House Calendar

Thursday, February 23, 2012

52nd DAY OF THE ADJOURNED SESSION

House Convenes at 9:30 A.M.

TABLE OF CONTENTS

Page No.

NOTICE CALENDAR

Favorable with Amendment

Consent Calendar

ORDERS OF THE DAY

ACTION CALENDAR

Third Reading

H. 753

An act relating to encouraging school districts and supervisory unions to provide services cooperatively or to consolidate governance structures

H. 761

An act relating to executive branch fees, including motor vehicle and fish and wildlife fees

Favorable with Amendment

H. 556

An act relating to creating a private activity bond advisory committee

Rep. Dickinson of St. Albans Town, 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. 32 V.S.A. § 993 is added to read:

§ 993. ADVISORY COMMITTEE

(a)(1) Creation; composition. There is created a private activity bond advisory committee, which shall consist of the following members:

(A) the state treasurer or his or her designee;

(B) the secretary of administration or his or her designee;

(C) the secretary of commerce and community development or his or her designee;

(D) two members who shall be representatives of the public, appointed by the governor.

(2) Each public representative shall serve for a two-year term beginning February 1, or until his or her successor is appointed. The terms of the public representatives shall be staggered so that only one member's term expires in each year.

(3) The state treasurer or designee shall serve as chair of the committee.

(4) The office of the state treasurer shall provide administrative support to the committee.

(5) Public representatives may receive reimbursement of expenses and per diem compensation pursuant to section 1010 of this title.

(b) Committee charge.

(1) The committee shall survey the expected need for private activity bond allocations among constituted and eligible issuing authorities empowered to issue such bonds on an annual basis.

(2)(A) The committee shall develop guidelines for allocation of private activity bonding capacity designed to maximize the availability of tax exempt financing among various sectors of the Vermont economy with a focus on economic development, housing, education, redevelopment, public works, energy, waste management, waste and recycling collection, transportation, and other activities that the committee determines will benefit the citizens of Vermont.

(B) The guidelines should support efforts and entities that increase the number of good-paying jobs in the state, promote economic development, support affordable housing, and affordable access to postsecondary education and training, and encourage the use of Vermont's human and natural resources in endeavors that maximize Vermont's comparative economic advantages, and be flexible enough to include new and innovative uses of private activity bonds, consistent with federal regulations and the Internal Revenue Code.

(3) The committee shall meet at least annually and shall hold at least one public hearing prior to submitting its recommendations to the emergency board. The committee shall further submit its recommendations in an annual report of its activities to the governor and the general assembly.

(4) On or before December 1 of each year, the committee shall make recommendations to the emergency board on the allocation, including any amounts reserved for contingency allocations, of the state's private activity bond ceiling for the following calendar year to and among the constituted issuing authorities empowered to issue such bonds.

(5) On its own initiative, at the request of the governor or at the request of the emergency board, the committee may make recommendations to the governor or emergency board concerning assignments or reallocation of any unused portion of the ceiling subsequent to the emergency board's initial allocation in a given year.

Sec. 2. TRANSITION OF PRIVATE ACTIVITY BOND ADVISORY COMMITTEE

Notwithstanding any provision of law to the contrary, on the effective date of this act, the private activity bond advisory committee created in Executive

Order 14-11 shall become for all lawful purposes the private activity bond committee authorized in Sec. 1 of this act; provided, however, that the term of the public representative first appointed by the governor pursuant to EO 14-11 shall end February 1, 2013, and the term of the public representative appointed second by the governor shall end February 1, 2014.

Sec. 3. 10 V.S.A. § 219(d) is amended to read:

(d) In order to assure the maintenance of the debt service reserve requirement in each debt service reserve fund established by the authority, there may be appropriated annually and paid to the authority for deposit in each such fund, such sum as shall be certified by the chair of the authority, to the governor or the governor-elect, the president of the senate, and the speaker of the house, as is necessary to restore each such debt service reserve fund to an amount equal to the debt service reserve requirement for such fund. The chair shall annually, on or about February 1, make, execute, and deliver to the governor or the governor-elect, the president of the senate, and the speaker of the house, a certificate stating the sum required to restore each such debt service reserve fund to the amount aforesaid, and the sum so certified may be appropriated, and if appropriated, shall be paid to the authority during the then current state fiscal year. The principal amount of bonds or notes

outstanding at any one time and secured in whole or in part by a debt service reserve fund to which state funds may be appropriated pursuant to this subsection shall not exceed ~~$100,000,000.00~~ $115,000,000.00, provided that the foregoing shall not impair the obligation of any contract or contracts entered into by the authority in contravention of the Constitution of the United States.

Sec. 4. 10 V.S.A. § 262(5) is amended to read:

(5) The principal obligation of the authority's mortgage does not exceed ~~$1,300,000.00~~ $1,500,000.00 which may be secured by land and buildings or by machinery and equipment, or both; unless an integral element of the project consists of the generation of heat or electricity employing biomass, geothermal, methane, solar, or wind energy resources to be primarily consumed at the project, in which case the principal obligation of the authority's mortgage does not exceed $2,000,000.00, which may be secured by land and by buildings, or machinery and equipment, or both; such principal obligation does not exceed 40 percent of the cost of the project; and the mortgagor is able to obtain financing for the balance of the cost of the project from other sources as provided in the following section;

Sec. 5. 10 V.S.A. § 216(15) is amended to read:

(15) To delegate to loan officers the power to review, approve and make loans under this chapter, subject to the approval of the manager, and to disburse funds on such loans, subject to the approval of the manager, provided that such loans do not exceed ~~$250,000.00~~ $350,000.00 in aggregate amount for any industrial loan for any three-year period for any particular individual, partnership, corporation, or other entity or related entity, or do not exceed ~~$200,000.00~~ $350,000.00 in aggregate amount if the loan is guaranteed by the Farm Services Agency, or its successor agency, or ~~$150,000.00~~ $300,000.00 in aggregate amount if the loan is not guaranteed by the Farm Services Agency, or its successor agency, for any agricultural loan for any three-year period for any particular individual, partnership, corporation, or other entity or related entity. No funds may be disbursed for any loan approved under this provision, except for any agricultural loan referenced above in an amount not to exceed $50,000.00, and no rejection of a loan by a loan officer pursuant to this subdivision shall become final, until three working days after the members of the authority are notified by facsimile, electronic mail, or overnight delivery mailed or sent on the day of approval or rejection, of the intention to approve or reject such loan. If any member objects within that three-day period, the approval or rejection will be held for reconsideration by the members of the authority at its next duly scheduled meeting;

Sec. 6. 10 V.S.A. § 221(a) is amended to read:

(a) Upon application of the proposed mortgagee, the authority may insure mortgage payments required to repay loans made by the mortgagee for the purpose of financing the costs of a project, upon such terms and conditions as the authority may prescribe; provided, however, that the total principal obligations of all mortgages insured under this subsection and under subsection (c) of this section outstanding at any one time shall not exceed ~~$9,000,000.00~~ $3,500,000.00. Before insuring any mortgage payments hereunder, the authority shall determine and incorporate each of the findings established by this subsection in its minutes. Such findings, when adopted by the authority shall be conclusive:

* * *

Sec. 7. EFFECTIVE DATE

This act shall take effect on passage.

(Committee Vote: 10-0-1)

Rep. O'Brien of Richmond, for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committee on **Commerce and Economic Development.**

(Committee Vote: 8-0-3)

H. 559

An act relating to health care reform implementation

Rep. Fisher of Lincoln, for the Committee on **Health Care,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 33 V.S.A. § 1802 is amended to read:

§ 1802. DEFINITIONS

For purposes of this subchapter:

* * *

(5) "Qualified employer" ~~means an employer that~~:

(A) means an entity which employed an average of not more than 50 employees on working days during the preceding calendar year and which:

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

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

(B) on and after January 1, 2016, shall include an entity which:

(i) employed an average of not more than 100 employees on working days during the preceding calendar year; and

(ii) meets the requirements of subdivisions (A)(i) and (A)(ii) of this subdivision (5).

(C) on and after January 1, 2017, shall include all employers meeting the requirements of subdivisions (A)(i) and (ii) of this subdivision (5), regardless of size.

* * *

Sec. 2. 33 V.S.A. § 1804 is amended to read:

§ 1804. QUALIFIED EMPLOYERS

~~[Reserved.]~~

(a)(1) Until January 1, 2016, a qualified employer shall be an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employed at least one and no more than 50 employees, and the term "qualified employer" includes self-employed persons. Calculation of the

number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week.

(2) An employer with 50 or fewer employees that offers a qualified health benefit plan to its employees through the Vermont health benefit exchange may continue to participate in the exchange even if the employer's size grows beyond 50 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

(b)(1) From January 1, 2016 until January 1, 2017, a qualified employer shall be an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employed at least one and no more than 100 employees, and the term "qualified employer" includes self-employed persons. Calculation of the number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week.

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

(c) On and after January 1, 2017, a qualified employer shall be an employer of any size which elects to make all of its full-time employees eligible for one or more qualified health plans offered in the Vermont health benefit exchange, and the term "qualified employer" includes self-employed persons. A full-time employee shall be an employee who works more than 30 hours per week.

Sec. 2a. 33 V.S.A. § 1806(b) is amended to read:

(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. Said plans may include child-only policies or family policies. If permitted under federal law, a qualified health benefit plan offered in conjunction with a stand-alone dental plan providing pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act shall be deemed to meet the requirements of this subsection.

(2) At least the ~~silver~~ bronze 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.

* * *

Sec. 2b. 33 V.S.A. § 1807(b) is amended to read:

(b) Navigators shall have the following duties:

* * *

(7) Provide information about and facilitate employers' establishment of cafeteria or premium-only plans under Section 125 of the Internal Revenue Code that allow employees to pay for health insurance premiums with pretax dollars.

Sec. 2c. EXCHANGE OPTIONS

In approving benefit packages for the Vermont health benefit exchange pursuant to 18 V.S.A. § 9375(b)(7), the Green Mountain Care board shall approve a full range of cost-sharing structures for each level of actuarial value. To the extent permitted under federal law, the board shall also allow health insurers to establish rewards, premium discounts, split benefit designs, rebates, or to otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by an insured to programs of health promotion and disease prevention pursuant to 33 V.S.A. § 1811(f)(2)(B).

Sec. 3. 33 V.S.A. § 1811 is added to read:

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

(a) As used in this section:

(1) "Health benefit plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health

maintenance organization health benefit plan offered through the Vermont health benefit exchange and issued to an individual or to an employee of a small employer. The 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 in which 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.

(2) "Registered carrier" means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a health benefit plan and who has a registration in effect with the commissioner of banking, insurance, securities, and health care administration as required by this section.

(3)(A) Until January 1, 2016, "small employer" means an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 50 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. An employer may continue to participate in the exchange even if the employer's size grows beyond 50 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

(B) Beginning on January 1, 2016, "small employer" means an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 100 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. An employer may continue to participate in the exchange even if the employer's size grows beyond 100 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

(b) No person may provide a health benefit plan to an individual or small employer unless the plan is offered through the Vermont health benefit exchange and complies with the provisions of this subchapter.

(c) No person may provide a health benefit plan to an individual or small employer unless such person is a registered carrier. The commissioner of banking, insurance, securities, and health care administration shall establish, by rule, the minimum financial, marketing, service and other requirements for registration. Such registration shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(d) A registered carrier shall guarantee acceptance of all individuals, small employers, and employees of small employers, and each dependent of such individuals and employees, for any health benefit plan offered by the carrier.

(e) A registered carrier shall offer a health benefit plan rate structure which at least differentiates between single person, two person, and family rates.

(f)(1) A registered carrier shall use a community rating method acceptable to the commissioner of banking, insurance, securities, and health care administration for determining premiums for health benefit plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating individuals, small employers, or employees of small employers, or the dependents of such individuals or employees:

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

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

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

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

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

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

(iii) provide that the reward under the program is available to all similarly situated individuals and shall comply with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act of 1996; and

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

(C) The commissioner's rules shall include:

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

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

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

(D) The commissioner may require a registered carrier to identify that percentage of a requested premium increase which is attributed to the

following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall occur at the time a rate increase is sought and shall be in the manner and form directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

(g) A registered carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this section. The requirements for certification shall be as the commissioner prescribes by rule.

(h) A registered carrier shall provide, on forms prescribed by the commissioner, full disclosure to a small employer of all premium rates and any risk classification formulas or factors prior to acceptance of a plan by the small employer.

(i) A registered carrier shall guarantee the rates on a health benefit plan for a minimum of 12 months.

(j) The commissioner shall disapprove any rates filed by any registered carrier, whether initial or revised, for insurance policies unless the anticipated medical loss ratios for the entire period for which rates are computed are at least 80 percent, as required by the Patient Protection and Affordable Care Act (Public Law 111-148).

(k) The guaranteed acceptance provision of subsection (d) of this section shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

Sec. 4. 8 V.S.A. § 4080g is added to read:

§ 4080g. GRANDFATHERED PLANS

(a) Application. Notwithstanding the provisions of 33 V.S.A. § 1811, on and after January 1, 2014, the provisions of this section shall apply to an individual, small group, or association plan that qualifies as a grandfathered health plan under Section 1251 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) ("Affordable Care Act").

In the event that a plan no longer qualifies as a grandfathered health plan under the Affordable Care Act, the provisions of this section shall not apply and the provisions of 33 V.S.A. § 1811 shall govern the plan.

(b) Small group plans.

(1) Definitions. As used in this subsection:

(A) "Small employer" means an employer who, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 50 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. The provisions of this subsection shall continue to apply until the plan anniversary date following the date that the employer no longer meets the requirements of this subdivision.

(B) "Small group" means:

(i) a small employer; or

(ii) an association, trust, or other group issued a health insurance policy subject to regulation by the commissioner under subdivision 4079(2), (3), or (4) of this title.

(C) "Small group plan" means a group health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered or issued to a small group, including but not limited to common health care plans approved by the commissioner under subdivision (5) of this subsection. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, dental policies, policies that supplement the Civilian Health and Medical Program of the Uniformed Services, or Medicare supplemental policies.

(D) "Registered small group carrier" means any person except an insurance agent, broker, appraiser, or adjuster who issues a small group plan and who has a registration in effect with the commissioner as required by this subsection.

(2) No person may provide a small group plan unless the plan complies with the provisions of this subsection.

(3) No person may provide a small group plan unless such person is a registered small group carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service and other requirements for registration. Such registration shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A small group carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(4)(A) A registered small group carrier shall guarantee acceptance of all small groups for any small group plan offered by the carrier. A registered small group carrier shall also guarantee acceptance of all employees or members of a small group and each dependent of such employees or members for any small group plan it offers.

(B) Notwithstanding subdivision (A) of this subdivision (b)(4), a health maintenance organization shall not be required to cover:

(i) a small employer which is not physically located in the health maintenance organization's approved service area; or

(ii) a small employer or an employee or member of the small group located or residing within the health maintenance organization's approved service area for which the health maintenance organization:

(I) is not providing coverage; and

(II) reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its network of providers to deliver adequate service because of its existing group contract obligations, including contract obligations subject to the provisions of this subsection and any other group contract obligations.

(5) A registered small group carrier shall offer one or more common health care plans approved by the commissioner. The commissioner, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the costs of plans offered by carriers and that ensure the development of an affordable common health care plan, providing for deductibles, coinsurance arrangements, managed care, cost containment provisions, and any other term, not inconsistent with the provisions of this title, deemed useful in making the plan affordable. A health maintenance organization may add limitations to a common health care plan if the commissioner finds that the limitations do not unreasonably restrict the insured from access to the benefits covered by the plans.

(6) A registered small group carrier shall offer a small group plan rate structure which at least differentiates between single-person, two-person and family rates.

(7)(A) A registered small group carrier shall use a community rating method acceptable to the commissioner for determining premiums for small group plans. Except as provided in subdivision (B) of this subdivision (7), the following risk classification factors are prohibited from use in rating small groups, employees or members of such groups, and dependents of such employees or members:

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

(ii) geographic area rating;

(iii) industry rating;

(iv) medical underwriting and screening;

(v) experience rating;

(vi) tier rating; or

(vii) durational rating.

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

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

(I) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (i) of this subdivision (7)(B) does not exceed 30 percent;

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

(III) provide that the reward under the program is available to all similarly situated individuals and complies with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act of 1996; and

(IV) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical

condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(iii) The commissioner's rules shall include:

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

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

(III) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (7)(B).

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

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

(i) offers a small group plan to a member small employer which is community rated in accordance with the provisions of subdivisions (A) and (B) of this subdivision (b)(7). The plan may include risk classifications in accordance with subdivision (B) of this subdivision (7);

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

(iii) offers one or more of the common health care plans approved by the commissioner under subdivision (5) of this subsection.

(E) The commissioner may revoke or deny the exemption set forth in subdivision (D) of this subdivision (7) if the commissioner determines that:

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

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

(8) A registered small group carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this subsection. The requirements for certification shall be as the commissioner by rule prescribes.

(9) A registered small group carrier shall provide, on forms prescribed by the commissioner, full disclosure to a small group of all premium rates and any risk classification formulas or factors prior to acceptance of a small group plan by the group.

(10) A registered small group carrier shall guarantee the rates on a small group plan for a minimum of six months.

(11)(A) A registered small group carrier may require that 75 percent or less of the employees or members of a small group with more than 10 employees participate in the carrier's plan. A registered small group carrier may require that 50 percent or less of the employees or members of a small group with 10 or fewer employees or members participate in the carrier's plan. A small group carrier's rules established pursuant to this subdivision shall be applied to all small groups participating in the carrier's plans in a consistent and nondiscriminatory manner.

(B) For purposes of the requirements set forth in subdivision (A) of this subdivision (11), a registered small group carrier shall not include in its calculation an employee or member who is already covered by another group health benefit plan as a spouse or dependent or who is enrolled in Catamount Health, Medicaid, the Vermont health access plan, or Medicare. Employees or members of a small group who are enrolled in the employer's plan and receiving premium assistance under 33 V.S.A. chapter 19 shall be considered to be participating in the plan for purposes of this subsection. If the small group is an association, trust, or other substantially similar group, the participation requirements shall be calculated on an employer-by-employer basis.

(C) A small group carrier may not require recertification of compliance with the participation requirements set forth in this subdivision (11) more often than annually at the time of renewal. If, during the recertification process, a small group is found not to be in compliance with the participation requirements, the small group shall have 120 days to become compliant prior to termination of the plan.

(12) This subsection shall apply to the provisions of small group plans. This subsection shall not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy; provided that no person may offer a health benefit plan or insurance policy to individual

employees or members of a small group as a means of circumventing the requirements of this subsection. The commissioner shall adopt, by rule, standards and a process to carry out the provisions of this subsection.

(13) The guaranteed acceptance provision of subdivision (4) of this subsection shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

(14) Registered small group carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring small group risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this subsection. Failure or delay in the formation of a reinsurance pool under this subsection shall not delay implementation of this subdivision. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis.

(c) Nongroup health benefit plans.

(1) Definitions. As used in this subsection:

(A) "Individual" means a person who is not eligible for coverage by group health insurance as defined by section 4079 of this title.

(B) "Nongroup plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered or issued to an individual, including but not limited to common health care plans approved by the commissioner under subdivision (5) of this subsection. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, Medicare supplemental policies, and dental policies. The term also does not include hospital indemnity policies or specified disease indemnity or expense policies, provided such policies are sold only as supplemental coverage when a common health care plan or other comprehensive health care policy is in effect.

(C) "Registered nongroup carrier" means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a nongroup plan and who has a registration in effect with the commissioner as required by this subsection.

(2) No person may provide a nongroup plan unless the plan complies with the provisions of this subsection.

(3) No person may provide a nongroup plan unless such person is a registered nongroup carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service, and other requirements for registration. Registration under this subsection shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A nongroup carrier may withdraw its registration upon at least six months' prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(4)(A) A registered nongroup carrier shall guarantee acceptance of any individual for any nongroup plan offered by the carrier. A registered nongroup carrier shall also guarantee acceptance of each dependent of such individual for any nongroup plan it offers.

(B) Notwithstanding subdivision (A) of this subdivision, a health maintenance organization shall not be required to cover:

(i) an individual who is not physically located in the health maintenance organization's approved service area; or

(ii) an individual residing within the health maintenance organization's approved service area for which the health maintenance organization:

(I) is not providing coverage; and

(II) reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its network of providers to deliver adequate service because of its existing contract obligations, including contract obligations subject to the provisions of this subsection and any other group contract obligations.

(5) A registered nongroup carrier shall offer two or more common health care plans approved by the commissioner. The commissioner, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the cost of plans offered by carriers. At least one plan shall be a low-cost common health care plan that may provide for deductibles, coinsurance arrangements, managed care, cost-containment provisions, and any other term not inconsistent with the provisions of this title that are deemed useful in making the plan affordable.

A health maintenance organization may add limitations to a common health care plan if the commissioner finds that the limitations do not unreasonably restrict the insured from access to the benefits covered by the plan.

(6) A registered nongroup carrier shall offer a nongroup plan rate structure which at least differentiates between single-person, two-person and family rates.

(7) For a 12-month period from the effective date of coverage, a registered nongroup carrier may limit coverage of preexisting conditions which exist during the 12-month period before the effective date of coverage; provided that a registered nongroup carrier shall waive any preexisting condition provisions for all individuals and their dependents who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to the carrier's common health care plan approved by the commissioner. If an individual has a preexisting condition excluded under a subsequent policy, such exclusion shall not continue longer than the period required under the original contract or 12 months, whichever is less. Credit shall be given for prior coverage that occurred without a break in coverage of 63 days or more. For an eligible individual as such term is defined in Section 2741 of Title XXVII of the Public Health Service Act, a registered nongroup carrier shall not limit coverage of preexisting conditions.

(8)(A) A registered nongroup carrier shall use a community rating method acceptable to the commissioner for determining premiums for nongroup plans. Except as provided in subdivision (B) of this subsection, the following risk classification factors are prohibited from use in rating individuals and their dependents:

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

(ii) geographic area rating;

(iii) industry rating;

(iv) medical underwriting and screening;

(v) experience rating;

(vi) tier rating; or

(vii) durational rating.

(B)(i) The commissioner shall, by rule, adopt standards and a process for permitting registered nongroup carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent and provided further that the commissioner's

rules may not permit any medical underwriting and screening and shall give due consideration to the need for affordability and accessibility of health insurance.

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

(I) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (B)(i) of this subdivision (8) does not exceed 30 percent;

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

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

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

(iii) The commissioner's rules shall include:

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

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

(III) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (8)(B).

(iv) The commissioner may require a registered nongroup carrier to identify that percentage of a requested premium increase which is attributed

to the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall occur at the time a rate increase is sought and shall be in the manner and form directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

(9) Notwithstanding subdivision (8)(B) of this subsection, the commissioner shall not grant rate increases, including increases for medical inflation, for individuals covered pursuant to the provisions of this subsection that exceed 20 percent in any one year; provided that the commissioner may grant an increase that exceeds 20 percent if the commissioner determines that the 20 percent limitation will have a substantial adverse effect on the financial safety and soundness of the insurer. In the event that this limitation prevents implementation of community rating to the full extent provided for in subdivision (8) of this subsection, the commissioner may permit insurers to correspondingly limit community rating provisions from applying to individuals who would otherwise be entitled to rate reductions.

(10) A registered nongroup carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this subsection. The requirements for certification shall be as the commissioner by rule prescribes.

(11) A registered nongroup carrier shall guarantee the rates on a nongroup plan for a minimum of 12 months.

(12) Registered nongroup carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring nongroup risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this subsection. Failure or delay in the formation of a reinsurance pool under this subsection shall not delay implementation of this subdivision. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis.

(13) The commissioner shall disapprove any rates filed by any registered nongroup carrier, whether initial or revised, for nongroup insurance policies unless the anticipated loss ratios for the entire period for which rates are computed are at least 70 percent. For the purpose of this subdivision, "anticipated loss ratio" shall mean a comparison of earned premiums to losses

incurred plus a factor for industry trend where the methodology for calculating trend shall be determined by the commissioner by rule.

* * * Green Mountain Care Board * * *

Sec. 5. 18 V.S.A. § 9374 is amended to read:

§ 9374. BOARD MEMBERSHIP; AUTHORITY

* * *

(g) The chair of the board or designee may apply for grant funding, if available, to advance or support any responsibility within the board's jurisdiction.

(h)(1) Expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the board shall be borne as follows:

(A) 40 percent by the state from state monies;

(B) 15 percent by the hospitals;

(C) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125;

(D) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101; and

(E) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

(2) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the board to perform its duties, the chair of the board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall

constitute service on the person to whom it is addressed. Each witness who appears before the chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however, any person subject to the board's authority shall not be eligible to receive fees or mileage under this section.

(1) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the chair upon properly being ordered to do so may be assessed an administrative penalty by the chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

(2) If an appeal or other petition for judicial review of a final order is not filed in connection with an order of the Green Mountain Care board under section 9381(b) of this chapter, the chair may file a certified copy of the final order with the clerk of a court of competent jurisdiction. The order so filed has the same effect as a judgment of the court and may be recorded, enforced, or satisfied in the same manner as a judgment of the court.

Sec. 5a. BILL-BACK REPORT

No later than February 1, 2013, the department of banking, insurance, securities, and health care administration and the Green Mountain Care board shall report to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance regarding the allocation of expenses among hospitals and health insurers to finance the department's and the board's regulatory activities pursuant to 18 V.S.A. §§ 9374(h) and 9415. The report shall address the basis for the formula and how it is applied and shall contain the department's and the board's recommendations for alternate expense allocation formulas or models.

* * * Unified Health Care Budget * * *

Sec. 6. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

* * *

(14) "Unified health care budget" means the budget established in accordance with section 9375a of this title.

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

Sec. 7. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

* * *

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

* * *

Sec. 8. 18 V.S.A. § 9403 is amended to read:

§ 9403. DIVISION OF HEALTH CARE ADMINISTRATION; PURPOSES

The division of health care administration is created in the department of banking, insurance, securities, and health care administration. The division shall assist the commissioner in carrying out the policies of the state regarding health care delivery, cost, and quality~~,~~ by providing oversight of health care quality and expenditures through the ~~certificate of need program and the unified health care budget for the state or with respect to Vermont residents~~, establishment and maintenance of consumer protection functions~~,~~ and oversight of quality assurance within the health care system. The division shall also establish and maintain a data base with information needed to carry out the commissioner's duties and obligations under this chapter and Title 8.

Sec. 9. 18 V.S.A. § 9405(b) is amended to read:

(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.

(1) The plan shall include:

* * *

(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the commissioner shall consider at least the following factors: the values and goals reflected in the state health plan; the needs of the population on a statewide basis; the needs of particular geographic areas of the state, as identified in the state health plan; the needs of uninsured and underinsured populations; the use of Vermont facilities by out-of-state residents; the use of out-of-state facilities by Vermont residents; the needs of populations with special health care needs;

the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; the cost impact of these resource requirements on health care expenditures; the services appropriate for the four categories of hospitals described in subdivision 9402(12) of this title; the overall quality and use of health care services as reported by the Vermont program for quality in health care and the Vermont ethics network; the overall quality and cost of services as reported in the annual hospital community reports; individual hospital four-year capital budget projections; ~~the unified health care budget;~~ and the four-year projection of health care expenditures prepared by the division.

* * *

Sec. 10. 18 V.S.A. § 9406 is amended to read:

~~§ 9406. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET~~

~~(a) Annually, the commissioner shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in section 9401 of this title.~~

~~(1) The budget shall:~~

~~(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.~~

~~(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont, and for all health care services provided to residents of this state.~~

~~(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.~~

~~(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.~~

~~(2) The commissioner shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.~~

~~(b)(1) Annually the division shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the commissioner under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:~~

~~(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organizations, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and~~

~~(B) expenditures for Medicare, all self-insured employers, and all other health insurance.~~

~~(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the division's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year, and an evaluation of the efficacy of any cost containment efforts the plan has made.~~

~~(3) The division's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.~~

~~(4) The division shall prepare a report of the final projections made under this subsection, and file the report with the general assembly on or before January 15 of each year.~~ [Repealed.]

Sec. 11. 18 V.S.A. 9375a is added to read:

§ 9375a. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET

(a) Annually, the board shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in sections 9371 and 9372 of this title.

(1) The budget shall:

(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.

(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont and for all health care services provided to residents of this state.

(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.

(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

(2) The board shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.

(b)(1) Annually the board shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the board under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:

(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organization, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and

(B) expenditures for Medicare, all self-insured employers, and all other health insurance.

(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the board's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year and an evaluation of the efficacy of any cost containment efforts the plan has made.

(3) The board's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department of banking, insurance, securities, and health care administration, and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.

(4) The board shall prepare a report of the final projections made under this subsection and file the report with the general assembly on or before January 15 of each year.

* * * Claims Edit Standards * * *

Sec. 11a. 18 V.S.A. § 9418a is amended to read:

§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT) codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate nationally recognized standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards ~~that are no more restrictive than the following,~~ except as provided in subsection (c) of this section:

(1) The CPT, HCPCS, and NCCI;

(2) National specialty society edit standards; or

(3) Other appropriate nationally recognized edit standards, guidelines, or conventions approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) or (2) of this section is not required:

(1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or

(2) For ~~services not addressed by NCCI standards or national specialty society edit standards~~ edits that the payer determines are more favorable to providers than the edit standards in subdivisions (b)(1) through (3) of this section or to address new codes not yet incorporated by a payer's edit management software, provided the edit standards are developed with input from the relevant Vermont provider community and national provider organizations and provided the edits are available to providers on the plan's websites and in their newsletters.

(d) Nothing in this section shall preclude a health plan, contracting entity, covered entity, or payer from determining that any such claim is not eligible for payment in full or in part, based on a determination that:

(1) The claim is contested as defined in subdivision 9418(a)(2) of this title;

(2) The service provided is not a covered benefit under the contract, including a determination that such service is not medically necessary or is experimental or investigational;

(3) The insured did not obtain a referral, prior authorization, or precertification, or satisfy any other condition precedent to receiving covered benefits from the health care provider;

(4) The covered benefit exceeds the benefit limits of the contract;

(5) The person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her coverage agreement;

(6) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or

(7) The health plan, contracting entity, covered entity, or payer determines through coordination of benefits that another entity is liable for the claim.

(e) Nothing in this section shall be deemed to require a health plan, contracting entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to dictate the amount of a claim to be paid by a health plan, contracting entity, covered entity, or payer to a health care provider.

(f) No health plan, contracting entity, covered entity, or payer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services (downcoding), except that a health plan, contracting entity, covered entity, or payer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines, and CPT conventions.

(g) Notwithstanding the provisions of subsection (d) of this section, and other than the edits contained in the conventions in subsections (a) and (b) of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for services on other bases and shall have the right to reassign or reduce the code level for selected claims for services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

(h) Every health plan, contracting entity, covered entity, and payer shall publish on its provider website and in its provider newsletter if applicable:

(1) The name of any commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) The standard or standards, pursuant to subsection (b) of this section, that the entity uses for claim edits;

(3) The payment percentages for modifiers; and

(4) Any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product after the effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer.

(i) Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide the information in subsection (h) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

(j) For purposes of this section, "health plan" includes a workers' compensation policy of a casualty insurer licensed to do business in Vermont.

(k) ~~Prior to the effective date of subsections (b) and (c) of this section, MVP Healthcare is requested to convene~~ Blue Cross and Blue Shield of Vermont and the Vermont Medical Society are requested to continue convening a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. ~~No later than January 1, 2012, the~~ The work group is requested to ~~report its findings and recommendations, including any recommendations for legislative changes to subsections (b) and (c) of this section,~~ provide an annual progress report to the house committee on health care and the senate ~~committee~~ committees on health and welfare and on finance.

(l) With respect to the work group established under subsection (k) of this section and to the extent required to avoid violations of federal antitrust laws, the department shall facilitate and supervise the participation of members of the work group.

* * * Certificate of Need * * *

Sec. 12. 18 V.S.A. § 9375(b) is amended to read:

(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 this chapter ~~13, subchapter 2 of this title~~ are consistent with such reforms.

* * *

(6) ~~Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business~~ Approve or disapprove requests for health insurance rate**s increases** pursuant to 8 V.S.A. § 4062 within 30 days of receipt of ~~such recommendations and~~ a request for approval from the commissioner of banking, insurance, securities, and health care administration, 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)~~(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012~~; and~~.

~~(C)~~(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning ~~July 1, 2012~~ January 1, 2013.

~~(7)~~(9) 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)~~(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

* * *

(11) Develop the unified health care budget pursuant to section 9375a of this title.

Sec. 13. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

(5) "Expenditure analysis" means the expenditure analysis developed pursuant to section ~~9406~~ 9375a of this title.

(6) "Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision ~~9432(10)~~ 9432(8) of this title, except health maintenance organizations.

* * *

(10) "Health resource allocation plan" means the plan adopted by the commissioner of banking, insurance, securities, and health care administration under section 9405 of this title.

* * *

(15) "Unified health care budget" means the budget established in accordance with section ~~9406~~ 9375a of this title.

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

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

Sec. 14. 18 V.S.A. § 9412 is amended to read:

§ 9412. ENFORCEMENT

(a) In order to carry out the duties under this chapter, ~~the commissioner,~~ in addition to the powers provided in this chapter, in chapter 220 of this title, and in Title 8, the commissioner and the board may examine the books, accounts, and papers of health insurers, health care providers, health care facilities, health plans, contracting entities, covered entities, and payers, as defined in section 9418 of this title, and may administer oaths and may issue subpoenas to a person to appear and testify or to produce documents or things.

* * *

Sec. 14a. 18 V.S.A. § 9431(b) is amended to read:

(b) In order to carry out the policy goals of this subchapter, the ~~department~~ board shall adopt by rule by ~~October 1, 2005~~ January 1, 2013, certificate of

need procedural guidelines to assist in its decision-making. The guidelines shall be consistent with the state health plan and the health resource allocation plan.

Sec. 15. 18 V.S.A. § 9433 is amended to read:

§ 9433. ADMINISTRATION

(a) The ~~commissioner~~ board shall exercise such duties and powers as shall be necessary for the implementation of the certificate of need program as provided by and consistent with this subchapter. The ~~commissioner~~ board shall issue or deny certificatesl of need.

(b) The ~~commissioner~~ board may adopt rules governing the review of certificate of need applications consistent with and necessary to the proper administration of this subchapter. All rules shall be adopted pursuant to 3 V.S.A. chapter 25 ~~of Title 3~~.

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

(d) The ~~commissioner~~ board shall administer the certificate of need program.

Sec. 16. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the ~~commissioner~~ board. For purposes of this subsection, a "new health care project" includes the following:

* * *

(3) The offering of any home health service, or the transfer or conveyance of more than a 50 percent ownership interest ~~of a home health agency~~ in a health care facility other than a hospital.

(4) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision ~~9432(7)(B)~~9432(8)(B) of this title, as determined by the ~~commissioner~~ board, shall be considered together in calculating the

amount of an expenditure. The ~~commissioner's~~ board's determination of functional interdependence of items of equipment under this subdivision shall have the effect of a final decision and is subject to appeal under ~~this subchapter~~ section 9381 of this title.

* * *

(b) A hospital shall not develop or have developed on its behalf a new health care project without issuance of a certificate of need by the ~~commissioner~~ board. For purposes of this subsection, a "new health care project" includes the following:

* * *

(2) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision ~~9432(7)(B)~~9432(8)(B) of this title, as determined by the ~~commissioner~~ board, shall be considered together in calculating the amount of an expenditure. The ~~commissioner's~~ board's determination of functional interdependence of items of equipment under this subdivision shall have the effect of a final decision and is subject to appeal under ~~this subchapter~~ section 9381 of this title.

* * *

(c) In the case of a project which requires a certificate of need under this section, expenditures for which are anticipated to be in excess of $30,000,000.00, the applicant first shall secure a conceptual development phase certificate of need, in accordance with the standards and procedures established in this subchapter, which permits the applicant to make expenditures for architectural services, engineering design services, or any other planning services, as defined by the ~~commissioner~~ board, needed in connection with the project. Upon completion of the conceptual development phase of the project, and before offering or further developing the project, the applicant shall secure a final certificate of need, in accordance with the standards and procedures established in this subchapter. Applicants shall not be subject to sanctions for failure to comply with the provisions of this subsection if such failure is solely the result of good faith reliance on verified project cost estimates issued by qualified persons, which cost estimates would have led a reasonable person to conclude the project was not anticipated to be in excess of $30,000,000.00 and therefore not subject to this subsection. The

provisions of this subsection notwithstanding, expenditures may be made in preparation for obtaining a conceptual development phase certificate of need, which expenditures shall not exceed $1,500,000.00 for non-hospitals or $3,000,000.00 for hospitals.

(d) If the ~~commissioner~~ board determines that a person required to obtain a certificate of need under this subchapter has separated a single project into components in order to avoid cost thresholds or other requirements under this subchapter, the person shall be required to submit an application for a certificate of need for the entire project, and the ~~commissioner~~ board may proceed under section 9445 of this title. The ~~commissioner's~~ board's determination under this subsection shall have the effect of a final decision and is subject to appeal under ~~this subchapter~~ section 9381 of this title.

(e) Beginning January 1, ~~2005~~ 2013, and biannually thereafter, the ~~commissioner~~ board may by rule adjust the monetary jurisdictional thresholds contained in this section. In doing so, the ~~commissioner~~ board shall reflect the same categories of health care facilities, services, and programs recognized in this section. Any adjustment by the ~~commissioner~~ board shall not exceed the consumer price index rate of inflation.

Sec. 16a. 18 V.S.A. § 9435 is amended to read:

§ 9435. EXCLUSIONS

* * *

(b) Excluded from this subchapter are community mental health or developmental disability center health care projects proposed by a designated agency and supervised by the commissioner of mental health or the commissioner of disabilities, aging, and independent living, or both, depending on the circumstances and subject matter of the project, provided the appropriate commissioner or commissioners make a written approval of the proposed health care project. The designated agency shall submit a copy of the approval with a letter of intent to the ~~commissioner~~ board.

* * *

(e) Upon request under 8 V.S.A. § 5102(f) by a Program for All-Inclusive Care for the Elderly (PACE) authorized under federal Medicare law, or by a Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) established in accordance with federal Medicare or Medicaid laws and regulations, the ~~commissioner~~ board may approve the exemption of the PACE program, PIHP, or PAHP from the provisions of this subchapter and from any other provisions of this chapter if the ~~commissioner~~ board determines that the purposes of this subchapter and the purposes of any other provision of this

chapter will not be materially and adversely affected by the exemption. In approving an exemption, the ~~commissioner~~ board may prescribe such terms and conditions as the ~~commissioner~~ board deems necessary to carry out the purposes of this subchapter and this chapter.

Sec. 17. 18 V.S.A. § 9437 is amended to read:

§ 9437. CRITERIA

A certificate of need shall be granted if the applicant demonstrates and the ~~commissioner~~ board finds that:

(1) the application is consistent with the health resource allocation plan;

(2) the cost of the project is reasonable, because:

(A) the applicant's financial condition will sustain any financial burden likely to result from completion of the project;

(B) the project will not result in an undue increase in the costs of medical care. In making a finding under this subdivision, the ~~commissioner~~ board shall consider and weigh relevant factors, including:

* * *

Sec. 18. 18 V.S.A. § 9439 is amended to read:

§ 9439. COMPETING APPLICATIONS

(a) The ~~commissioner~~ board shall provide by rule a process by which any person wishing to offer or develop a new health care project may submit a competing application when a substantially similar application is pending. The competing application must be filed and completed in a timely manner, and the original application and all competing applications shall be reviewed concurrently. A competing applicant shall have the same standing for administrative and judicial review under this subchapter as the original applicant.

(b) When a letter of intent to compete has been filed, the review process is suspended and the time within which a decision must be made as provided in subdivision 9440(d)(4) of this title is stayed until the competing application has been ruled complete or for a period of 55 days from the date of notification under subdivision 9440(c)(8) as to the original application, whichever is shorter.

(c) Nothing in this subchapter shall be construed to restrict the ~~commissioner~~ board to granting a certificate of need to only one applicant for a new health care project.

(d) The ~~commissioner~~ board may, by rule, establish regular review cycles for the addition of beds for skilled nursing or intermediate care.

(e) In the case of proposals for the addition of beds for skilled nursing or intermediate care, the ~~commissioner~~ board shall identify in advance of the review the number of additional beds to be considered in that cycle or the maximum additional financial obligation to be incurred by the agencies of the state responsible for financing long-term care. The number of beds shall be consistent with the number of beds determined to be necessary by the health resource management plan or state health plan, whichever applies, and shall take into account the number of beds needed to develop a new, efficient facility.

(f) Unless an application meets the requirements of subsection 9440(e) of this title, the ~~commissioner~~ board shall consider disapproving a certificate of need application for a hospital if a project was not identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan required under subdivision 9454(a)(6) of this title. The ~~commissioner~~ board shall review all hospital four-year capital plans as part of the review under subdivision 9437(2)(B) of this title.

Sec. 19. 18 V.S.A. § 9440 is amended to read:

§ 9440. PROCEDURES

(a) Notwithstanding 3 V.S.A. chapter 25 ~~of Title 3~~, a certificate of need application shall be in accordance with the procedures of this section.

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

(A) institutional utilization data, including an explanation of the unique character of services and a description of case mix;

(B) a population based description of the institution's service area;

(C) the applicant's financial statements;

(D) third party reimbursement data;

(E) copies of feasibility studies, surveys, designs, plans, working drawings, or specifications developed in relation to the proposed project;

(F) annual reports and four-year long range plans;

(G) leases, contracts, or agreements of any kind that might affect quality of care or the nature of services provided;

(H) the status of all certificates issued to the applicant under this subchapter during the three years preceding the date of the application. As a condition to deeming an application complete under this section, the ~~commissioner~~ board may require that an applicant meet with the ~~commissioner~~ board to discuss the resolution of the applicant's compliance with those prior certificates; and

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

(2) In addition to the information required for submission, an applicant may submit, and the ~~commissioner~~ board shall consider, any other information relevant to the application or the review criteria.

(c) The application process shall be as follows:

(1) Applications shall be accepted only at such times as the ~~commissioner~~ board shall establish by rule.

(2)(A) Prior to filing an application for a certificate of need, an applicant shall file an adequate letter of intent with the ~~commissioner~~ board no less than 30 days or, in the case of review cycle applications under section 9439 of this title, no less than 45 days prior to the date on which the application is to be filed. The letter of intent shall form the basis for determining the applicability of this subchapter to the proposed expenditure or action. A letter of intent shall become invalid if an application is not filed within six months of the date that the letter of intent is received or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule. Except for requests for expedited review under subdivision (5) of this subsection, public notice of such letters of intent shall be provided in newspapers having general circulation in the region of the state affected by the letter of intent. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application or petition to intervene must be filed. In addition, a copy of the public notice shall be sent to the clerk of the municipality in which the health care facility is located. Upon receipt, the clerk shall post the notice in or near the clerk's office and in at least two other public places in the municipality.

(B) Applicants who agree that their proposals are subject to jurisdiction pursuant to section 9434 of this title shall not be required to file a letter of intent pursuant to subdivision (A) of this subdivision (2) and may file an application without further process. Public notice of the application shall be provided upon filing as provided for in subdivision (A) of this subdivision (2) for letters of intent.

(3) The ~~commissioner~~ board shall review each letter of intent and, if the letter contains the information required for letters of intent as established by the ~~commissioner~~ board by rule, within 30 days, determine whether the project described in the letter will require a certificate of need. If the ~~commissioner~~ board determines that a certificate of need is required for a proposed expenditure or action, an application for a certificate of need shall be filed before development of the project begins.

(4) Within 90 days of receipt of an application, the ~~commissioner~~ board 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~~ board 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~~ board's notice that additional information is required shall not be included within the maximum review period permitted under this subsection. The ~~commissioner~~ board 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.

(5) An applicant seeking expedited review of a certificate of need application may simultaneously file a letter of intent and an application with the ~~commissioner~~ board. Upon making a determination that the proposed project may be uncontested and does not substantially alter services, as defined by rule, or upon making a determination that the application relates to a health care facility affected by bankruptcy proceedings, the ~~commissioner~~ board shall issue public notice of the application and the request for expedited review and identify a date by which a competing application or petition for interested party status must be filed. If a competing application is not filed and no person opposing the application is granted interested party status, the ~~commissioner~~ board may formally declare the application uncontested and may issue a certificate of need without further process, or with such abbreviated process as the ~~commissioner~~ board deems appropriate. If a competing application is filed or a person opposing the application is granted interested party status, the applicant shall follow the certificate of need standards and procedures in this section, except that in the case of a health care facility affected by bankruptcy proceedings, the ~~commissioner~~ board after notice and an opportunity to be heard may issue a certificate of need with such abbreviated process as the ~~commissioner~~ board deems appropriate, notwithstanding the contested nature of the application.

(6) If an applicant fails to respond to an information request under subdivision (4) of this subsection within six months or, in the case of review

cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule, the application will be deemed inactive unless the applicant, within six months, requests in writing that the application be reactivated and the ~~commissioner~~ board grants the request. If an applicant fails to respond to an information request within 12 months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule, the application will become invalid unless the applicant requests, and the ~~commissioner~~ board grants, an extension.

(7) For purposes of this section, "interested party" status shall be granted to persons or organizations representing the interests of persons who demonstrate that they will be substantially and directly affected by the new health care project under review. Persons able to render material assistance to the ~~commissioner~~ board by providing nonduplicative evidence relevant to the determination may be admitted in an amicus curiae capacity but shall not be considered parties. A petition seeking party or amicus curiae status must be filed within 20 days following public notice of the letter of intent, or within 20 days following public notice that the application is complete. The ~~commissioner~~ board shall grant or deny a petition to intervene under this subdivision within 15 days after the petition is filed. The ~~commissioner~~ board shall grant or deny the petition within an additional 30 days upon finding that good cause exists for the extension. Once interested party status is granted, the ~~commissioner~~ board shall provide the information necessary to enable the party to participate in the review process~~. Such information includes~~, including information about procedures, copies of all written correspondence, and copies of all entries in the application record.

(8) Once an application has been deemed to be complete, public notice of the application ~~will~~ shall be provided in newspapers having general circulation in the region of the state affected by the application. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application under section 9439 of this title or a petition to intervene must be filed.

(9) The health care ombudsman's office established under 8 V.S.A. chapter 107, subchapter ~~1A of chapter 107 of Title 8~~ or, in the case of nursing homes, the long-term care ombudsman's office established under 33 V.S.A. § 7502, is authorized but not required to participate in any administrative or judicial review of an application under this subchapter and shall be considered an interested party in such proceedings upon filing a notice of intervention with the ~~commissioner~~ board.

(d) The review process shall be as follows:

(1) The ~~commissioner~~ board shall review:

(A) The application materials provided by the applicant.

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

(2) ~~The department~~ Except as otherwise provided in subdivision (c)(5) and subsection (e) of this section, the board shall hold a public hearing during the course of a review.

(3) The ~~commissioner~~ board 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~~ board 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.

(4) After reviewing each application, the ~~commissioner~~ board 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~~ board may impose in furtherance of the purposes of this subchapter, or a denial. In granting a partial approval or a conditional approval the ~~commissioner~~ board 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.

(5) If the ~~commissioner~~ board proposes to render a final decision denying an application in whole or in part, or approving a contested application, the ~~commissioner~~ board 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~~ board. The ~~commissioner~~ board may also permit the parties to present additional evidence.

(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.

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

(e) The ~~commissioner~~ board 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~~ board 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~~ board 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~~ board under this section may appeal ~~the decision to the supreme court~~ pursuant to the provisions of section 9381 of this title.

(g) If the ~~commissioner~~ board has reason to believe that the applicant has violated a provision of this subchapter, a rule adopted pursuant to this subchapter, or the terms or conditions of a prior certificate of need, the ~~commissioner~~ board may take into consideration such violation in determining whether to approve, deny, or approve the application subject to conditions. The applicant shall be provided an opportunity to contest whether such violation occurred, unless such an opportunity has already been provided. The ~~commissioner~~ board may impose as a condition of approval of the application that a violation be corrected or remediated before the certificate may take effect.

Sec. 20. 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~~ board, and any testimony taken before the ~~commissioner~~ board or a hearing officer appointed by the ~~commissioner~~ board shall be submitted or taken under oath. The form and manner of the submission shall be prescribed by the ~~commissioner~~ board. The authority granted to the ~~commissioner~~ board under this section is in addition to any other authority granted to the ~~commissioner~~ board 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~~ board 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~~ board or a hearing officer appointed by the ~~commissioner~~ board or who knowingly testifies falsely in any proceeding before the ~~commissioner~~ board or a hearing officer appointed by the ~~commissioner~~ board shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

Sec. 20a. 18 V.S.A. § 9440b is amended to read:

§ 9440b. INFORMATION TECHNOLOGY; REVIEW PROCEDURES

Notwithstanding the procedures in section 9440 of this title, upon approval by the general assembly of the health information technology plan developed under section 9351 of this title, the ~~commissioner~~ board shall establish by rule standards and expedited procedures for reviewing applications for the purchase or lease of health care information technology that otherwise would be subject to review under this subchapter. Such applications may not be granted or approved unless they are consistent with the health information technology plan and the health resource allocation plan. The ~~commissioner's~~ board's rules may include a provision requiring that applications be reviewed by the health information advisory group authorized under section 9352 of this title. The advisory group shall make written findings and a recommendation to the ~~commissioner~~ board in favor of or against each application.

Sec. 20b. 18 V.S.A. § 9441 is amended to read:

§ 9441. FEES

(a) The ~~commissioner~~ board shall charge a fee for the filing of certificate of need applications. The fee shall be calculated at the rate of 0.125 percent of project costs.

(b) The maximum fee shall not exceed $20,000.00 and the minimum filing fee is $250.00 regardless of project cost. No fee shall be charged on projects amended as part of the review process.

(c) The ~~commissioner~~ board may retain such additional professional or other staff as needed to assist in particular proceedings under this subchapter and may assess and collect the reasonable expenses for such additional staff from the applicant. The ~~commissioner~~ board, on petition by the applicant and opportunity for hearing, may reduce such assessment upon a proper showing by the applicant that such expenses were excessive or unnecessary. The authority granted to the ~~commissioner~~ board under this section is in addition to any other authority granted to the ~~commissioner~~ board under law.

Sec. 20c. 18 V.S.A. § 9442 is amended to read:

§ 9442. BONDS

In any circumstance in which bonds are to be or may be issued in connection with a new health care project subject to the provisions of this subchapter, the certificate of need shall include the requirement that all information required to be provided to the bonding agency shall be provided also to the ~~commissioner~~ board within a reasonable period of time. The ~~commissioner~~ board shall be authorized to obtain any information from the bonding agency deemed necessary to carry out the duties of monitoring and oversight of a certificate of need. The bonding agency shall consider the recommendations of the ~~commissioner~~ board in connection with any such proposed authorization.

Sec. 20d. 18 V.S.A. § 9443 is amended to read:

§ 9443. EXPIRATION OF CERTIFICATES OF NEED

(a) Unless otherwise specified in the certificate of need, a project shall be implemented within five years or the certificate shall be invalid.

(b) No later than 180 days before the expiration date of a certificate of need, an applicant that has not yet implemented the project approved in the certificate of need may petition the ~~commissioner~~ board for an extension of the implementation period. The ~~commissioner~~ board may grant an extension in ~~his or her~~ its discretion.

(c) Certificates of need shall expire on the date the ~~commissioner~~ board accepts the final implementation report filed in connection with the project implemented pursuant to the certificate.

* * *

Sec. 21. 18 V.S.A. § 9444 is amended to read:

§ 9444. REVOCATION OF CERTIFICATES; MATERIAL CHANGE

(a) The ~~commissioner~~ board may revoke a certificate of need for substantial noncompliance with the scope of the project as designated in the application, or for failure to comply with the conditions set forth in the certificate of need granted by the ~~commissioner~~ board.

(b)(1) In the event that after a project has been approved, its proponent wishes to materially change the approved project, all such changes are subject to review under this subchapter.

(2) Applicants shall notify the ~~commissioner~~ board of a nonmaterial change to the approved project. If the ~~commissioner~~ board decides to review a nonmaterial change, ~~he or she~~ the board may provide for any necessary process, including a public hearing, before approval. Where the ~~commissioner~~

board decides not to review a change, such change will be deemed to have been granted a certificate of need.

Sec. 21a. 18 V.S.A. § 9445 is amended to read:

§ 9445. ENFORCEMENT

(a) Any person who offers or develops any new health care project within the meaning of this subchapter without first obtaining a certificate of need as required herein, or who otherwise violates any of the provisions of this subchapter, may be subject to the following administrative sanctions by the ~~commissioner~~ board, after notice and an opportunity to be heard:

(1) The ~~commissioner~~ board may order that no license or certificate permitted to be issued by the department or any other state agency may be issued to any health care facility to operate, offer, or develop any new health care project for a specified period of time, or that remedial conditions be attached to the issuance of such licenses or certificates.

(2) The ~~commissioner~~ board may order that payments or reimbursements to the entity for claims made under any health insurance policy, subscriber contract, or health benefit plan offered or administered by any public or private health insurer, including the Medicaid program and any other health benefit program administered by the state be denied, reduced, or limited, and in the case of a hospital that the hospital's annual budget approved under subchapter 7 of this chapter be adjusted, modified, or reduced.

(b) In addition to all other sanctions, if any person offers or develops any new health care project without first having been issued a certificate of need or certificate of exemption therefore, or violates any other provision of this subchapter or any lawful rule or regulation promulgated thereunder, the board, the commissioner, the state health care ombudsman, the state long-term care ombudsman, and health care providers ~~or~~ and consumers located in the state shall have standing to maintain a civil action in the superior court of the county wherein such alleged violation has occurred, or wherein such person may be found, to enjoin, restrain, or prevent such violation. Upon written request by the ~~commissioner~~ board, it shall be the duty of the attorney general of the state to furnish appropriate legal services and to prosecute an action for injunctive relief to an appropriate conclusion, which shall not be reimbursed under subdivision (2) of this subsection.

(c) After notice and an opportunity for hearing, the ~~commissioner~~ board may impose on a person who knowingly violates a provision of this subchapter, or a rule or order adopted pursuant to this subchapter or 8 V.S.A. § 15, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than

$100,000.00 or one-tenth of one percent of the gross annual revenues of the health care facility, whichever is greater, which shall not be reimbursed under subdivision (a)(2) of this section, and the ~~commissioner~~ board may order the entity to cease and desist from further violations, and to take such other actions necessary to remediate a violation. A person aggrieved by a decision of the ~~commissioner~~ board under this subdivision may appeal ~~the commissioner's decision to the supreme court~~ under section 9381 of this title.

(d) The ~~commissioner~~ board shall adopt by rule criteria for assessing the circumstances in which a violation of a provision of this subchapter, a rule adopted pursuant to this subchapter, or the terms or conditions of a certificate of need require that a penalty under this section shall be imposed, and criteria for assessing the circumstances in which a penalty under this section may be imposed.

Sec. 22. 18 V.S.A. § 9446 is amended to read:

§ 9446. HOME HEALTH AGENCIES; GEOGRAPHIC SERVICE AREAS

The terms of a certificate of need relating to the boundaries of the geographic service area of a home health agency may be modified by the ~~commissioner~~ board, in consultation with the commissioner of aging and independent living, after notice and opportunity for hearing, or upon written application to the ~~commissioner~~ board by the affected home health agencies or consumers, demonstrating a substantial need therefor. Service area boundaries may be modified by the ~~commissioner~~ board to take account of natural or physical barriers that may make the provision of existing services uneconomical or impractical, to prevent or minimize unnecessary duplication of services or facilities, or otherwise to promote the public interest. The ~~commissioner~~ board shall issue an order granting such application only upon a finding that the granting of such application is consistent with the purposes of 33 V.S.A. chapter 63, subchapter 1A ~~of chapter 63 of Title 33~~ and the health resource allocation plan established under section 9405 of this title and after notice and an opportunity to participate on the record by all interested persons, including affected local governments, pursuant to rules adopted by the ~~commissioner~~ board.

* * * Hospital Budgets * * *

Sec. 23. 18 V.S.A. chapter 221, subchapter 7 is amended to read:

Subchapter 7. Hospital Budget Review

* * *

§ 9453. POWERS AND DUTIES

(a) The ~~commissioner~~ board shall:

* * *

(b) To effectuate the purposes of this subchapter the ~~commissioner~~ board may adopt rules under 3 V.S.A. chapter 25 ~~of Title 3~~.

§ 9454. HOSPITALS; DUTIES

(a) Hospitals shall file the following information at the time and place and in the manner established by the ~~commissioner~~ board:

* * *

(7) such other information as the ~~commissioner~~ board may require.

* * *

§ 9456. BUDGET REVIEW

(a) The ~~commissioner~~ board shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter, and in accordance with a schedule established by the ~~commissioner~~ board. The ~~commissioner~~ board shall require the submission of documentation certifying that the hospital is participating in the Blueprint for Health if required by section 708 of this title.

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

* * *

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

(c) Individual hospital budgets established under this section shall:

(1) be consistent with the health resource allocation plan;

(2) take into consideration national, regional, or instate peer group norms, according to indicators, ratios, and statistics established by the ~~commissioner~~ board;

* * *

(d)(1) Annually, the ~~commissioner~~ board shall establish a budget for each hospital by September 15, followed by a written decision by October 1. Each hospital shall operate within the budget established under this section.

(2)(A) It is the general assembly's intent that hospital cost containment conduct is afforded state action immunity under applicable federal and state antitrust laws, if:

(i) the ~~commissioner~~ board requires or authorizes the conduct in any hospital budget established by the ~~commissioner~~ board under this section;

(ii) the conduct is in accordance with standards and procedures prescribed by the ~~commissioner~~ board; and

(iii) the conduct is actively supervised by the ~~commissioner~~ board.

(B) A hospital's violation of the ~~commissioner's~~ board's standards and procedures shall be subject to enforcement pursuant to subsection (h) of this section.

(e) The ~~commissioner~~ board may establish~~, by rule,~~ a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks. The ~~commissioner~~ board may waive one or more of the review processes listed in subsection (b) of this section.

(f) The ~~commissioner~~ board may, upon application, adjust a budget established under this section upon a showing of need based upon exceptional or unforeseen circumstances in accordance with the criteria and processes established under section 9405 of this title.

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

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

(2)(A) After notice and an opportunity for hearing, the ~~commissioner~~ board may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This

subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

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

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

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

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

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

(3)(A) The ~~commissioner~~ board 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~~ board and required pursuant to this subchapter. The authority granted to the ~~commissioner~~ board under this subsection is in addition to any other authority granted to the ~~commissioner~~ board under law.

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

* * *

* * * Provider Bargaining Groups * * *

Sec. 24. 18 V.S.A. § 9409 is amended to read:

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

(a) The commissioner may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. A bargaining group is authorized to negotiate~~,~~ on behalf of all participating providers with the commissioner, the secretary of administration, the secretary of human services, the Green Mountain Care Board, or the commissioner of labor with respect to any matter in this chapter; chapter 13, 219, 220, or 222 of this title; ~~chapters~~ 21 V.S.A. chapter 9 ~~and 11 of Title 21~~; and ~~chapter~~ 33 V.S.A. chapters 18 and 19 ~~of Title 33, in regard~~ with respect to provider regulation, provider reimbursement, administrative simplification, information technology, medical malpractice reform, workforce planning, or quality of health care.

* * *

(c) The rules relating to negotiations shall include a nonbinding arbitration process to assist in the resolution of disputes. Nothing in this section shall be construed to limit the authority of the commissioner, the commissioner of labor, the secretary of administration, the Green Mountain Care board, or the secretary of human services to reject the recommendation or decision of the arbiter.

* * * Insurance Rate Reviews * * *

Sec. 25. 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 filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, health maintenance organization, or a managed care organization and 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) 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~~ and

(B) a decision by the Green Mountain Care board has been applied by the commissioner as provided ~~herein, unless the commissioner shall sooner give his or her written approval thereto~~ in subdivision (2) of this subsection.

(2)(A) Prior to approving a rate ~~increase~~ pursuant to this subsection, the commissioner shall seek approval for such rate ~~increase~~ from the Green Mountain Care board established in 18 V.S.A. chapter 220~~, which~~. The commissioner shall make a recommendation to the Green Mountain Care board about whether to approve or disapprove the rate within 30 days of receipt of a completed application from an insurer. In the event that the commissioner does not make a recommendation to the board within the 30-day period, the commissioner shall be deemed to have recommended approval of the rate, and the Green Mountain Care board shall review the rate request pursuant to subdivision (B) of this subsection.

(B) The Green Mountain Care board shall review rate requests forwarded by the commissioner pursuant to subdivision (A) of this subsection and shall approve or disapprove ~~the~~ a rate ~~increase~~ request within ~~10 business~~ 30 days of receipt of the commissioner's recommendation or, in the absence of a recommendation from the commissioner, the expiration of the 30-day period following the department's receipt of the completed application. In the event that the board does not approve or disapprove a rate within 30 days, the board shall be deemed to have approved the rate request.

(C) The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board within five business days of the board's decision.

~~(2)~~(3) 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 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. The board may, in its discretion, conduct a hearing on the premium rate jointly with any such hearing before the commissioner.

~~(3) After the expiration of the review period provided herein or at any time after having given written approval~~

(b) At any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section, the commissioner may, after a hearing of which at least 20 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)~~(c) 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)~~ (d) of this section. In addition, the insurer shall post the summaries on its website.

~~(c)~~(d)(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 rate 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~~ submitting the policy or rate for the Green Mountain Care board's approval 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~~ rates.

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

(A) the requirement in ~~subdivision~~ subdivisions (a)(1) and (2) for the Green Mountain Care board's approval ~~for any~~ on rate ~~increase~~ requests;

(B) the review standards in subdivision ~~(a)(2)~~ (a)(3) 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) and (d) 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.

(3) Medicare supplemental insurance policies shall be exempt only from the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests and shall be subject to the remaining provisions of this section.

Sec. 26. 18 V.S.A. § 9381(a) is amended to read:

(a)(1) 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.

(2) Only decisions by the board shall be appealable under this subsection. Recommendations to the board by the commissioner of banking, insurance, securities, and health care administration pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.

Sec. 26a. HEALTH CARE OMBUDSMAN REPORT

No later than January 15, 2013, the state health care ombudsman, in collaboration with the department of banking, insurance, securities, and health care administration and the agency of human services, shall report to the house committee on health care and the senate committees on health and welfare and on finance regarding the ombudsman's current and projected funding and resource needs, suggestions for funding mechanisms to meet those needs, and recommendations on how best to coordinate or consolidate the consumer protection efforts of the ombudsman's office, the department, and the agency.

* * * Payment Reform Pilots * * *

Sec. 27. 18 V.S.A. § 9377 is amended to read:

§ 9377. PAYMENT REFORM; PILOTS

* * *

(b)(1) The board~~, in collaboration with the commissioner of Vermont health access,~~ 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~~ this section.

(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:

* * *

~~(4)~~(3) In addition to the objectives identified in subdivision ~~(a)(3)~~ (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

* * *

(e) The board or designee 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 board in developing and implementing the pilot projects and to advise the Green Mountain Care board in setting overall policy goals.

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

(g)(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.

(3) 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.

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

* * * Blueprint for Health * * *

Sec. 28. 18 V.S.A. § 702 is amended to read:

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

(a)(1) The department of Vermont health access shall be responsible for the Blueprint for Health.

(2) The director of the Blueprint, in collaboration with the ~~commissioner~~ commissioners of health, of mental health, ~~and the commissioner~~ of Vermont health access, and of disabilities, aging, and independent living, shall oversee the development and implementation of the Blueprint for Health, including a strategic plan describing the initiatives and implementation time lines and strategies. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration and the chair of the Green Mountain Care board.

(b)(1)(A) The commissioner of Vermont health access shall establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall include the commissioner of health; the commissioner of mental health; a representative from the ~~department of banking, insurance, securities, and health care administration~~ Green Mountain Care board; a representative from the department of Vermont health access; an individual appointed jointly by the president pro tempore of the senate and the speaker of the house of representatives; a representative from the Vermont medical

society; a representative from the Vermont nurse practitioners association; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine professions; a primary care professional serving low income or uninsured Vermonters; a licensed professional mental health counselor with clinical experience in Vermont; a representative of the Vermont assembly of home health agencies who has clinical experience; a representative from a self-insured employer who offers a health benefit plan to its employees; and a representative of the state employees' health plan, who shall be designated by the commissioner of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan.

* * *

Sec. 28a. BLUEPRINT PARTICIPATION; LEGISLATIVE INTENT

It is the intent of the general assembly that**:**

(1) Access to and health insurer and Medicaid payments for a community health team should begin as soon as a medical practice begins preparation for Blueprint recognition.

(2) The director of the Blueprint use the statutory discretion afforded by 18 V.S.A. § 706(c)(2) to increase payments to medical home practices in recognition of the efforts needed to satisfy the updated National Committee for Quality Assurance scoring requirements.

(3) To the extent permitted under federal law, all health insurance plans, including the multistate plans, will be active participants in the Blueprint for Health.

* * * HMO Reporting Requirement * * *

Sec. 29. 8 V.S.A. § 5106(a) is amended to read:

(a) Every organization subject to this chapter, annually, within ~~120~~ 90 days of the close of its fiscal year, shall file a report with the commissioner, said report verified by an appropriate official of the organization, showing its financial condition on the last day of the preceding fiscal year. The report shall be prepared in accordance with the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual for health maintenance organizations and shall be in such general form and context, as approved by, and shall contain any other information required by the National Association of Insurance Commissioners together with any useful or necessary modifications or adaptations thereof required, approved or accepted by the

commissioner for the type of organization to be reported upon, and as supplemented by additional information required by the commissioner.

* * * Vermont Program for Quality in Health Care * * *

Sec. 30. 18 V.S.A. § 9416 is amended to read:

§ 9416. VERMONT PROGRAM FOR QUALITY IN HEALTH CARE

(a) The commissioner of health shall contract with the Vermont Program for Quality in Health Care, Inc. to implement and maintain a statewide quality assurance system to evaluate and improve the quality of health care services rendered by health care providers of health care facilities, including managed care organizations, to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care, and that the cost of health care rendered was considered reasonable by the providers of professional health services in that area. The commissioner of health shall ensure that the information technology components of the quality assurance system ~~are incorporated into and~~ comply with, and the commissioner of Vermont health access shall ensure such components are incorporated into, the statewide health information technology plan developed under section 9351 of this title and any other information technology initiatives coordinated by the secretary of administration pursuant to 3 V.S.A. § 2222a.

(b) The Vermont Program for Quality in Health Care, Inc. shall file an annual report with the commissioner of health. The report shall include an assessment of progress in the areas designated by the commissioner of health, including comparative studies on the provision and outcomes of health care and professional accountability.

* * *

* * * Discretionary Clauses * * *

Sec. 31. 8 V.S.A. § 4062f is added to read:

§ 4062f. DISCRETIONARY CLAUSES PROHIBITED

(a) The purpose of this section is to ensure that health insurance benefits, ~~and~~ disability income protection coverage, and life insurance benefits are contractually guaranteed and to avoid the conflict of interest that may occur when the carrier responsible for providing benefits has discretionary authority to decide what benefits are due. Nothing in this section shall be construed to impose any requirement or duty on any person other than a health insurer or an insurer offering disability income protection coverage.

(b) As used in this section:

(1) "Disability income protection coverage" means a policy, contract, certificate, or agreement that provides for weekly, monthly, or other periodic payments for a specified period during the continuance of disability resulting from illness, injury, or a combination of illness and injury.

(2) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(3) "Health insurer" means an insurance company that provides health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, a managed care organization, a health maintenance organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by a public or private entity; as well as entities offering policies for specific disease, accident, injury, hospital indemnity, dental care, disability income, long-term care, and other limited benefit coverage.

(4) "Life insurance" means a policy, contract, certificate, or agreement that provides life insurance as defined in subdivision 3301(a)(1) of this title.

(c) No policy, contract, certificate, or agreement offered or issued in this state by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

(d) No policy, contract, certificate, or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

(e) No policy, contract, certificate, or agreement of life insurance offered or issued in this state may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

* * * Prescription Drug Cost-Sharing * * *

Sec. 32. 8 V.S.A. § 4089i is amended to read:

§ 4089i. PRESCRIPTION DRUG COVERAGE

(a) A health insurance or other health benefit plan offered by a health insurer shall provide coverage for prescription drugs purchased in Canada, and used in Canada or reimported legally or purchased through the I-SaveRx program on the same benefit terms and conditions as prescription drugs purchased in this country. For drugs purchased by mail or through the internet, the plan may require accreditation by the Internet and Mailorder Pharmacy Accreditation Commission (IMPAC/tm) or similar organization.

(b) A health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall not include an annual limit on prescription drug benefits.

(c) A health insurance or other health plan offered by a health insurer or pharmacy benefit manager shall limit a beneficiary's out-of-pocket expenditures for prescription drugs, including specialty drugs, to no more per individual and family insured per year than the least amount necessary to meet both:

(1) the deductible and out-of-pocket limits in Sec. 1302(c) 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; and

(2) the minimum deductible requirements of Section 223 of the Internal Revenue Code of 1986.

(d) As used in this section:

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

(2) "Out-of-pocket expenditure" means a co-payment, coinsurance, deductible, or other cost-sharing mechanism.

(3) "Pharmacy benefit manager" shall have the same meaning as in section 4089j of this title.

(e) The department of banking, insurance, securities and health care administration shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

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

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(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, or a combination product as defined in 21 C.F.R. § 3.2(e).

* * *

(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.

(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, or item of medical food as defined in the federal Orphan Drug Act, as amended, 21 U.S.C. § 360ee(b)(3), provided to a health care provider for free distribution to patients.

* * *

(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 of financial donations or of free:

(i) prescription drugs;

(ii) over-the-counter drugs;

(iii) medical devices;

(iv) biological products; or

(v) medical equipment or supplies.

* * *

(d) 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. In any action brought pursuant to this section, the attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Fraud Act, 9 V.S.A. chapter 63.

Sec. 32b. 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 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 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:

* * *

(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 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~~ such products or connects individual recipients with the monetary value of the ~~samples~~ products provided.

* * *

(D) Any public reporting of the provision of free prescription or over-the-counter drugs, medical devices, biological products, medical equipment, or supplies to a free clinic shall not include information that allows for the identification of individual recipients of such products or connects individual recipients with the monetary value of the products provided.

(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 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.

* * *

(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 October 1. The report shall include:

(A) Information on allowable expenditures and permitted gifts required to be disclosed under this section, which shall present information in aggregate form 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. In accordance with subdivisions (1)(B), (1)(D), and (2)(A) of this subsection, information on samples and donations to free clinics 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.

* * *

(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. In any action brought pursuant to this section, the attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Fraud Act, 9 V.S.A. chapter 63.

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

* * * Medicaid Waiver Approval * * *

Sec. 33. DUAL ELIGIBLE PROJECT PROPOSAL

(a) It is the intent of the general assembly to provide the agency of human services with the authority to enter into negotiations with the Centers for Medicare and Medicaid Services (CMS) to seek waivers as needed to operate an integrated system of coverage for individuals who are eligible for Medicare and Medicaid, and to provide the agency of human services with the authority to implement the program approved by CMS. Any waivers sought pursuant to this section shall promote the health care reform goals established in No. 48 of the Acts of 2011, including universal coverage; integration of health, mental health, and substance abuse treatment; administrative simplification; and payment reform.

(b)(1) The agency of human services may seek a waiver or waivers from CMS to enable the agency to better serve individuals who are eligible for both Medicare and Medicaid ("dual eligibles") through a consolidated program operated by the agency of human services or by a department of the agency of

human services. The waiver or waivers sought pursuant to this section may be consolidated with or filed in conjunction with Vermont's Medicaid Section 1115 Global Commitment to Health waiver renewal, any Choices for Care waiver modifications, or a state children's health insurance program (SCHIP) waiver. Any modifications of the Choices for Care waiver shall be consistent with No. 56 of the Acts of 2005.

(2) The agency may seek permission to serve the dual eligibles population as a public managed care organization or through another administrative mechanism that enables the agency to integrate services for the dual eligibles, pursue administrative flexibility and simplification, or otherwise align health coverage programs. The agency shall seek permission to implement payment mechanisms that ensure the health coverage provided under the waiver or waivers is consistent with and supportive of the payment reform initiatives established by the Green Mountain Care board.

(3) The agency shall seek a waiver to create a consolidated program which:

(A) includes eligibility standards, methodologies, and procedures that are neither more restrictive than the standards, methodologies, and procedures in effect as of January 1, 2012 nor more restrictive than the standards, methodologies, and procedures for dual eligible individuals who are not enrolled in this consolidated program.

(B) does not reduce the amount, duration, or scope of services covered by Medicaid and Medicare or impose limits on enrollment or access to services.

(C) ensures that an individual in the consolidated program receives a level of service that is equivalent to or greater than the individual would have received if he or she were not in the consolidated program.

(D) provides reasonable opportunity for an individual to disenroll from the consolidated program and transition to traditional Medicaid and Medicare coverage.

(E) as provided in the terms and conditions for the Choices for Care Section 1115 waiver, includes an independent advocacy system for all participants and applicants in the consolidated program which includes, at a minimum**,** access to area agency on aging advocacy, legal services**,** and the long-term care and health care ombudsmen.

(F) at a minimum, as required under 42 USC § 1395a(a), guarantees individuals a choice of health care providers who offer the same service or

services within the individual's ISP and a choices of providers for services that are not offered through the individual's ISP.

(G) unless otherwise appropriated by the general assembly, invests at least 50 percent of the remaining funds at the end of the state fiscal year in the consolidated program.

(H) maintains state provider payment rates in the consolidated program that:

(i) permit providers to deliver services, on a solvent basis, that are consistent with efficiency, economy, access, and quality of care; and

(ii) are at least comparable to the average weighted payment rates that eligible providers would have received from Medicaid and Medicare in the absence of the consolidated program, subject to modifications as a result of:

(I) changes to federal Medicare rates;

(II) provider rates set by the Green Mountain Care board pursuant to 18 V.S.A. § 9376; or

(III) rate negotiations between the providers in an ISP and the agency of human services.

(4) The agency of human services shall enter into a waiver only if it provides individuals enrolled in the consolidated program who become ineligible for Medicaid or Medicare or who choose to opt out of the program with a seamless transition process between coverage provided by the consolidated program and traditional Medicaid coverage, Medicare coverage, or both to ensure that the process does not result in a reduction or loss of services during the transition.

(5) The agency of human services or designee shall include the following provisions in its contracts with integrated service providers (ISP):

(A) a broad range of services for individuals, to be provided by the ISP or through contracts between the ISP and other service providers**,** and coordination between the ISP and other service or health care providers, including the individual's medical home, the Blueprint for Health community health teams, and Support And Services at Home (SASH), as appropriate.

(B) an enforcement mechanism to ensure that the ISP and any subcontractors provide integrated services as required by the waiver and the contract provisions.

(C) transparent quality assurance measures for evaluating the performance of the ISP and any subcontractors and a method for making the measures public.

(6) The agency of human services shall provide dual eligible individuals with meaningful information about their care options, including services through Medicaid, Medicare, and the consolidated program established in this section. The agency shall develop enrollee materials and notices that are accessible and understandable to those individuals who will be enrolled in the consolidated program, including individuals with disabilities, speech and vision limitations, or limited English proficiency.

(7) The agency of human services shall establish by rule a comprehensive and accessible appeals process, including an opportunity for an individual to request an independent clinical assessment of medical or functional limitations when appealing an eligibility determination, a denial in services, or a reduction in services.

(c)(1) The agency of human services shall implement the program approved by CMS by rule.

(2) Prior to filing proposed rules, the agency shall seek input on the proposed rules from a workgroup that includes providers**,** beneficiaries**,** and advocates for beneficiaries.

Sec. 34. GLOBAL COMMITMENT; CHOICES FOR CARE; SCHIP

(a) It is the intent of the general assembly to provide the agency of human services with the authority to renew and implement Vermont's Medicaid Section 1115 Global Commitment to Health ("Global Commitment") waiver or to request a new waiver from the Centers for Medicare and Medicaid Services (CMS) with similar terms and conditions as Global Commitment. It is also the intent of the general assembly to provide the agency with the authority to modify or renew the Choices for Care waiver consistent with the provisions of No. 56 of the Acts of 2005 and to seek a state children's health insurance program (SCHIP) waiver to allow for greater administrative flexibility and simplification, as well as to seek advantageous financial terms similar to those in the Global Commitment waiver. Any waivers sought pursuant to this section shall promote the health care reform goals established in No. 48 of the Acts of 2011, including universal coverage; administrative simplification; integration of health, mental health, and substance abuse; and payment reform.

(b) The secretary of human services or designee may seek to renew the Global Commitment waiver, seek a new Medicaid or SCHIP waiver, modify the Choices for Care waiver, or a combination thereof, to enable the agency to:

(1) Maintain the public managed care entity structure, financial provisions, and flexibility provided in the Global Commitment terms and conditions and extend these provisions and flexibility to the Choices for Care and Dr. Dynasaur programs.

(2) Maintain the waiver terms for special demonstration populations, such as individuals with traumatic brain injury and others currently provided for in Global Commitment, as well as for any special demonstration populations covered and services provided to eligible individuals under Choices for Care.

(3) Eliminate terms and conditions which are outdated or for which state options are now available.

(4) Eliminate Catamount Health Assistance in order to comply with the insurance provisions in this act and in the federal Affordable Care Act.

(5) Obtain federal matching funds for any state financial assistance provided to individuals purchasing insurance through the Vermont health benefit exchange in order to promote seamless health coverage for eligible individuals and to achieve universal coverage, affordability, and administrative simplification. The secretary or designee shall analyze the impacts of offering state financial assistance to individuals with incomes below 350 percent of the federal poverty level.

(6) Ensure a streamlined transition between Medicaid and the Vermont health benefit exchange.

(7) Modify payment mechanisms to ensure that the health coverage provided under any waiver program is consistent with and supportive of the payment reform initiatives established by the Green Mountain Care board.

(c) Any waiver or waivers sought pursuant to this section may be consolidated or filed in conjunction with Vermont's Global Commitment to Health waiver renewal, Choices for Care waiver modifications, SCHIP waiver, or combination thereof. The secretary of human services or designee shall implement the program or programs approved by CMS by rule.

Sec. 34a. Sec. 17 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 17. FEDERAL HEALTH CARE REFORM; DEMONSTRATION PROGRAMS

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

include Medicare as a participant in the Blueprint for Health as described in 18 V.S.A. chapter 13 ~~of Title 18~~.

(2) Upon establishment by the secretary of HHS of a shared savings program pursuant to Sec. 3022 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 or other federal authority established to allow for payment and delivery system reform, the secretary of human services may apply to the secretary of HHS to enable ~~Vermont~~ the state's Medicaid and SCHIP programs, including any waiver programs under Global Commitment to Health or Choices for Care, to ~~participate in the program by establishing~~ engage in payment reform ~~pilot projects as provided for by Sec. 14 of this act~~ activities consistent with the payment reform initiatives established by the Green Mountain Care board pursuant to 18 V.S.A. chapter 220. The chair of the Green Mountain Care board or designee may apply to the secretary of HHS to enable Vermont to advance the payment reform goals established in No. 48 of the Acts of 2011 and consistent with the board's authority.

(b)(1) Medicaid waivers. The intent of this section is to provide the secretary of human services with the authority to pursue Medicaid and SCHIP participation in the Blueprint for Health and new payment reform initiatives established by the Green Mountain Care board through any existing or new waiver.

(2) Upon establishment by the secretary of HHS of a health home demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152; Section 1115 or 2107 of the Social Security Act; or other federal authority, the secretary of human services may apply to the secretary of HHS to include Medicaid or SCHIP as a participant in the Blueprint for Health as described in 18 V.S.A. chapter 13 ~~of Title 18~~ and other payment reform initiatives established by the Green Mountain Care board pursuant to 18 V.S.A. chapter 220. ~~In the alternative, under Section 1115 of the Social Security Act, the secretary of human services may apply for an amendment to an existing Section 1115 waiver or may include in the renegotiation of the Global Commitment for Health Section 1115 waiver a request to include Medicaid as a participant in the Blueprint for Health as described in chapter 13 of Title 18.~~

Sec. 35. WAIVER UPDATES AND INFORMATION

(a) The secretary of human services or designee shall present information and updates on the waiver proposal to the house committees on appropriations, on human services, and on health care and the senate committees on

appropriations and on health and welfare as requested, and no later than January 30, 2013. When the general assembly is not in session, the secretary or designee shall present information and updates to the health access oversight committee upon request. The secretary or designee shall be available to the health access oversight committee on a monthly basis to provide an update in person or by telephone on the status of waiver planning, application, and negotiations, including updates on the substantive provisions and issues provided for in Secs. 33–34 of this act. If the health access oversight committee elects not to meet in person or by telephone during a month, the secretary or designee shall provide a monthly update by telephone conference call to interested parties and stakeholders, including a time for questions from the public. In addition, the secretary or designee shall provide updates at each meeting of the Medicaid and exchange advisory board and to other advisory committees upon request.

(b) The secretary of human services or designee shall present a transition plan for individuals eligible for or enrolled in the Vermont health access plan, the employer-sponsored insurance premium assistance program, and Catamount Health to the house committees on appropriations, on human services, and on health care and the senate committees on appropriations and on health and welfare by January 15, 2013.

Sec. 35a. WAIVERS; INTENT

It is the intent of the general assembly that the transition from Catamount Health and the Vermont health access plan to the Vermont health benefit exchange with additional subsidies should be accomplished in such a way that it minimizes the financial exposure of low-income Vermonters, including the amounts of their premiums and out-of-pocket costs, and recognizes the need to limit the financial exposure of the state of Vermont.

* * * Health Access Eligibility Unit * * *

Sec. 36. 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.

* * * Technical and Clarifying Changes * * *

Sec. 37. 18 V.S.A. § 701 is amended to read:

§ 701. DEFINITIONS

For the purposes of this chapter:

* * *

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

* * *

(11) "Hospital" shall have the same meaning as in section ~~9456~~ 9451 of this title.

* * *

Sec. 38. 18 V.S.A. § 9391 is amended to read:

§ 9391. NOMINATION AND APPOINTMENT PROCESS

* * *

(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 and the name of any incumbent who declares that he or she wishes to be a candidate to succeed himself or herself.

(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. The names of candidates submitted and not selected shall remain confidential.

* * *

Sec. 39. Sec. 31(a) of No. 48 of the Acts of 2011 is amended to read:

(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, as provided in 3 V.S.A. § 259.

* * * Sports Injuries * * *

Sec. 39a. 16 V.S.A. § 1431(d) is amended to read:

(d) Participation in athletic activity.

(1) A coach shall not permit a youth athlete to continue to participate in any training session or competition associated with a school athletic team if the coach has reason to believe that the athlete has sustained a concussion or other head injury during the training session or competition.

(2) A coach shall not permit a youth athlete who has been prohibited from training or competing pursuant to subdivision (1) of this subsection 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.

* * * Rulemaking Authority * * *

Sec. 40. HOSPITAL BUDGET REVIEW RULES

For the purposes of hospital budget reviews pursuant to 18 V.S.A. chapter 221, subchapter 7, the Green Mountain Care board shall apply Rule 7.500 of the department of banking, insurance, securities, and health care administration, as that rule exists on the effective date of this section, until March 1, 2013 or the board's adoption of a permanent rule on hospital budget reviews pursuant to Sec. 40a of this act, whichever is earlier.

Sec. 40a. RULEMAKING

No later than January 1, 2013, the Green Mountain Care board shall adopt rules pursuant to 3 V.S.A. chapter 25 implementing the amendments in this act to 8 V.S.A. § 4062 (insurance rate review) and to 18 V.S.A. chapter 221, subchapters 5 (certificate of need) and 7 (hospital budget review).

* * * Position Transfer * * *

Sec. 40b. TRANSFER OF POSITION

On or before January 1, 2013, one health care administrator position shall be transferred from the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

* * * Maximizing Federal Funds * * *

Sec. 40c. MAXIMIZING PREMIUM TAX CREDITS AND COST-SHARING SUBSIDIES

No later than January 15, 2013, the secretary of administration or designee shall recommend to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance strategies for maximizing the number of Vermont residents who will be eligible to receive federal premium tax credits or cost-sharing subsidies, or both, in the Vermont health benefit exchange and for maximizing the amount of the federal credits and subsidies that eligible Vermonters will receive.

* * * Health Access Oversight Committee * * *

Sec. 40d. 2 V.S.A. § 852 is amended to read:

§ 852. FUNCTIONS AND DUTIES

(a) The health access oversight committee shall ~~carry on~~ monitor, oversee, and provide a continuing review of ~~the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs~~ health care and human services programs in Vermont when the general assembly is not in session.

(b) In conducting its ~~review~~ oversight and in order to fulfill its duties, the committee ~~shall~~ may consult the following:

(1) Consumers and advocacy groups ~~regarding their satisfaction and complaints~~.

(2) Health care providers ~~regarding their satisfaction and complaints~~.

(3) The department of Vermont health access.

(4) The department of banking, insurance, securities, and health care administration.

(5) The department of health.

(6) The department for children and families.

(7) The department of disabilities, aging, and independent living.

(8) The department of mental health.

(9) The agency of human services.

(10) The agency of administration.

(11) The Green Mountain Care board.

(12) The director of health care reform.

~~(6)~~(13) The attorney general.

~~(7)~~(14) The health care ombudsman.

(15) The long-term care ombudsman.

~~(8)~~(16) The Vermont program for quality in health care.

~~(9)~~(17) Any other person or entity as determined by the committee.

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to ~~the state Medicaid program and other state~~ health care and

human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the general assembly.

* * * Repeals * * *

Sec. 41. REPEALS

(a) 8 V.S.A. § 4089b(h) (insurance quality task force) is repealed July 1, 2012.

(b) 18 V.S.A. § 9409a (provider reimbursement survey) is repealed on passage.

(c) 8 V.S.A. § 4080c (safety net) is repealed January 1, 2014, except that plans issued or renewed in 2013 shall remain in effect until their anniversary date in calendar year 2014 to the extent consistent with the provisions of the Affordable Care Act and related guidance and regulations.

(d) Sec. 6 (health access eligibility unit transfer) of No. 48 of the Acts of 2011 is repealed on passage.

(e) 33 V.S.A. chapter 13, subchapter 2 (payment reform pilots) is repealed on passage.

(f) 18 V.S.A. § 4632(a)(7) (DVHA prescribed product report) is repealed on passage.

(g) [Deleted].

(h) 33 V.S.A. chapter 19, subchapter 3 (Vermont Health Access Plan; employer-sponsored insurance assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage by the department of Vermont health access as authorized by the Centers on Medicare and Medicaid Services.

(i) 8 V.S.A. §§ 4080a (small group market) and 4080b (nongroup market) are repealed January 1, 2014, except that plans issued or renewed in 2013 shall remain in effect until their anniversary date in calendar year 2014 to the extent consistent with the provisions of the Affordable Care Act and related guidance and regulations.

(j) 8 V.S.A. § 4062d (market security trust) is repealed July 1, 2012.

Sec. 41a. TRANSITIONAL PROVISIONS; IMPLEMENTATION

(a) Except as otherwise provided in subsection (c) of this section, small employers may enroll in health insurance plans offered though the Vermont health benefit exchange beginning at the earliest on October 1, 2013 and at the latest on the renewal date of any small group plan the employer purchased prior to January 1, 2014.

(b) Except as otherwise provided in subsections (c) and (d) of this section, individuals in the nongroup market may enroll in health insurance plans offered though the Vermont health benefit exchange beginning at the earliest on October 1, 2013 and at the latest on the renewal date of any nongroup plan the individual purchased prior to January 1, 2014, if allowed under federal law.

(c) Notwithstanding Sec. 41(i) of this act, repealing 8 V.S.A. §§ 4080a and 4080b, the department of banking, insurance, securities, and health care administration and the Green Mountain Care board may continue to approve rates and forms for nongroup and small group health insurance plans under the statutes and rules in effect prior to the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. In the alternative, the department of banking, insurance, securities, and health care administration may allow individuals and small employers to extend coverage under an existing health insurance plan. The department of banking, insurance, securities, and health care administration and the Green Mountain Care board shall maintain their authority pursuant to this subsection until the exchange is able to enroll all qualified individuals and small employers who apply for coverage through the exchange.

(d) Notwithstanding Sec. 41(h) of this act, repealing the Vermont health access plan and employer-sponsored insurance assistance, the department of Vermont health access may continue to provide employer-sponsored insurance assistance and coverage through the Vermont health access plan to eligible individuals beyond the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. The department of Vermont health access shall maintain its authority to administer these programs until the exchange is able to enroll all qualified applicants who apply for coverage through the exchange.

(e) Notwithstanding the provisions of 8 V.S.A. §§ 4080a(d)(1) and 4080b(d)(1), a health insurer shall not be required to guarantee acceptance of any individual, employee, or dependent on or after January 1, 2014 for a small group plan offered pursuant to 8 V.S.A. § 4080a or a nongroup plan offered pursuant to 8 V.S.A. § 4080b except as required by the department of banking, insurance, securities, and health care administration or the Green Mountain Care board, or both, pursuant to subsection (c) of this section.

(f) To the extent permitted under the Affordable Care Act, in implementing the Vermont health benefit exchange, it is the intent of the general assembly

not to impair the health care coverage provided to Vermonters through collective bargaining agreements entered into prior to January 1, 2013 and in effect on January 1, 2014 until the date that any such collective bargaining agreement relating to such health care coverage terminates.

Sec. 42. EFFECTIVE DATES

(a) Secs. 5 (Green Mountain Care board authority), 5a (bill-back report), 6–11 (unified health care budget), 11a (claims edit standards), 12–14 (Green Mountain Care board duties, health care administration), 23 (hospital budgets), 24 (provider bargaining groups), 25 and 26 (insurance rate reviews), 26a (ombudsman's report), 27 (payment reform pilot projects, 28 (Blueprint for Health), 28a (Blueprint intent), 29 (HMO reporting requirements), 33–35a (waivers), 36 (health access eligibility unit), 37–39 (technical/clarifying changes), 40b (transfer of position), 40c (maximizing federal funds), 41 (repeals), and 41a (transitional provisions) of this act and this section shall take effect on passage.

(b) Secs. 40 (hospital budget rules) and 40a (rulemaking) of this act shall take effect on passage, provided that in order to comply with the deadlines contained in this act, the Green Mountain Care board may begin the rulemaking process prior to passage.

(c) Secs. 1 and 2 (50 employees or fewer), 2a (qualified health benefit plans), 2b (navigators), and 2c (exchange options) shall take effect on July 1, 2012.

(d) Sec. 30 (VPQHC) shall take effect on July 1, 2013.

(e) Sec. 31 (prohibition on discretionary clauses) shall take effect on January 1, 2013 and shall apply to all policies, contracts, certificates, and agreements renewed, offered, or issued in this state with effective dates on or after such date.

(f)(1) Secs. 32(a), (d), and (e) (prescription drug coverage); 32a and 32b (prescribed products); 39a (sports injuries); and 40d (health access oversight committee) shall take effect on July 1, 2012.

(2) Sec. 32(b) and (c) (prescription drug cost-sharing) shall take effect on October 1, 2012 and shall apply to all health insurance plans and health benefit plans on and after October 1, 2012 on such date as a health insurer issues, offers, or renews the plan, but in no event later than October 1, 2013.

(g) Secs. 3 (merged insurance market) and 4 (grandfathered plans) shall take effect on January 1, 2013, provided that:

(1) the department of banking, insurance, securities, and health care administration and the Green Mountain Care board may adopt rules as needed

before that date to ensure that enrollment in the health insurance plans will be available no later than October 1, 2013; and

(2) January 1, 2014 shall be the earliest date that coverage may begin under a plan offered in the merged market.

(h) Secs. 14a–22 (certificates of need) shall take effect on January 1, 2013, and the Green Mountain Care board shall have sole jurisdiction over all applications for new certificates of need and over the administration of all existing certificates of need on and after that date, provided that for applications already in process on that date, the rules and procedures in place at the time the application was filed shall continue to apply until a final decision is made on the application.

(Committee Vote: 8-2-1)

Rep. Johnson of South Hero, for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committee on **Health Care.**

(Committee Vote: 6-2-3)

Amendment to be offered by Rep. Olsen of Jamaica to the recommendation of amendment of the Committee on Health Care to H. 559

Rep. Olsen of Jamaica moves that the recommendation of the committee on Health Care be amended as follows:

First: In Sec. 32, 8 V.S.A. § 4089i, in subsection (a), by striking out "or purchased through the I-SaveRx program"

Second: By adding a Sec. 32c to read:

Sec. 32c. I-SaveRx PRESCRIPTION DRUG PROGRAM; REPORT

(a) No later than December 1, 2012, the legislative joint fiscal office shall submit a report to the house committee on health care and the senate committee on health and welfare regarding Vermont's participation in the I-SaveRx prescription drug program enacted in No. 2 of the Acts of 2005.

(b) The joint fiscal office's report shall contain an analysis of the total cost to the state of implementing and administering the I-SaveRx program, the total number of participants in the program by year and in the aggregate, and an estimate of the total savings realized by program participants during the program's operation. The office shall also identify the program's successes and failures and provide an assessment of the relative merits to the state of pursuing similar efforts in the future.

Third: In Sec. 41, Repeals, by striking subsection (g) in its entirety and inserting in lieu thereof the following:

(g) No. 2 of the Acts of 2005 (I-SaveRx prescription drug program) is repealed on passage. Notwithstanding any provision of Sec. 2 of No. 2 of the Acts of 2005 to the contrary, repeal of such act shall constitute Vermont's withdrawal from the I-SaveRx agreement and terminate its related cooperative relationship with the state of Illinois.

Fourth: In Sec. 42, Effective Dates, in subsection (a), following "29 (HMO reporting requirements", by inserting ", 32c (I-SaveRx report),"

Amendment to be offered by Rep. Olsen of Jamaica to the recommendation of amendment of the Committee on Health Care to H. 559

Rep. Olsen of Jamaica moves that the report of the committee on Health Care be amended as follows:

First: By adding a Sec. 3a to read as follows:

Sec. 3a. 33 V.S.A. § 1811 is amended to read:

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

(a) As used in this section:

(1) "Health benefit plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan ~~offered through the Vermont health benefit exchange and~~ issued to an individual or to an employee of a small employer. The 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 in which 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.

* * *

(b) ~~No person may provide a health benefit plan to an individual or small employer unless the plan is offered through the Vermont health benefit~~

~~exchange and complies with the provisions of this subchapter.~~

~~(c)~~ No person may provide a health benefit plan to an individual or small employer unless such person is a registered carrier. The commissioner of banking, insurance, securities, and health care administration shall establish, by rule, the minimum financial, marketing, service and other requirements for registration. Such registration shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

~~(d)~~(c) A registered carrier shall guarantee acceptance of all individuals, small employers, and employees of small employers, and each dependent of such individuals and employees, for any health benefit plan offered by the carrier.

~~(e)~~(d) A registered carrier shall offer a health benefit plan rate structure which at least differentiates between single person, two person, and family rates.

~~(f)(1)~~(e)(1) A registered carrier shall use a community rating method acceptable to the commissioner of banking, insurance, securities, and health care administration for determining premiums for health benefit plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating individuals, small employers, or employees of small employers, or the dependents of such individuals or employees:

* * *

~~(g)~~(f) A registered carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this section. The requirements for certification shall be as the commissioner prescribes by rule.

~~(h)~~(g) A registered carrier shall provide, on forms prescribed by the commissioner, full disclosure to a small employer of all premium rates and any risk classification formulas or factors prior to acceptance of a plan by the small employer.

~~(i)~~(h) A registered carrier shall guarantee the rates on a health benefit plan for a minimum of 12 months.

~~(j)~~(i) The commissioner shall disapprove any rates filed by any registered carrier, whether initial or revised, for insurance policies unless the anticipated medical loss ratios for the entire period for which rates are computed are at least 80 percent, as required by the Patient Protection and Affordable Care Act (Public Law 111-148).

~~(k)~~(j) The guaranteed acceptance provision of subsection ~~(d)~~(c) of this section shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

Second: By adding a Sec. 3b to read as follows:

Sec. 3b. Sec. 2 of No. 48 of the Acts of 2011 is amended to read:

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:

* * *

(2)(A) As provided in Sec. 4 of this act, no later than ~~November~~ October 1, 2013, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling individuals and ~~small~~ employers with 50 or fewer employees for coverage beginning January 1, 2014. Beginning January 1, 2014, the commissioner of banking, insurance, securities, and health care administration may require qualified health benefit plans to be sold to individuals and small groups through the Vermont health benefit exchange, provided that the commissioner shall also allow qualified and nonqualified plans that comply with the required provision

of the Affordable Care Act to be sold to individuals and small groups outside the exchange. 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.

* * *

(3) ~~As provided in Sec. 4 of this act, no~~ No later than October 1, 2015, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling employers with 100 or fewer employees for coverage beginning January 1, 2016. No later than ~~November~~ October 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.

Third: In Sec. 42, Effective Dates, by adding a subsection (i) to read as follows:

(i) Secs. 3a and 3b of this act shall take effect within 30 days of a finding by the commissioner of banking, insurance, securities, and health care administration, the commissioner of Vermont health access, or the Green Mountain Care board that the average premium for a qualified health benefit plan offered through the Vermont health benefit exchange at any actuarial value exceeds by 10 percent or more the average cost of an actuarially equivalent grandfathered plan.

Amendment to be offered by Reps. Higley of Lowell and Clark of Vergennes to the recommendation of amendment of the Committee on Health Care to H. 559

Reps. Clark of Vergennes and Higley of Lowell move that the recommendation of the committee on Health Care be amended as follows:

First: In Sec. 3, 33 V.S.A. § 1811, in the first sentence of subdivision (a)(1), following "organization health benefit plan", by striking out "offered through the Vermont health benefit exchange and"

Second: In Sec. 3, 33 V.S.A. § 1811, by striking out subsection (b) in its entirety and relettering the remaining subsections to be alphabetically correct

Third: In Sec. 3, 33 V.S.A. § 1811, in subsection (k), by striking out "subsection (d)" and inserting in lieu thereof "subsection (c)"

Fourth: By adding a Sec. 3a to read as follows:

Sec. 3a. Sec. 2 of No. 48 of the Acts of 2011 is amended to read:

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:

* * *

(2)(A) As provided in Sec. 4 of this act, no later than ~~November~~ October 1, 2013, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling individuals and ~~small~~ employers with 50 or fewer employees for coverage beginning January 1, 2014. Beginning January 1, 2014, the commissioner of banking, insurance, securities, and health care administration may require qualified health benefit plans to be sold to individuals and small groups through the Vermont health benefit exchange, provided that the commissioner shall also allow qualified and nonqualified plans that comply with the required provision of the Affordable Care Act to be sold to individuals and small groups outside the exchange. 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.

* * *

(3) ~~As provided in Sec. 4 of this act, no~~ No later than October 1, 2015, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall make plans available to employers with 100 or fewer employees for coverage beginning January 1, 2016. No later than ~~November~~ October 1, 2016, the Vermont health benefit exchange ~~established in 33 V.S.A. chapter 18, subchapter 1~~ shall ~~begin enrolling~~ make plans available to large employers for coverage beginning January 1, 2017.

* * *

Fifth: In Sec. 41a (transitional provisions), by striking out subsection (c) in its entirety; in subsection (e), following "8 V.S.A. § 4080b", by striking out "except as required by the department of banking, insurance, securities, and health care administration or the Green Mountain Care board, or both, pursuant to subsection (c) of this section"; and by relettering the remaining subsections to be alphabetically correct

Sixth: In Sec. 42, Effective Dates, in subsection (g), following "Secs. 3 (merged insurance markets)", by inserting ", 3a (strategic plan),"

Amendment to be offered by Rep. Browning of Arlington to the recommendation of amendment of the Committee on Health Care to H. 559

Rep. Browning of Arlington moves that the recommendation of the committee on Health Care be amended as follows:

First: By adding a Sec. 39b to read:

Sec. 39b. 33 V.S.A. chapter 19, subchapter 9 is added to read:

Subchapter 9. Medical Debt Loan Fund

§ 2091. MEDICAL DEBT LOAN FUND

(a) The medical debt loan fund is established in the state treasury as a special fund to finance zero-interest loans to individuals experiencing extreme financial hardship as the direct result of medical debt.

(b) Into the fund shall be deposited:

(1) loan payments collected by the director of economic opportunity pursuant to subsection 2092(b) of this title;

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

(3) to the extent authorized under federal law, federal funds for Medicaid, Medicare, and the Vermont health benefit exchange established in chapter 18, subchapter 1 of this title; and

(4) 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 department 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) payments to health care providers; and

(2) zero-interest loans to individuals experiencing extreme financial hardship as the direct result of medical debt.

Second: By adding a Sec. 39c to read:

Sec. 39c. 3 V.S.A. § 3903a is added to read:

§ 3903a. MEDICAL DEBT; PAYMENTS; LOANS

(a) Not later than January 1, 2013, the director of economic opportunity, in consultation with the commissioner of Vermont health access, shall establish a loan program to be administered by the designated community services agencies established under section 3903 of this title. The purpose of the loans shall be to provide emergency assistance to individuals whose medical debt has resulted in extreme financial hardship. The loans shall be used to assist individuals with meeting immediate and urgent individual and family needs.

(b) Loans shall be available only to Vermont residents, and recipients of the loans shall not be charged interest. The loan terms and conditions as well as the program's eligibility criteria shall be established by the director of economic opportunity in consultation with the commissioner of Vermont health access and shall be consistent with the amount of money available in the medical debt loan fund established in 33 V.S.A. § 2091. The director shall establish criteria for repayment of loans, which shall include a provision specifying that the amount of the repayment due in any year shall be withheld pursuant to the provisions of 32 V.S.A. chapter 151, subchapter 12 from any tax refund to which a loan recipient is entitled in that year.

(c) The director shall develop a process by which the funds provided to loan recipients may be paid directly to an applicable health care provider or providers in the full amount of a recipient's outstanding medical debt.

(d) Beginning December 1, 2014, each community services agency shall report annually to the director of economic opportunity and the commissioner of Vermont health access the status of the loans issued under this section, as well as any other information deemed relevant by the director and the commissioner. The director and the commissioner shall aggregate such information and report it to the governor and the general assembly not later than January 1 of each year beginning in 2014.

Third: In Sec. 42, Effective Dates, in subdivision (f)(1), following "39a (sports injuries);", by inserting "Secs. 39b and 39c (medical debt loan fund);"

Amendment to be offered by Rep. Fagan of Rutland City to the recommendation of amendment of the Committee on Health Care to H. 559

Rep. Fagan of Rutland City moves that the recommendation of the committee on Health Care be amended as follows:

First: By adding a Sec. 41b to read as follows:

Sec. 41b. Sec. 9 of No. 48 of the Acts of 2011 is amended to read:

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~~ September 15, 2012.

* * *

Second: In Sec. 42, Effective Dates, in subsection (a), by striking out "41 (repeals), and 41a (transitional provisions) of this act" and inserting in lieu thereof "41 (repeals), 41a (transitional provisions), and 41b (financing plans) of this act"

Amendment to be offered by Rep. Donahue of Northfield to the recommendation of amendment of the Committee on Health Care to H. 559

Rep. Donahue of Northfield moves that the recommendation of Health Care be amended as follows:

First: By adding a Sec. 11b to read as follows:

Sec. 11b. 18 V.S.A. chapter 221, subchapter 8 is added to read:

Subchapter 8. Mental Health and Substance Abuse Treatment

Quality Assurance

§ 9461. QUALITY INDICATORS

(a) The department of banking, insurance, securities, and health care administration shall develop performance quality indicators to evaluate and ensure that health insurers, including managed care organizations that contract with health insurers to administer the insurers' mental health benefits, comply with the provisions of 8 V.S.A. § 4089b and related rules.

(b) The departments of health and of mental health shall develop clinical and performance quality measures to evaluate and ensure that health care

professionals and health care facilities in Vermont provide high quality mental health and substance abuse treatment services to their patients.

§ 9462. QUALITY IMPROVEMENT PROJECTS

In addition to reviewing mental health and substance abuse treatment data pursuant to subdivision 9375(b)(12) of this title, the Green Mountain Care board shall consider the results of any quality improvement projects not otherwise confidential or privileged undertaken by managed care organizations for mental health and substance abuse care and treatment pursuant to 8 V.S.A. § 4089b(d)(1)(B)(vii) and subsection 9414(i) of this title.

Second: In Sec. 12, 18 V.S.A. § 9375(b), by adding a subdivision (12) to read as follows:

(12) Review data regarding mental health and substance abuse treatment reported to the department of banking, insurance, securities, and health care administration pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the mental health technical advisory group established pursuant to subdivision 9374(e)(2) of this title.

Third: In Sec. 42, Effective Dates, by adding a subsection (i) to read as follows:

(i) Sec. 11b (mental health and substance abuse quality assurance) shall take effect on July 1, 2012.

H. 718

An act relating to the department of public service and the public service board

Rep. Shand of Weathersfield, 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:

* * * Effective Date of the CBES * * *

Sec. 1. 21 V.S.A. § 268 is amended to read:

§ 268. COMMERCIAL BUILDING ENERGY STANDARDS

* * *

(c) Revision and interpretation of energy standards. No later than January 1, 2011, the commissioner shall complete rulemaking to amend the commercial building energy standards to ensure that commercial building construction must be designed and constructed in a manner that complies with ANSI/ASHRAE/IESNA standard 90.1-2007 or the 2009 edition of the IECC, whichever provides the greatest level of energy savings. These amendments

shall be effective ~~three months~~ one year after final adoption and shall apply to construction commenced on and after the date they become effective. At least every three years after January 1, 2011, the commissioner of public service shall amend and update the CBES by means of administrative rules adopted in accordance with 3 V.S.A. chapter 25. The commissioner shall ensure that appropriate revisions are made promptly after the issuance of updated standards for commercial construction under the IECC or ASHRAE/ANSI/IESNA standard 90.1, whichever provides the greatest level of energy savings. Prior to final adoption of each required revision of the CBES, the department of public service shall convene an advisory committee to include one or more mortgage lenders; builders; building designers; architects; civil, mechanical, and electrical engineers; utility representatives; and other persons with experience and expertise, such as consumer advocates and energy conservation experts. The advisory committee may provide the commissioner of public service with additional recommendations for revision of the CBES.

* * *

(2) ~~Except for the amendments required by this subsection to be adopted by January 1, 2011, each~~ Each time the CBES are amended by the commissioner of public service, the amended CBES shall become effective upon a date specified in the adopted rule, a date that shall not be less than ~~three months~~ one year after the date of adoption. Except for the amendments required by this subsection to be adopted by January 1, 2011, persons submitting an application for any local permit authorizing commercial construction, or an application for construction plan approval by the commissioner of public safety pursuant to 20 V.S.A. chapter 173, before the effective date of the amended CBES shall have the option of complying with the applicable provisions of the earlier or the amended CBES. After the effective date of the original or the amended CBES, any person submitting such an application for commercial construction in an area subject to the CBES shall comply with the most recent version of the CBES.

* * *

Sec. 2. RETROACTIVE APPLICATION

Sec. 1 of this act shall apply to rules adopted under 21 V.S.A. § 268 (commercial building energy standards) on or after September 1, 2011. The department of public service shall conform to the provisions of Sec. 1 of this act, the effective date contained in those rules under 21 V.S.A. § 268 most recently adopted prior to the effective date of this section. The department shall file a conforming copy of the rules with the secretary of state and the legislative committee on administrative rules. The filing shall be deemed to

comply with 3 V.S.A. § 843 (filing of adopted rules) as long as the sole rule revision contained in the filing is the change in the effective date required by this section.

* * * Coordination of Energy Planning * * *

Sec. 3. 30 V.S.A. § 202 is amended to read:

§ 202. ELECTRICAL ENERGY PLANNING

(a) The department of public service, through the director for regulated utility planning, shall constitute the responsible utility planning agency of the state for the purpose of obtaining for all consumers in the state proper utility service at minimum cost under efficient and economical management consistent with other public policy of the state. The director shall be responsible for the provision of plans for meeting emerging trends related to electrical energy demand, supply, safety and conservation.

(b) The department, through the director, shall prepare an electrical energy plan for the state. The plan shall be for a 20-year period and shall serve as a basis for state electrical energy policy. The electric energy plan shall be based on the principles of "least cost integrated planning" set out in and developed under section 218c of this title. The plan shall include at a minimum:

(1) an overview, looking 20 years ahead, of statewide growth and development as they relate to future requirements for electrical energy, including patterns of urban expansion, statewide and service area economic growth, shifts in transportation modes, modifications in housing types and design, conservation and other trends and factors which, as determined by the director, will significantly affect state electrical energy policy and programs;

(2) an assessment of all energy resources available to the state for electrical generation or to supply electrical power, including among others, fossil fuels, nuclear, hydro-electric, biomass, wind, fuel cells, and solar energy and strategies for minimizing the economic and environmental costs of energy supply, including the production of pollutants, by means of efficiency and emission improvements, fuel shifting, and other appropriate means;

(3) estimates of the projected level of electrical energy demand;

(4) a detailed exposition, including capital requirements and the estimated cost to consumers, of how such demand shall be met based on the assumptions made in subdivision (1) of this subsection and the policies set out in subsection (c) of this section; and

(5) specific strategies for reducing electric rates to the greatest extent possible in Vermont over the most immediate ~~five-year~~ six-year period, for the next succeeding ~~five-year~~ six-year period, and long-term sustainable strategies

for achieving and maintaining the lowest possible electric rates over the full 20-year planning horizon consistent with the goal of maintaining a financially stable electric utility industry in Vermont.

(c) In developing the plan, the department shall take into account the protection of public health and safety; preservation of environmental quality; the potential for reduction of rates paid by all retail electricity customers; the potential for reduction of electrical demand through conservation, including alternative utility rate structures; use of load management technologies; efficiency of electrical usage; utilization of waste heat from generation; and utility assistance to consumers in energy conservation.

(d) In establishing plans, the director shall:

(1) Consult with:

(A) the public;

(B) Vermont municipal utilities;

(C) Vermont cooperative utilities;

(D) Vermont investor-owned utilities;

(E) Vermont electric transmission companies;

(F) environmental and residential consumer advocacy groups active in electricity issues;

(G) industrial customer representatives;

(H) commercial customer representatives;

(I) the public service board;

(J) an entity designated to meet the public's need for energy efficiency services under subdivision 218c(a)(2) of this title;

(K) other interested state agencies; and

(L) other energy providers.

(2) To the extent necessary, include in the plan surveys to determine needed and desirable plant improvements and extensions and coordination between utility systems, joint construction of facilities by two or more utilities, methods of operations, and any change that will produce better service or reduce costs. To this end, the director may require the submission of data by each company subject to supervision, of its anticipated electrical demand, including load fluctuation, supplies, costs, and its plan to meet that demand and such other information as the director deems desirable.

(e) The department shall conduct public hearings on the final draft and shall consider the evidence presented at such hearings in preparing the final plan. The plan shall be adopted no later than January 1, ~~2004~~ 2012 and readopted in accordance with this section by every sixth January 1 thereafter, and shall be submitted to the general assembly each time the plan is adopted or readopted. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the submission to be made under this subsection.

(f) After adoption by the department of a final plan, any company seeking board authority to make investments, to finance, to site or construct a generation or transmission facility or to purchase electricity or rights to future electricity, shall notify the department of the proposed action and request a determination by the department whether the proposed action is consistent with the plan. In its determination whether to permit the proposed action, the board shall consider the department's determination of its consistency with the plan along with all other factors required by law or relevant to the board's decision on the proposed action. If the proposed action is inconsistent with the plan, the board may nevertheless authorize the proposed action if it finds that there is good cause to do so. The department shall be a party to any proceeding on the proposed action, except that this section shall not be construed to require a hearing if not otherwise required by law.

(g) The director shall annually review that portion of a plan extending over the next ~~five~~ six years. The department, through the director, shall ~~annually~~ biennially extend the plan by ~~one~~ two additional ~~year~~ years; and from time to time, ~~but in no~~ and in any event ~~less than~~ every ~~five years~~ sixth year, institute proceedings to review a plan and make revisions, where necessary. The ~~five year~~ six-year review and any interim revisions shall be made according to the procedures established in this section for initial adoption of the plan. The six-year review and any revisions made in connection with that review shall be performed contemporaneously with readoption of the comprehensive energy plan under section 202b of this title.

(h) The plans adopted under this section ~~shall be submitted to the energy committees of the general assembly and~~ shall become the electrical energy portion of the state energy plan.

(i) It shall be a goal of the electrical energy plan to assure, by 2028, that at least 60 MW of power are generated within the state by combined heat and power (CHP) facilities powered by renewable fuels or by nonqualifying SPEED resources, as defined in section 8002 of this title. In order to meet this goal, the plan shall include incentives for development and strategies to identify locations in the state that would be suitable for CHP. The plan shall

include strategies to assure the consideration of CHP potential during any process related to the expansion of natural gas services in the state.

Sec. 4. 30 V.S.A. § 202b is amended to read:

§ 202b. STATE COMPREHENSIVE ENERGY PLAN

(a) The department of public service, in conjunction with other state agencies designated by the governor, shall prepare a comprehensive state energy plan covering at least a 20-year period. The plan shall seek to implement the state energy policy set forth in section 202a of this title. The plan shall include:

(1) A comprehensive analysis and projections regarding the use, cost, supply and environmental effects of all forms of energy resources used within Vermont.

(2) Recommendations for state implementation actions, regulation, legislation, and other public and private action to carry out the comprehensive energy plan.

(b) In developing or updating the plan's recommendations, the department of public service shall seek public comment by holding public hearings in at least five different geographic regions of the state on at least three different dates, and by providing notice through publication once a week and at least seven days apart for two or more successive weeks in a newspaper or newspapers of general circulation in the regions where the hearings will be held, and by delivering notices to all licensed commercial radio and television stations with transmitting facilities within the state, plus Vermont Public Radio and Vermont Educational Television.

(c) The department shall adopt a state energy plan by ~~no later than~~ January 1, ~~1994~~ 2012 and shall readopt the plan by every sixth January 1 thereafter. On adoption or readoption, the plan shall be submitted to the general assembly. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to such submission.

(1) Upon adoption of the plan, analytical portions of the plan may be updated ~~annually~~ and published biennially.

(2) Every fourth year after the adoption or readoption of a plan under this section, the department shall publish the manner in which the department will engage the public in the process of readopting the plan under this section.

(3) The publication requirements of subdivisions (1) and (2) of this subsection may be met by inclusion of the subject matter in the department's biennial report.

(4) The plan's implementation recommendations shall be updated by the department no less frequently than every ~~five~~ six years. These recommendations shall be updated prior to the expiration of ~~five~~ six years if the general assembly passes a joint resolution making a request to that effect. If the department proposes or the general assembly requests the revision of implementation recommendations, the department shall hold public hearings on the proposed revisions.

(d) ~~Any distribution~~ Distribution of the plan to members of the general assembly shall be in accordance with the provisions of 2 V.S.A. § 20(a)–(c).

Sec. 5. INTENT; RETROACTIVE APPLICATION

In enacting Secs. 3 (20-year electric plan) and 4 (comprehensive energy plan), the general assembly intends to set the readoption of these plans by the department of public service (the department) on a regular six-year cycle beginning with the comprehensive energy plan adopted by the department in December 2011. The department's adoption of that plan in December 2011 shall be deemed to satisfy the requirements of 30 V.S.A. §§ 202 and 202b, as amended by Secs. 3 and 4 of this act, to adopt plans by January 1, 2012.

Sec. 6. 21 V.S.A. § 269 is amended to read:

§ 269. COMPLIANCE PLAN

The commissioner of public service shall perform all of the following:

(1) No later than September 1, 2011, issue a plan for achieving compliance with the energy standards adopted under this subchapter no later than February 1, 2017 in at least 90 percent of new and renovated residential and commercial building space. In preparing this plan, the department shall review enforcement mechanisms for building energy codes that have been adopted in other jurisdictions and shall solicit the comments and recommendations of one or more mortgage lenders; builders; building designers; architects; civil, mechanical, and electrical engineers; utility representatives; environmental organizations; consumer advocates; energy efficiency experts; the attorney general; and other persons who are potentially affected or have relevant expertise.

(2) No later than ~~June 30, 2012~~ December 31, 2013, by means of administrative rules adopted in accordance with 3 V.S.A. chapter 25:

(A) Establish active training and enforcement programs to meet the energy standards adopted under this subchapter.

(B) Establish a system for measuring the rate of compliance each year with the energy standards adopted under this chapter. Following

establishment of this system, the commissioner also shall provide for such annual measurement.

* * * Electronic Filings and Case Management * * *

Sec. 7. 30 V.S.A. § 11(a) is amended to read:

(a) The forms, pleadings, and rules of practice and procedure before the board shall be prescribed by it. The board shall promulgate and adopt rules which include, among other things, provisions that:

(1) A utility whose rates are suspended under the provisions of section 226 of this title shall, within 30 days from the date of the suspension order, file with the board ~~10 copies of~~ all exhibits it intends to use in the hearing thereon together with the names of witnesses it intends to produce in its direct case and a short statement of the purposes of the testimony of each witness. Except in the discretion of the board, a utility shall not be permitted to introduce into evidence in its direct case exhibits which are not filed in accordance with this rule.

* * *

Sec. 8. 30 V.S.A. § 11a is added to read:

§ 11a. ELECTRONIC FILING AND ISSUANCE

(a) As used in this section:

(1) "Confidential document" means a document containing confidential information that is filed with the board and parties in a proceeding subject to a protective order duly issued by the board.

(2) "Document" means information inscribed on a tangible medium or stored in an electronic or other medium and retrievable in perceivable form.

(3) "Electronic filing" means the transmission of documents to the board by electronic means.

(4) "Electronic filing system" means a board-designated system that provides for the electronic filing of documents with the board and for the electronic issuance of documents by the board. If the system provides for the filing or issuance of confidential documents, it shall be capable of maintaining the confidentiality of confidential documents and of limiting access to confidential documents to individuals explicitly authorized to access such confidential documents.

(5) "Electronic issuance" means:

(A) the transmission by electronic means of a document that the board has issued, including an order, proposal for decision, or notice; or

(B) the transmission of a message from the board by electronic means informing the recipients that the board has issued a document, including an order, proposal for decision, or notice and that the document is available for viewing and retrieval from an electronic filing system.

(6) "Electronic means" means any board-authorized method of electronic transmission of a document.

(b) The board, in consultation with the commissioner of information and innovation or designee, by order, rule, procedure, or practice may:

(1) provide for electronic issuance of any notice, order, proposal for decision, or other process issued by the board, notwithstanding any other service requirements set forth in this title or in 10 V.S.A. chapter 43;

(2) require electronic filing of documents with the board;

(3) for any filing or submittal to the board for which the filing or submitting entity is required to provide notice or a copy to another state agency under this title or under 10 V.S.A. chapter 43, waive such requirement if the state agency will receive notice of and access to the filing or submittal through an electronic filing system; and

(4) for any filing, order, proposal for decision, notice, or other process required to be served or delivered by first-class mail or personal delivery under this title or under 10 V.S.A. chapter 43, waive such requirement to the extent the required recipients will receive the filing, order, proposal of decision, notice, or other process by electronic means or will receive notice of and access to the filing, order, proposal for decision, notice, or other process through an electronic filing system.

(c) Any order, rule, procedure, or practice issued under subsection (b) of this section shall include exceptions to accommodate parties and other participants who are unable to file or receive documents by electronic means.

(d) Subsection (b) of this section shall not apply to the requirements for service of citations and notices in writing as set forth in 30 V.S.A. §§ 111(b), 111a(i), and 2804.

Sec. 9. 30 V.S.A. § 20(a) is amended to read:

(a)(1) The board or department may authorize or retain legal counsel, ~~official stenographers,~~ expert witnesses, advisors, temporary employees, and other research services:

* * *

(4) The board or department may authorize or retain official stenographers in any proceeding within its jurisdiction, including proceedings listed in subsection (b) of this section.

Sec. 10. 3 V.S.A. § 2222 is amended to read:

§ 2222. POWERS AND DUTIES; BUDGET AND REPORT

(a) In addition to the duties expressly set forth elsewhere by law the secretary shall:

* * *

(9) Submit to the general assembly concurrent with the governor's annual budget request required under 32 V.S.A. § 306, a strategic plan for information technology and information security which outlines the significant deviations from the previous year's ~~information technology~~ plan, and which details the plans for information technology activities of state government for the following fiscal year as well as the administration's financing recommendations for these activities. For purposes of this section, "information security" shall mean protecting information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide integrity, confidentiality, and availability. All such plans shall be reviewed and approved by the commissioner of information and innovation prior to being included in the governor's annual budget request. The plan shall identify the proposed sources of funds for each project identified. The plan shall also contain a review of the state's information technology and information security and an identification of priority projects by agency. The plan shall include, for any proposed information technology activity with a cost in excess of $100,000.00:

(A) a life-cycle costs analysis including planning, purchase and development of applications, the purchase of hardware and the ~~on-going~~ ongoing operation and maintenance costs to be incurred over the expected life of the systems; and a cost-benefit analysis which shall include acquisition costs as well as operational and maintenance costs over the expected life of the system;

(B) the cost savings ~~and/or~~ or service delivery improvements or both which will accrue to the public or to state government;

(C) a statement identifying any impact of the proposed new computer system on the privacy or disclosure of individually identifiable information;

(D) a statement identifying costs and issues related to public access to nonconfidential information;

(E) a statewide budget for all information technology activities with a cost in excess of ~~$100,000~~ $100,000.00.

(10) The secretary shall annually submit to the general assembly a five-year information technology and information security plan which indicates the anticipated information technology activities of the legislative, executive, and judicial branches of state government. For purposes of this section, "information technology activities" shall mean:

(A) the creation, collection, processing, storage, management, transmission, or conversion of electronic data, documents, or records;

(B) the design, construction, purchase, installation, maintenance, or operation of systems, including both hardware and software, which perform these activities.

* * *

Sec. 11. 22 V.S.A. § 901 is amended to read:

§ 901. DEPARTMENT OF INFORMATION AND INNOVATION

The department of information and innovation, created in 3 V.S.A. § 2283b, shall have all the responsibilities assigned to it by law, including the following:

(1) to provide direction and oversight for all activities directly related to information technology and information security, including telecommunications services, information technology equipment, software, accessibility, and networks in state government. For purposes of this section, "information security" is defined as in 3 V.S.A. § 2222(a)(9);

(2) to manage GOVnet;

(3) to review all information technology and information security requests for proposal in accordance with agency of administration policies;

(4) to review and approve information technology activities in all departments with a cost in excess of $100,000.00, and annually submit to the general assembly a strategic plan and a budget for information technology and information security as required of the secretary of administration by 3 V.S.A. § 2222(a)(9). For purposes of this section, "information technology activities" is defined in 3 V.S.A. § 2222(a)(10);

(5) to administer the independent review responsibilities of the secretary of administration described in 3 V.S.A. § 2222(g);

(6) to perform the responsibilities of the secretary of administration under 30 V.S.A. § 227b;

(7) to administer communication, information, and technology services, which are transferred from the department of buildings and general services;

(8) to inventory technology assets within state government;

(9) to coordinate information technology and information security training within state government;

* * *

(11) to provide technical support and services to the department of human resources and of finance and management for the statewide central accounting and encumbrance system, the statewide budget development system, the statewide human resources management system, and other agency of administration systems as may be assigned by the secretary; and

(12) Not later than July 1, 2013, to adopt rules requiring the auditing and updating of state websites.

Sec. 12. 22 V.S.A. § 904 is added to read:

§ 904. STATE WEBSITE AUDITING

Any state agency that maintains or operates a state website shall cause that website to be audited and updated pursuant to rules adopted by the department of information and innovation under subdivision 901(12) of this chapter.

* * * Condemnation Hearing: Service of Citation * * *

Sec. 13. 30 V.S.A. § 111(b) is amended to read:

(b) The citation shall be served upon each person having any legal interest in the property~~, including each municipality and each planning body where the property is situate like a summons,~~ or on absent persons in such manner as the supreme court may by rule provide for service of process in civil actions. The board also shall give notice of the hearing to each municipality and each planning body where the property is located. The board, in its discretion, may schedule a joint hearing of some or all petitions relating to the same project and concerning properties or rights located in the same town or abutting towns.

* * * Filing Rate Schedules with the Board * * *

Sec. 14. 30 V.S.A. § 225 is amended to read:

§ 225. RATE SCHEDULES

(a) Within a time to be fixed by the board, each company subject to the provisions of this chapter shall file with the board and the department, with separate filings to the directors for regulated utility planning and public advocacy, schedules which shall be open to public inspection, showing all rates

including joint rates for any service performed or any product furnished by it within the state, and as a part thereof shall file the rules and regulations that in any manner affect the tolls or rates charged or to be charged for any such service or product. Those schedules, or summaries of the schedules approved by the department, shall be published by the company in two newspapers with general circulation in the state within 15 days after such filing. A change shall not thereafter be made in any such schedules, including schedules of joint rates or in any such rules and regulations, except upon 45 days notice to the board and to the department of public service, and such notice to parties affected by such schedules as the board shall direct. The board shall consider the department's recommendation and take action pursuant to sections 226 and 227 of this title before the date on which the changed rate is to become effective. All such changes shall be plainly indicated upon existing schedules, or by filing new schedules in lieu thereof 45 days prior to the time the same are to take effect. Subject only to temporary increases, rates may not thereafter be raised without strictly complying with the notice and filing requirements set forth in this section. In no event may a company amend, supplement or alter an existing filing or substantially revise the proof in support of such filing in order to increase, decrease or substantiate a pending rate request, unless, upon opportunity for hearing, the company demonstrates that such a change in filing or proof is necessary for the purpose of providing adequate and efficient service. However, upon application of any company subject to the provisions of this chapter, and with the consent of the department of public service, the board may for good cause shown prescribe a shorter time within which such change may be made; but a change which in effect decreases such tolls or rates may be made upon five days' notice to the board and the department of public service and such notice to parties affected as the board shall direct.

* * *

* * * CPG: Recommendations of Municipal and

Regional Planning Commissions * * *

Sec. 15. 30 V.S.A. § 248 is amended to read:

§ 248. NEW GAS AND ELECTRIC PURCHASES, INVESTMENTS, AND FACILITIES; CERTIFICATE OF PUBLIC GOOD

* * *

(f) However, the plans for the construction of such a facility within the state must be submitted by the petitioner to the municipality and regional planning commissions no less than 45 days prior to application for a certificate of public good under this section, unless the municipal and regional planning commissions shall waive such requirement. Such municipal or regional

planning commission may hold a public hearing on the proposed plans. Such commissions ~~shall~~ may make recommendations~~, if any,~~ to the public service board and to the petitioner ~~at least seven days prior to filing of the petition~~ within 21 days after the date the petition is filed with the public service board.

* * *

* * * Universal Service Fund Studies * * *

Sec. 16. 30 V.S.A. § 7515 is amended to read:

§ 7515. HIGH-COST BASIC TELECOMMUNICATIONS SERVICE

(a) The general assembly intends that the universal service charge be used in the future as a means of keeping basic telecommunications service affordable in all parts of this state, thereby maintaining universal service. ~~In the future, and after this section has been amended by further act of legislation, payments may be made to reduce the cost of basic telecommunications service in areas where that cost would otherwise jeopardize universal service or uniform economic development.~~

(b) The commissioner of public service, in conjunction with the public service board, shall conduct a study of the costs and other factors affecting the delivery of local exchange service by the incumbent local exchange carriers (the providers of last resort). The study shall ~~be conducted either as an independent inquiry or as part of a proceeding or docket affecting other matters~~ include an informal workshop process to be conducted by the board. Such process shall be noticed to the general public and structured to allow written and verbal comments by the general public, service providers, public officials, and others as determined by the board. The study shall:

(1) After considering information on how various factors affect the costs of providing telecommunications service in Vermont and elsewhere, estimate the current costs and estimate, on a forward-looking basis, the differential costs of providing local exchange service to various customer groups throughout Vermont.

(2) Estimate the relationship between basic telecommunications service charges and universal service, and the threshold level beyond which universal residential service is likely to be harmed.

(3) Estimate the relationship between basic telecommunications service charges and opportunities for uniform economic development throughout the state, and the threshold prices beyond which such opportunities may be adversely affected.

(4) Estimate the potential effects of local exchange competition on uniform and affordable basic telecommunications service charges in all parts of the state.

(5) Examine policy options by which the cost to customers may be managed so as not to jeopardize universal service and the uniform economic development opportunities, including at least the following:

(A) establishing a maximum price for basic telecommunications service, beyond which customers would have access, without regard to income, to credits or vouchers negotiable for local exchange service from a local exchange provider or competitive access provider;

(B) broadening eligibility for the lifeline program; and

(C) establishing a mechanism to adjust the level of support for higher cost customers over time to reflect legal rights, recover historic costs, and reflect the advantages of improved technology and increased efficiency.

(6) Examine the actions, if any, of the Federal Communications Commission (FCC) in revising its universal service fund, and the need, if any, for additional action in Vermont. In particular, the study shall examine the impact on Vermont services caused by the FCC's report and order released November 18, 2011, which, among other things, expands the federal universal service fund to include broadband deployment in unserved areas. Further, the study shall consider the potential impact of various legal challenges to the FCC action on the federal universal service fund.

(7) Propose mechanisms to support universal service and rural economic development while securing the benefits of telecommunications competition for Vermont households and businesses.

(8) Include an audit of the universal service fund to examine, among other things, the contributions made to the fund in terms of the categories of telecommunications service providers covered as well as the specific services charged. In addition, the audit shall assess the disbursements made from the fund.

(9) Consider any other relevant issues that may arise during the course of the study.

(c) The results of the study, together with any plan for amending and distributing funds under this section, shall be submitted to the ~~general assembly~~ house committee on commerce and economic development and the senate committee on finance on or before ~~January 15, 1996~~ December 1, 2012.

(d) The commissioner of public service may contract with a consultant to conduct the study required by this section. Costs incurred in conducting the

study shall be reimbursed from the state universal service fund up to $75,000.00.

(e) To the extent this study may require disclosure of confidential information by a telecommunications service provider, such confidential information shall be disclosed to a third party pursuant to a protective agreement. In no event shall the third party be a person or persons employed by a business competitor or whose primary duties engage them in business competition with a telecommunications service provider submitting the confidential information. The third party may be the consultant retained by the commissioner under subsection (d) of this section or may be another third party agreed upon by the commissioner and the telecommunications service providers. The third party shall be responsible for aggregating the information and, once aggregated, may publicly disclose such information consistent with the purposes of this section. The confidentiality requirements of this subsection shall not affect whether information provided to an agency of the state or a political subdivision of the state pursuant to other laws is or is not subject to disclosure.

Sec. 17. STUDY ON THE STATE USF AND PREPAID WIRELESS TELECOMMUNICATIONS SERVICES

(a) The commissioner of public service or designee, in consultation with the commissioner of taxes or designee, shall convene a work group to study issues related to application of the state's universal service charge established under 30 V.S.A. chapter 88 to prepaid wireless telecommunications services. The work group shall include representatives of prepaid wireless telecommunications service providers, Vermont retailers of prepaid wireless telecommunications services, consumers, the enhanced-911 program, and any other stakeholders identified by the commissioner. The study shall consider:

(1) the retail transactions subject to the charge;

(2) the amount of the charge;

(3) application of the charge to bundled telecommunications services;

(4) the effective date of any adjustments to the charge;

(5) billing and collection procedures, including:

(A) notice of charges to consumers; and

(B) various payment and collection methods, including payment and collection procedures similar to those used for the sales and use tax imposed under 32 V.S.A. chapter 233;

(6) the ability of retailers or the department of taxes, if applicable, to retain a percentage of the fees collected to offset collection and administration costs and, if so, the percentage which may be retained; and

(7) any other matter deemed relevant by the commissioner.

(b) The commissioner, on behalf of the work group established under subsection (a) of this section, shall report his or her findings and recommendations to the house committee on commerce and economic development and the senate committee on finance not later than December 1, 2012. The report shall include draft legislation for consideration during the 2013 legislative session.

(c) It is the intent of the general assembly that the study authorized under this section shall not circumscribe any obligation which may be imposed on a wireless telecommunications service provider in pending or future proceedings before the public service board concerning designation as an eligible telecommunications carrier.

* * * Effective Dates * * *

Sec. 18. EFFECTIVE DATES

This act shall take effect on passage, except that Sec. 12 (relating to state website auditing) shall take effect 60 days after the department of information and innovation adopts rules pursuant to 22 V.S.A. § 901(12).

(Committee Vote: 10-0-1)

Action Under Rule 52

J.R.S. 47

Joint resolution urging the United States Postal Service not to implement its proposed major reductions and urging Congress to enact the Postal Service Protection Act

(For text see House Journal 2/22/2012)

NOTICE CALENDAR

Favorable with Amendment

H. 365

An act relating to designating skiing and snowboarding as the official state sports

Rep. Moran of Wardsboro, for the Committee on **General, Housing and Military Affairs,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

In recognition of the importance that sports and fitness can play in the personal lives of Vermonters and in the economic well-being of the state, the general assembly finds:

(1) The history of skiing and snowboarding is heavily linked to Vermont.

(2) In 1934, the country's first ski area opened near Woodstock when the first rope tow ski lift was installed on Clinton Gilbert's farm. This was followed by many other historical Vermont firsts in the ski industry, including the nation's first ski race which was held on Mount Mansfield in 1934, the nation's first J-bar lift which was installed at Bromley Ski Area in 1936, the nation's first ski patrol which was established at Stowe Ski Area in 1936, the nation's first T-bar lift which was installed at Pico Peak Ski Area in 1940, and the nation's first major chair lift which was installed at the Stowe Ski Area in 1940.

(3) In 1938, C. Minot Dole founded the National Ski Patrol in Vermont. Dole later used the National Ski Patrol model to convince the U.S. Army to activate a division of American mountain soldiers on skis, known as the 10th Mountain Division. Approximately 240 Vermonters served in the famed winter warfare division during World War II, with a dozen killed in action in the battle against the Germans in the Italian Alps.

(4) In 1952, Rutland's Andrea Mead-Lawrence, whose parents ran Pico Mountain, became the first American woman to win two Olympic gold medals in skiing. Stowe's Billy Kidd won the silver medal at the 1964 Innsbruck Olympics and the gold and bronze medals at the 1970 World Championships.

The skiing Cochrans—Barbara Ann, Lindy, Marilyn, and Bobby—from Richmond dominated the world racing scene in the 1960s and 1970s, with Barbara Ann winning the gold medal at the 1972 winter Olympics. Nordic skier Bill Koch, from Brattleboro, skied in four Olympics—1976, 1980, 1984,

and 1992. Koch won the 1976 silver medal, a first for an American Nordic skier, a bronze medal in the 1982 Federation Internationale de Ski Nordic World Championships, and a bronze medal in the 1982 World Cup Championships. Most recently, at the 2010 Winter Olympics, Hannah Kearney of Norwich won the gold medal in the women's freestyle skiing event.

(5) Vermont is home to many public schools, academies, and colleges that are world-class training grounds for skiing and snowboarding.

(6) In 1982, the Suicide Six Resort in Pomfret was the first resort in the United States to allow snowboarding.

(7) In the 1980s, Vermont was the first state in the country to host what is now known as a snowboard park at the Sonnenberg Ski Area in Barnard.

(8) The U.S. Open for Snowboarding is held in Vermont. This event is the renowned first competition for snowboarding and offers an exciting opportunity to watch the world's best snowboarders exhibiting their skills.

(9) At the 2002 Winter Olympics, Ross Powers of Stratton and Kelly Clark of Dover won the men's and women's gold medal respectively in the snowboarding halfpipe event.

(10) The United States Olympic Committee named Hannah Teeter of Belmont, the 2006 Winter Olympics women's halfpipe gold medalist, as the 2006 Sportswoman of the Year, the top honor that the committee confers. She returned to the Winter Olympics in 2010 to win a silver medal in the women's halfpipe while Kelly Clark followed immediately behind her in the competition, capturing the bronze medal.

(11) The United States Olympic Committee named former United States Halfpipe Head Coach Bud Keene of Stowe the 2006 National Coach of the Year.

(12) In 1977, Vermonter Jake Burton Carpenter founded a snowboard company in his barn and perfected the technology to build snowboards. Today, this Burlington-based company is the worldwide leader in the manufacture and sale of snowboards. Jake and Donna Burton Carpenter were inducted into the United States National Ski and Snowboarding Hall of Fame in 2007.

(13) Increasingly, there is an alarmingly high number of obese children in the United States. Both skiing and snowboarding promote healthy outdoor exercise for children, their parents, and people of all ages.

(14) Vermont historically ranks as the third largest ski and snowboard state, with over four million snowboarder and skier visits per year, and both sports are a critical part of our state's economy, heritage, and way of life.

(15) Designating skiing and snowboarding as the Vermont state sports will encourage individuals to travel to Vermont to ski and snowboard where they will patronize local hotels and restaurants and purchase Vermont goods and services.

Sec. 2. 1 V.S.A. § 516 is added to read:

§ 516. STATE SPORTS

The state winter sports shall be skiing and snowboarding.

Sec. 3. EFFECTIVE DATE

This bill shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to designating skiing and snowboarding as the official winter state sports"

(Committee Vote: 7-0-1)

H. 577

An act relating to public water systems

Rep. Fagan of Rutland City, for the Committee on **Fish, Wildlife & Water Resources,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 10 V.S.A. § 1624a is amended to read:

§ 1624a. AWARDS FOR POLLUTION ABATEMENT PROJECTS FOR COMBINED SEWER OVERFLOWS

(a) When the department finds that a proposed water pollution abatement project not covered under section 1625 of this title is necessary, that the proposed type, kind, quality, size, and estimated cost of the project, including operation cost and sewage disposal charges, are suitable for abatement of pollution, and that the project or the prescribed project phases are necessary to meet the intent of the water quality classifications established by the board or by statute under chapter 47 of this title, the department may award state financial assistance to the project. These projects may include ancillary work determined by the secretary to be necessary to attain the water quality goals.

(b) The assistance shall consist of:

(1) A grant of 25 percent of the eligible project cost.

(2) A loan from the Vermont environmental protection agency (EPA) pollution control revolving fund or the Vermont pollution control revolving fund of 50 percent of the eligible project cost. No interest shall be charged. In a certificate to the Vermont municipal bond bank, the secretary shall recommend the term, repayment schedule and other terms and conditions of the loan.

(c) Notwithstanding the percentages of assistance provided for in subsection (b) of this section, when a municipality is certified by the secretary of commerce and community development to be within a designated job development zone, the grant to the municipality shall be 50 percent of eligible project costs and the loan shall be 25 percent of eligible project costs.

(d) Grants and loans under this section may be made from state and federal sources, as determined by the secretary.

(e) A loan agreement may be entered into by action of the legislative body of the municipality, using procedures specified by applicable general or special enabling authority, following:

(1) authorization by the electorate of issuance of bonds in the amount of 25 percent of project costs, unless the municipality has determined to use some other method of financing its share of project cost; and

(2) authorization by the electorate of indebtedness in the amount of the loan under this section.

(f) A loan agreement may include provisions for deferred repayment if the electorate has authorized the future issuance of bonds to make a final repayment of the loan, and the authorization specifies whether the bond agreements will pledge the full faith and credit of the municipality or sufficient revenues from municipal sewage disposal charges.

(1) Except as provided in subdivision (2) ~~below~~ of this subsection, loan repayments shall be according to the following schedule:

(A) 0.50 percent in the first year and increasing thereafter at 0.50 percent per year through the ninth year; and

(B) 5.0 percent in the 10th year through the 19th year; and

(C) the remainder in the 20th year.

(2) Notwithstanding subdivision ~~(f)~~(1) of this ~~section~~ subsection, a municipality shall be entitled to loan repayment under this subdivision if repayment would produce municipal sewer rates in the municipality which exceed 150 percent of the current state average rate for a family of four. For purposes of this calculation, the municipality's sewer rates shall be deemed to

include operating costs, payments on the municipality's water pollution control debt, and repayment of five percent of the principal of the loan under this section. The following shall be minimum repayments under this subdivision:

(A) 0.25 percent per year in the first through the tenth year, dating from the issuance of the certification of completion of the project;

(B) 0.50 percent in the 11th year and increasing thereafter at 0.50 percent per year through the 19th year; and

(3) the remainder in the 20th year. When a loan is issued with deferred repayment provisions pursuant to authorization of the electorate under this section for the future issuance of bonds, upon maturity of the loan, if other sources of revenue are available, the legislative body of the municipality may elect not to issue bonds to make the final payment on the loan. The term of these bonds, if issued, shall not exceed 20 years. As authorized in the initial vote, these bonds may be secured by a pledge of the full faith and credit of the municipality or by sufficient revenues from municipal sewage disposal charges.

(g) State financial assistance under this section shall be made to the extent that funds are available and according to a system of priorities established by the secretary. In establishing this system, priority shall be given to pollution abatement and not to the support of demand growth, and to projects discharging into or near lakes on January 1, 1988.

(h) Notwithstanding subsection (b) of this section, a loan awarded from the Vermont environmental protection agency pollution control revolving loan fund for a combined sewer overflow abatement project that is included on a priority list and that is capitalized, in whole or in part, with a federal clean water state revolving fund grant that includes loan forgiveness provisions may be for up to 100 percent of the eligible project cost.

Sec. 2. 10 V.S.A. § 1675 is amended to read:

§ 1675. PERMITS; CONDITIONS; DURATION; SUSPENSION OF REVOCATION

(a) Authority to issue, renew, or deny permit. The secretary may issue, renew, or deny a public water system permit required by this chapter. As part of this authority, the secretary may issue general operating permits for the operation of transient noncommunity water systems.

* * *

(e) ~~Duration of permit. An operating permit shall be valid for the period of time specified in the permit but not more than ten years.~~

(f) Suspension or revocation of permits.

(1) The secretary may, after notice and opportunity for hearing, revoke or suspend any permit issued pursuant to the authority under this title if the secretary finds that:

(A) the permit holder submitted materially false or inaccurate information;

(B) the permit holder has violated any material requirement, restriction or condition of this chapter, any rule promulgated thereunder, or any permit or certification issued pursuant to this chapter, or any assurance of discontinuance or order relating to the provisions of this chapter or the rules promulgated thereunder; or

(C) there is a change in any condition that requires either a temporary or permanent restriction, limitation or elimination of the permitted use.

(2) Revocation shall be effective upon actual notice thereof to the permit holder or permit holder's designated agent.

* * *

(i) Notwithstanding the requirements of this subsection, the secretary may issue an operating permit for an existing public water system that is unable to comply with the standards adopted under this chapter provided that:

(1) The operating permit contains a compliance schedule that is designed to achieve compliance with the applicable standards within a reasonable period of time based on the nature and extent of the applicable standards at issue;

(2) The secretary finds that the continued operation of the public water system pursuant to the compliance schedule and associated permit conditions shall not present an unacceptable risk to public health; and

(3) The person who owns the public water system shall be responsible for informing all persons using the system of the nature and extent of the noncompliance with the applicable standards.

Sec. 3. 10 V.S.A. § 1676 is amended to read:

~~§ 1676. TEMPORARY PERMITS~~

~~(a) The secretary may issue a temporary operation permit for public water system if such issuance will not unreasonably contribute to a public health risk, and the system is unable to comply with:~~

~~(1) any physical facility requirement established in the Vermont standards and requirements for water system design and construction;~~

~~(2) any operational requirement established by rules adopted under this chapter; or~~

~~(3) operator certification requirements.~~

~~(b) A temporary permit shall:~~

~~(1) contain a schedule which requires compliance with this chapter and the rules adopted under this chapter by a specified date;~~

~~(2) require the person who owns or operates the system to inform all persons using the system of the nature and extent of the noncompliance with this chapter or rules of this chapter;~~

~~(3) be valid for not more than three years. A temporary permit may be renewed.~~

~~(c) A temporary permit may contain any conditions, requirements, schedules, restrictions or monitoring and testing programs that the secretary deems necessary to prevent a public health risk.~~

~~(d) [Deleted.]~~

~~(e) A temporary permit may not be issued for a new public water source if there are agricultural lands in the area that are likely to affect the proposed new source.~~

Sec. 4. 24 V.S.A. § 4753a is amended to read:

§ 4753a. AWARDS FROM REVOLVING LOAN FUNDS

(a) Pollution control. The general assembly shall approve all categories of awards made from the special funds established by section 4753 of this title for water pollution control facility construction, in order to assure that such awards conform with state policy on water quality and pollution abatement, and with the state policy that, except as provided in subsection (c) of this section, municipal entities shall receive first priority in the award of public monies for such construction, including monies returned to the revolving funds from previous awards. To facilitate this legislative oversight, the secretary of natural resources shall annually no later than January 15 report to the house and senate committees on institutions and on natural resources and energy on all awards made from the relevant special funds during the prior and current fiscal years, and shall report on and seek legislative approval of all the types of projects for which awards are proposed to be made from the relevant special funds during the current or any subsequent fiscal year. Where feasible, the specific projects shall be listed.

(b) Water supply. The secretary of natural resources shall no later than January 15, 2000 recommend to the house and senate committees on

institutions and on natural resources and energy a procedure for reporting to and seeking the concurrence of the legislature with regard to the special funds established by section 4753 of this title for water supply facility construction.

(c) Failed wastewater and potable water supply system loans. Notwithstanding other priorities established in law, the secretary may award up to $500,000.00 of the funds from the Vermont environmental protection agency control fund and the Vermont pollution control revolving fund, combined, to a state agency, the Vermont housing finance agency, or a municipality for the administration of loans to households with income equal to or less than 200 percent of the state average median household income for the repair or replacement of failed wastewater systems and failed potable water supplies, as those terms are defined in ~~section~~ 10 V.S.A.§ 1972 ~~of Title 10~~. Upon award of funds under this section, the state agency, Vermont housing finance agency, or municipality shall agree, pursuant to a memorandum of understanding with the secretary of natural resources, to repay the funds awarded to the special fund from which they were drawn.

(d) Loan forgiveness; pollution control. Notwithstanding any other provision of law regarding loan forgiveness, upon the award of a loan from the Vermont environmental protection agency pollution control revolving fund, the secretary of natural resources, in a manner that is consistent with federal grant provisions, may forgive up to 50 percent of a loan if the award is made for a project on a priority list capitalized, at least in part, from funds appropriated from a federal clean water state revolving fund (CWSRF) grant when the CWSRF grant includes provisions authorizing loan forgiveness. Such loan forgiveness shall apply to both state and federal funds used to capitalize loans.

(e) Loan forgiveness; drinking water. Notwithstanding any other provision of law regarding loan forgiveness, upon the award of a loan from the Vermont environmental protection agency drinking water state revolving fund, the secretary of natural resources, in a manner consistent with federal grant provisions, may forgive up to 100 percent of a loan if the award is made for a project on the priority list and is capitalized, in whole or in part, from funds appropriated from a drinking water state revolving fund (DWSRF) grant when the DWSRF grant includes provisions authorizing loan forgiveness. Such loan forgiveness shall apply to both state and federal funds used to capitalize loans.

(f) Loan forgiveness standard. The secretary shall establish standards, policies, and procedures as necessary for implementing subsections (d) and (e) of this section for allocating the funds among projects and for revising standard priority lists in order to comply with requirements associated with federal capitalization grant agreements.

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2012.

(Committee Vote: 9-0-0)

Rep. Shaw of Pittsford, for the Committee on **Corrections and Institutions,** recommends the bill ought to pass when amended as recommended by the Committee on **Fish, Wildlife & Water Resources** and when further amended as follows:

Rep. Shaw moves that the bill as proposed for amendment by the Committee on Fish, Wildlife and Water Resources be further amended as follows:

First: In Sec. 1, 10 V.S.A. § 1624a, by striking subsection (h) in its entirety and inserting in lieu thereof the following:

(h) Notwithstanding subsection (b) of this section, a loan awarded from the Vermont environmental protection agency pollution control revolving loan fund for a combined sewer overflow abatement project may be for up to 100 percent of the eligible project cost if:

(1) the project is included on a priority list; and

(2) the project is capitalized, at least in part, with a federal clean water state revolving fund grant that includes loan forgiveness provisions.

Second: In Sec. 4, 24 V.S.A. § 4753a, by striking subsections (d) and (e) in their entirety and inserting in lieu thereof the following:

(d) Loan forgiveness; pollution control. Notwithstanding any other provision of law regarding loan forgiveness, upon the award of a loan from the Vermont environmental protection agency pollution control revolving fund (CWSRF), the secretary of natural resources, in a manner that is consistent with federal grant provisions, may forgive up to 50 percent of a loan if the award is made for a project on a priority list and the project is capitalized, at least in part, from funds derived from a federal CWSRF capitalization grant that includes provisions authorizing loan forgiveness. Such loan forgiveness shall be based on the loan value, but funds to be forgiven shall only consist of federal funds, except where the loan is used as a match to other federal grants requiring nonfederal funds as a match.

(e) Loan forgiveness; drinking water. Notwithstanding any other provision of law regarding loan forgiveness, upon the award of a loan from the Vermont environmental protection agency drinking water state revolving fund (DWSRF), the secretary of natural resources, in a manner that is consistent with federal grant provisions, may forgive up to 100 percent of a loan if the

award is made for a project on the priority list and the project is capitalized, at least in part, from funds derived from a federal DWSRF capitalization grant that includes provisions authorizing loan forgiveness. Such loan forgiveness shall be based on the loan value, but funds to be forgiven shall only consist of federal funds, except where the loan is used as a match to other federal grants requiring nonfederal funds as a match.

(Committee Vote: 9-0-2)

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. 272

House concurrent resolution congratulating Harriette B. Lerrigo-Leidich of North Bennington on her 100th birthday

H.C.R. 273

House concurrent resolution designating February 29, 2012 as Afterschool, Summer, and Expanded Learning Day at the State House

H.C.R. 274

House concurrent resolution in memory of Garry Chalmers Simpson, a master of the cinematic, performing, and television arts

H.C.R. 275

House concurrent resolution in memory of former Representative Carl H. Reidel of North Ferrisburgh

H.C.R. 276

House concurrent resolution commemorating the 250th anniversary of the town of Hinesburg

H.C.R. 277

House concurrent resolution in memory of former East Montpelier Town Clerk and Treasurer Sylvia Tosi

S.C.R. 37

Senate concurrent resolution honoring the military valor of United States Army Staff Sgt. Dylan J. Maynard

Public Hearings

February 28, 2012 - Room 11 - 7:00 PM - Judicial Retention of Justices Karen Carroll, Dennis Pearson, and Barry Peterson

Information Notice

Deadline for Introducing Bills

Pursuant to Rule 40(b) of the Rules and Orders of the Vermont House of Representatives, during the second year of the biennium, except with the prior consent of the Committee on Rules, no member may introduce a bill into the House drafted in standard form after the last day of January. Bills may be introduced in Short Form until the second Friday after Town Meeting Day.

In order to meet this deadline all sign out sheets must be submitted to the Legislative Council no later than the close of business on Friday, January 27, 2012. Requests for short form bills may be made until Wednesday, February 15, 2012.

Pursuant to Rule 40(c) during the second year of the biennium, except with the prior consent of the Committee on Rules, no committee, except the Committees on Appropriations, Ways and Means or Government Operations, may introduce a bill drafted in standard form after the last day of March. The Committees on Appropriations, Ways and Means bills may be drafted in standard form at any time, and Government Operations bills, pertaining to city or town charter changes, may be drafted in standard form at any time.