causing death as defined in 13 V.S.A. § 501;

(2) Assault and robbery with a dangerous weapon as defined in 13 V.S.A. § 608(b);

(3) Assault and robbery causing bodily injury as defined in 13 V.S.A. § 608(c);

(4) Aggravated assault as defined in 13 V.S.A. § 1024;

(5) Murder as defined in 13 V.S.A. § 2301;

(6) Manslaughter as defined in 13 V.S.A. § 2304;

(7) Kidnapping as defined in 13 V.S.A. § 2405;

(8) Unlawful restraint as defined in 13 V.S.A. §§ 2406 and 2407;

(9) Maiming as defined in 13 V.S.A. § 2701;

(10) Sexual assault as defined in 13 V.S.A. § 3252(a)(1) or (2);

(11) Aggravated sexual assault as defined in 13 V.S.A. § 3253;

(12) Burglary into an occupied dwelling as defined in 13 V.S.A. § 1201(c); or

(13) Lewd or lascivious conduct with a child as defined in 13 V.S.A. § 2602.

(e) An offender incarcerated for driving while under the influence of alcohol under 23 V.S.A. § 1210(d) or (e) may be furloughed to the community up to 180 days prior to completion of the minimum sentence at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (d) of this section, provided that an offender sentenced to a minimum term of fewer than 270 days shall not be eligible for furlough under this subsection until the offender has served at least 90 days of his or her minimum term of incarceration and provided that the commissioner uses electronic equipment to monitor the offender's location and blood alcohol level continually, or other equipment such as an alcohol ignition interlock system, or both.

(f) Prior to release under this section, the department shall screen and, if appropriate, assess each felony drug and property offender for substance abuse treatment needs using an assessment tool designed to assess the suitability of a broad range of treatment services, and it shall use the results of this assessment in preparing a reentry plan. The department shall attempt to identify all

necessary services in the reentry plan and work with the offender to make connections to necessary services prior to release so that the offender can begin receiving services immediately upon release.

Report of Committee of Conference

H. 38

An act relating to ensuring educational continuity for children of military families.

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

The Committee of Conference to which were referred the disagreeing votes of the two Houses upon House Bill entitled:

H. 38 An act relating to ensuring educational continuity for children of military families

Respectfully reports that it has met and considered the same and recommends that the House accede to the Senate proposals of amendment, and that the bill be further amended:

First: In Sec. 1, 16 V.S.A. § 806l, subsection A, subdivision 1, in the second sentence, by striking the words "provisions of this compact and the rules promulgated hereunder" and inserting in lieu thereof the words "rules promulgated under this compact"

Second: By striking out Sec. 2 in its entirety and inserting in lieu thereof a new Sec. 2 to read:

Sec. 2. 16 V.S.A. § 164(20) is added to read:

(20) Pursuant to section 806g of this title, constitute the State Council for the Interstate Compact on Educational Opportunity for Military Children and appoint to the council a compact commissioner and military family education liaison, who may be the same person. The board may appoint additional members.

KEVIN J. MULLIN
ROBERT A. STARR
VIRGINIA V. LYONS
Committee on the part of the Senate

PHILIP PELTZ
BRIAN A. CAMPION
PATTI J. LEWIS
Committee on the part of the House

S. 100

An act relating to making miscellaneous amendments to education laws

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

The Committee of Conference to which were referred the disagreeing votes of the two Houses upon Senate Bill entitled:

S. 100 An act relating to making miscellaneous amendments to education laws

Respectfully report that they have met and considered the same and recommend that the Senate accede to the House proposal of amendment and the House proposal be further amended as follows:

First: By striking out Sec. 27 (special education information management system) in its entirety and inserting in lieu thereof the following: "Sec. 27. [Deleted.]"

Second: In Sec. 32, 16 V.S.A. § 562, subdivision (11), by striking out the number "$200,000.00" and inserting in lieu thereof the number "$350,000.00"

Third: Immediately prior to Sec. 39, by inserting a reader assistance note to read: "* * * Student Athletes; Concussions * * *"

Fourth: In Sec. 40, 16 V.S.A. § 1431, in subsection (a), by striking out subdivision (4) in its entirety

Fifth: In Sec. 40, 16 V.S.A. § 1431, in subsection (b), by striking out the words "and the Vermont School Boards Association" and also in subsection (b), by striking out the words "those associations" and inserting in lieu thereof the words "that association"

Sixth: In Sec. 40, 16 V.S.A. § 1431, by striking out subsection (d) in its entirety and inserting in lieu thereof a new subsection (d) to read:

(d) Participation in athletic activity. A coach shall not permit a youth athlete to train or compete with a school athletic team if the athlete has been removed or prohibited from participating in a training session or competition associated with the school athletic team due to symptoms of a concussion or other head injury until the athlete has been examined by and received written permission to participate in athletic activities from a health care provider licensed pursuant to Title 26 and trained in the evaluation and management of concussions and other head injuries.

COMMITTEE ON THE PART OF THE SENATE	COMMITTEE ON THE PART OF THE HOUSE
SEN. KEVIN J. MULLIN	REP. HOWARD T. CRAWFORD
SEN. SARA BRANON KITTELL	REP. JOHANNAH L. DONOVAN
SEN. PHILIP E. BARUTH	REP. GARY L. GILBERT

Consent Calendar

Concurrent Resolutions

The following concurrent resolutions have been introduced for approval by the Senate and House and will be adopted automatically unless a Senator or Representative requests floor consideration before the end of the session of the next legislative day. Requests for floor consideration in either chamber should be communicated to the Secretary's office and/or the House Clerk's office, respectively. For text of resolutions, see Addendum to House Calendar and Senate Calendar.

H.C.R. 171

House concurrent resolution honoring Robert Howe for his 41 years of dedicated public service on behalf of the state of Vermont

H.C.R. 172

House concurrent resolution congratulating Claude Mumbere on winning the 2011 Vermont Poetry Out Loud: National Recitation Contest

H.C.R. 173

House concurrent resolution honoring former Representative Neal Hoag for his dedicated public service on behalf of the citizens of Woodford

H.C.R. 174

House concurrent resolution congratulating Vergennes Union Elementary School on being named a 2011 Fit & Healthy Kids School Wellness Award recognition-level winner

H.C.R. 175

House concurrent resolution honoring Taylor Coppenrath on his continuing success in European professional basketball

H.C.R. 176

House concurrent resolution congratulating the town of Bridport on the 250th anniversary of its municipal incorporation

H.C.R. 177

House concurrent resolution congratulating the town of Weybridge on its 250th birthday

H.C.R. 178

House concurrent resolution commemorating the 250th anniversary of the incorporation of the town of New Haven

H.C.R. 179

House concurrent resolution congratulating IBM on its centennial anniversary

H.C.R. 180

House concurrent resolution recognizing the Vermont Mountain Bike Association's important role in outdoor nonmotorized recreation

H.C.R. 181

House concurrent resolution congratulating the town of Woodstock on its 250th anniversary

H.C.R. 182

House concurrent resolution congratulating the Long Trail School on its 35th anniversary

H.C.R. 183

House concurrent resolution congratulating Kaitlin Leroux-Eastman on being named the 2011 Vermont Boys & Girls Clubs Youth of the Year

H.C.R. 184

House concurrent resolution honoring the inspiring family of Felipe and Elena Ixcot and the Benedictine Brothers of the Weston Priory who offered them refuge and love for a quarter of a century

H.C.R. 185

House concurrent resolution congratulating the Northfield Elementary School Destination ImagiNation Vermont state championship team

H.C.R. 186

House concurrent resolution commemorating World Veterinary Year and the 250th anniversary of the veterinary medical profession

H.C.R. 187

House concurrent resolution celebrating the historic Park-McCullough House as a cultural treasure in the town of Bennington

H.C.R. 188

House concurrent resolution honoring Elise A. Guyette on the publication of *Discovering Black Vermont: African American Farmers in Hinesburgh, Vermont, 1790–1890*

H.C.R. 189

House concurrent resolution commemorating the 250th anniversary of the town of Tunbridge

H.C.R. 190

House concurrent resolution designating June 18, 2011 as Founders Day in Bennington

H.C.R. 191

House concurrent resolution congratulating Matt Martin on his being named Boys & Girls Clubs of Brattleboro Youth of the Year

H.C.R. 192

House concurrent resolution congratulating the 2011 Rice Memorial High School Green Knights Division I championship boys' basketball team

H.C.R. 193

House concurrent resolution commemorating National Train Day 2011 and the 40th anniversary of Amtrak

S.C.R. 20

Senate concurrent resolution congratulating the South Burlington Land Trust on winning the Green Mountain Environmental Leadership Awards' 2011 Courage in Leadership Award

S.C.R. 21

Senate concurrent resolution congratulating the Lake Champlain Committee on winning the Green Mountain Environmental Leadership Awards' 2011 Citizen Science Award

S.C.R. 22

Senate concurrent resolution congratulating Freeaire Refrigeration of Waitsfield and its president, Richard Travers, on winning the Green Mountain Environmental Leadership Awards' 2011 What a Great Idea! Award

S.C.R. 23

Senate concurrent resolution congratulating Judge Franklin Swift Billings, Jr., and Mrs. Pauline Richardson Gillingham Billings on their 60th wedding anniversary

S.C.R. 24

Senate concurrent resolution honoring Paolo Rovetto for his amazing disc jockeying achievements