House Calendar

Thursday, May 03, 2012

122nd DAY OF THE ADJOURNED SESSION

House Convenes at 9:30 A.M.

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Committee of Conference Report

Ordered to Lie

ORDERS OF THE DAY

ACTION CALENDAR

Action Postponed Until May 3, 2012

Senate Proposal of Amendment

H. 535

An act relating to racial disparities in the Vermont criminal justice system

The Senate proposes to the House to amend the bill by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. DATA COLLECTION AND ANALYSIS; APPROPRIATION

(a) Research regarding sentencing practices routinely concludes that two variables drive sentencing decisions—the seriousness of the offense and the defendant's risk to reoffend. The Vermont Center for Justice Research ("the center") shall examine the effect of these and other variables, including the race of the defendant, on sentencing decisions in Vermont, for a five-year period. The center shall use data from the Federal Bureau of Investigation Interstate Identification Index, the department of motor vehicles, the Vermont criminal information center, the department of corrections, and the Vermont courts to explain if the disparities are based on legal or nonlegal factors. The center's research shall focus on the following:

(1) How do the sentences of people of particular census categories, in the aggregate and by national incident-based reporting system race data fields (NIBRS), which currently include white, black, Asian, Native American or Alaskan Native, and Hispanic, compare to the sentences of white defendants with respect to sentence type, length of sentence, and level of restriction?

(2) How does the actual time spent by people of particular census categories, in the aggregate and by NIBRS race data fields, under department of corrections' supervision (and the degree of restriction) compare to the time spent by (and the degree of restriction of) white defendants?

(3) If disparate sentencing patterns or disparate service patterns exist for people of particular census categories, in the aggregate and by NIBRS race data fields, what variables included in the study design explain the disparity?

(b) On or before December 15, 2012, results of the study shall be reported to the house and senate committees on judiciary, to the court administrator, and to each organization or entity represented on the governor's criminal justice cabinet.

(c) The human rights commission is authorized to transfer $20,000.00 from its existing budget to the Vermont Center for Justice Research to finance this data collection analysis and report and is authorized to apply for and receive grants for the same purpose.

Sec. 2. 20 V.S.A. § 2366 is added to read:

§ 2366. LAW ENFORCEMENT AGENCIES; BIAS-FREE POLICING POLICY; RACE DATA COLLECTION

(a) No later than January 1, 2013, every state, local, county, and municipal law enforcement agency that employs one or more certified law enforcement officers shall adopt a bias-free policing policy. The policy shall contain the essential elements of such a policy as determined by the Law Enforcement Advisory Board after its review of the current Vermont State Police Policy and the most current model policy issued by the office of the attorney general.

(b) The policy shall encourage ongoing bias-free law enforcement training for state, local, county, and municipal law enforcement agencies.

(c) State, local, county, and municipal law enforcement agencies that employ one or more certified law enforcement officers are encouraged to work with the Vermont association of chiefs of police to extend the collection of roadside-stop race data uniformly throughout state law enforcement agencies, with the goal of obtaining uniform roadside-stop race data for analysis.

Sec. 3. 20 V.S.A. § 2358 is amended to read:

§ 2358. MINIMUM TRAINING STANDARDS

* * *

(e) The criteria for all minimum training standards under this section shall include anti-bias training approved by the Vermont criminal justice training council.

Sec. 4. 24 V.S.A. § 1939 is amended as follows:

§ 1939. LAW ENFORCEMENT ADVISORY BOARD

* * *

(e) The board shall examine how individuals make complaints to law enforcement and suggest, on or before December 15, 2012, to the senate and house committees on judiciary what procedures should exist to file a complaint.

Sec. 5. CRIMINAL JUSTICE AGENCIES; BIAS-FREE CRIMINAL JUSTICE POLICY

The general assembly encourages all criminal justice entities through their professional rules of conduct to ensure that all actions taken are done in a manner that is free of bias.

(For text see House Journal 3/27/2012)

Amendment to be offered by Rep. Lippert of Hinesburg to H. 535

Rep. Lippert of Hinesburg moves that the House concur with the Senate proposal of amendment with further amendment thereto in Sec. 1, by striking subsection (c) in its entirety and inserting in lieu thereof a new subsection (c) to read as follows:

(c) The general assembly appropriates $20,000.00 to the Vermont Center for Justice Research to support this data collection, analysis, and report.

H. 747

An act relating to cigarette manufacturers

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

In Sec. 1, 7 V.S.A. § 1003, by striking out subsection (g) in its entirety and inserting in lieu thereof a new subsection (g) to read:

(g) As used in this section, "little cigars" means any rolls of tobacco wrapped in leaf tobacco or any substance containing tobacco, other than any roll of tobacco which is a cigarette within the meaning of 32 V.S.A. § 7202(1) and as to which 1,000 units weigh not more than three pounds.

Second: By striking out Sec. 5 and inserting in lieu thereof a new Sec. 5 to read:

Sec. 5. 33 V.S.A. § 1920 is amended to read:

§ 1920. AGENT FOR SERVICE OF PROCESS

(a) Any nonresident or foreign nonparticipating manufacturer that has not registered to do business in the state as a foreign corporation or other business entity shall, as a condition precedent to having its brand families included or retained in the directory, appoint and continually engage without interruption the services of an agent in this state to act as agent for the service of process on whom all process, and any action or proceeding against it concerning or arising out of the enforcement of this subchapter or subchapter 1A of this chapter, or both, may be served in any manner authorized by law. Such service shall constitute legal and valid service of process on the nonparticipating manufacturer. The nonparticipating manufacturer shall provide the name, address, telephone number, and satisfactory proof of the appointment and availability of such agent to the attorney general. The secretary of state shall

be designated as agent for service of process for importers of nonparticipating manufacturers located outside the United States. Service shall be made upon the secretary of state in accordance with the provisions of 12 V.S.A. §§ 851 and 852.

* * *

Third: By adding Secs. 9 and 10 to read:

Sec. 9. 6 V.S.A. § 561 is amended to read:

§ 561. INTENT

The intent of this act is to establish policy and procedures for growing industrial hemp in Vermont so that farmers and other businesses in the Vermont agricultural industry can take advantage of this market opportunity ~~when federal regulations permit~~.

Sec. 10. REPEAL

Sec. 3 of No. 212 of the Acts of the 2007 Adj. Sess. (2008) (delayed effective date of industrial hemp cultivation program) is repealed.

and that after passage the title of the bill be amended to read: "An act relating to cigarette manufacturers, commercial cigarette rolling machines, and industrial hemp"

(For text see House Journal 3/20/2012)

Report of Committee of Conference

S. 199

An act relating to immunization exemptions and the immunization pilot program

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

S. 199 An act relating to immunization exemptions and the immunization pilot program

Respectfully report that they have met and considered the same and recommend that the Senate accede to the House proposal of amendment and the House proposal be further amended as follows:

Respectfully reports that it has met and considered the same and recommends that the House Proposal of Amendment be further amended as follows:

First: By striking Sec. 1 in its entirety and inserting in lieu thereof the following:

Sec. 1. 18 V.S.A. § 1121 is amended to read:

§ 1121. IMMUNIZATIONS REQUIRED PRIOR TO ATTENDING SCHOOL AND CHILD CARE FACILITIES

* * *

(c) To the extent permitted under the federal Health Insurance Portability and Accountability Act, Pub. L. 104-191, all schools and child care facilities shall make publicly available the aggregated immunization rates of the student body for each required vaccine using a standardized form that shall be created by the department of health. Each school and child care facility shall annually, on or before January 1, submit its standardized form containing the student body's aggregated immunization rates to the department of health. Notwithstanding section 1120 of this title, for the purposes of this subsection only, the term "child care facility" shall exclude a family day care home licensed or registered under 33 V.S.A. chapter 35.

Second: By striking Sec. 2 in its entirety and inserting in lieu thereof the following:

Sec. 2. 18 V.S.A. § 1122 is amended to read:

§ 1122. EXEMPTIONS

(a) ~~A~~ Notwithstanding subsections 1121(a) and (b) of this title, a person may remain in school or in the child care facility without a required immunization:

(1) If the person~~,~~ or, in the case of a minor, the person's parent or guardian presents a ~~written statement, from~~ form created by the department and signed by a licensed health care practitioner authorized to prescribe vaccines or a health clinic~~, or nurse~~ stating that the person is in the process of being immunized. The person may continue to attend school or the child care facility ~~as long as~~ for up to six months while the immunization process is being accomplished;

(2) If a health care practitioner, licensed to practice in Vermont and authorized to prescribe vaccines, certifies in writing that a specific immunization is or may be detrimental to the person's health or is not appropriate~~;~~, provided that when a particular vaccine is no longer contraindicated, the person shall be required to receive the vaccine; or

(3) If the person~~,~~ or, in the case of a minor, the person's parent or guardian ~~states in writing~~ annually provides a signed statement to the school or

child care facility on a form created by the Vermont department of health that the person, parent, or guardian:

(A) ~~has~~ holds religious beliefs or ~~philosophical~~ personal convictions opposed to immunization;

(B) has reviewed and understands evidence-based educational material provided by the department of health regarding immunizations, including information about the risks and benefits of immunization;

(C) understands that failure to complete the required immunization schedule increases the risk to the person and others of contracting or carrying a vaccine-preventable infectious disease; and

(D) understands that there are persons with special health needs attending schools and child care facilities who are unable to be immunized or who are at heightened risk of contracting a vaccine-preventable communicable disease and for whom such a disease could be life-threatening.

(b) The health department may provide by rule for further exemptions to immunization based upon sound medical practice.

(c) A form signed pursuant to subdivision (a)(3) of this section and the fact that such a form was signed shall not be:

(1) construed to create or deny civil liability for any person; or

(2) admissible as evidence in any civil proceeding.

(d) In the event the immunization rate for measles, mumps, rubella (MMR); diphtheria, tetanus, pertussis (DTaP); or tetanus, diphtheria, pertussis (Tdap) drops below a threshold of 90 percent statewide, the commissioner of health shall suspend use of personal exemptions for the applicable vaccine by persons enrolled in schools in the state. The suspension shall apply beginning at the start of the academic year following the department's determination. At least two months prior to the start of an academic year in which the suspension shall apply, schools shall provide written notice of the department's determination to each current and incoming student in the state or, in the case of a minor, to the person's parent or guardian. The suspension of personal exemptions shall terminate once the immunization rate for the applicable vaccine in question has remained above a 90-percent threshold statewide for three consecutive academic years.

Third: In Sec. 3, 18 V.S.A.§ 1124, subdivision (a), in the second sentence by striking the word "philosophical" and inserting in lieu thereof "personal"

Fourth: By inserting after Sec. 5, REPORT, a new section to read as follows:

Sec. 6. INTERIM WORKING GROUP ON PROTECTING IMMUNOCOMPROMISED STUDENTS AND STUDENTS WITH SPECIAL HEALTH NEEDS

(a) The departments of education and of health shall convene a working group on how to protect immunocompromised students and students with special health needs, which shall study the feasibility of allowing these students to enroll in a public school maintained by an adjoining school district, where the adjoining school district has a higher immunization rate than the school maintained by the student's school district of residence. For the purpose of protecting immunocompromised students and students with special health needs, the working group shall also assess the necessity and practicability of requiring adults employed at schools to be fully immunized. The working group shall submit a report of its findings and recommendations to the senate committee on health and welfare and the house committee on health care on or before January 1, 2013.

(b) The working group shall be composed of the following members:

(1) the commissioner of education or designee, who shall serve as co-chair;

(2) the commissioner of health or designee, who shall serve as co-chair;

(3) one medical professional with training or experience treating immunocompromised patients, appointed by the commissioner of health;

(4) one medical professional specializing in pediatric care, appointed by the commissioner of health;

(5) the executive director of the Vermont Superintendents Association; and

(6) a member of the Vermont-National Education Association.

(c) For the purposes of its study, the working group shall have joint administrative support from the departments of education and of health.

(d) The working group on protecting immunocompromised students shall cease to exist on January 31, 2013.

and by renumbering Sec. 5, EFFECTIVE DATE, to be Sec. 7

Fifth: In the newly renumbered Sec. 7, EFFECTIVE DATE, in the title, by striking "DATE" and inserting in lieu thereof "DATES", and before the period by inserting the phrase ", except that Sec. 2(d) shall take effect one year thereafter"

REP. MICHAEL FISHER

REP. KRISTY K. SPENGLER

REP. GEORGE W. TILL

COMMITTEE ON THE PART OF THE HOUSE

SEN. KEVIN J. MULLIN

SEN. CLAIRE D. AYER

COMMITTEE ON THE PART OF THE SENATE

Addendum to the Report of Committee of Conference

S. 199

Recommends that the Report of the Committee of Conference be rescinded and the bill be amended by striking all after the enacting clause and inserting in lieu thereof:

Sec. 1. 18 V.S.A. § 1121 is amended to read:

§ 1121. IMMUNIZATIONS REQUIRED PRIOR TO ATTENDING SCHOOL AND CHILD CARE FACILITIES

* * *

(c) To the extent permitted under the federal Health Insurance Portability and Accountability Act, Pub. L. 104-191, all schools and child care facilities shall make publicly available the aggregated immunization rates of the student body for each required vaccine using a standardized form that shall be created by the department of health. Each school and child care facility shall annually, on or before January 1, submit its standardized form containing the student body's aggregated immunization rates to the department of health. Notwithstanding section 1120 of this title, for the purposes of this subsection only, the term "child care facility" shall exclude a family day care home licensed or registered under 33 V.S.A. chapter 35.

Sec. 2. 18 V.S.A. § 1122 is amended to read:

§ 1122. EXEMPTIONS

(a) ~~A~~ Notwithstanding subsections 1121(a) and (b) of this title, a person may remain in school or in the child care facility without a required immunization:

(1) If the person~~,~~ or, in the case of a minor, the person's parent or guardian presents a ~~written statement, from~~ form created by the department and signed by a licensed health care practitioner authorized to prescribe vaccines or a health clinic~~, or nurse~~ stating that the person is in the process of being immunized. The person may continue to attend school or the child care facility ~~as long as~~ for up to six months while the immunization process is being accomplished;

(2) If a health care practitioner, licensed to practice in Vermont and authorized to prescribe vaccines, certifies in writing that a specific immunization is or may be detrimental to the person's health or is not appropriate~~;~~, provided that when a particular vaccine is no longer contraindicated, the person shall be required to receive the vaccine; or

(3) If the person~~,~~ or, in the case of a minor, the person's parent or guardian ~~states in writing~~ annually provides a signed statement to the school or child care facility on a form created by the Vermont department of health that the person, parent, or guardian:

(A) ~~has~~ holds religious beliefs or philosophical convictions opposed to immunization;

(B) has reviewed and understands evidence-based educational material provided by the department of health regarding immunizations, including information about the risks of adverse reactions to immunization;

(C) understands that failure to complete the required vaccination schedule increases risk to the person and others of contracting or carrying a vaccine-preventable infectious disease; and

(D) understands that there are persons with special health needs attending schools and child care facilities who are unable to be vaccinated or who are at heightened risk of contracting a vaccine-preventable communicable disease and for whom such a disease could be life-threatening.

(b) The health department may provide by rule for further exemptions to immunization based upon sound medical practice.

(c) A form signed pursuant to subdivision (a)(3) of this section and the fact that such a form was signed shall not be:

(1) construed to create or deny civil liability for any person; or

(2) admissible as evidence in any civil proceeding.

Sec. 3. 18 V.S.A. § 1124 is amended as follows:

§ 1124. ACCESS TO AND REPORTING OF IMMUNIZATION RECORDS

(a) In addition to any data collected in accordance with the requirements of the Centers for Disease Control and Prevention, the Vermont department of health shall annually collect from schools the immunization rates for at least those students in the first and eighth grades for each required vaccine. The data collected by the department shall include the number of medical, philosophical, and religious exemptions filed for each required vaccine and the number of students with a provisional admittance.

(b) Appropriate health personnel, including school nurses, shall have access to immunization records of anyone enrolled in Vermont schools or child care facilities, when access is required in the performance of official duties related to the immunizations required by this subchapter. Access to student immunization records shall only be provided with the prior written consent of parents and students as required by the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, and any regulations adopted thereunder.

Sec. 4. 18 V.S.A. § 1130(b)(1) is amended to read:

(b)(1) The department of health shall establish an immunization pilot program with the ultimate goal of ensuring universal access to vaccines for all Vermonters at no charge to the individual and to reduce the cost at which the state may purchase vaccines. The pilot program shall be in effect from January 1, 2010, through December 31, ~~2012~~ 2014. During the term of the pilot program, the department shall purchase, provide for the distribution of, and monitor the use of vaccines as provided for in this subsection and subsection (c) of this section. The cost of the vaccines and an administrative surcharge shall be reimbursed by health insurers as provided for in subsections (e) and (f) of this section.

Sec. 5. REPORT

The Vermont department of health shall submit a report to the general assembly on or before January 15, 2014 containing data collected pursuant to 18 V.S.A. § 1124(a) for the purpose of informing future policy discussions regarding immunization exemptions.

Sec. 6. INTERIM WORKING GROUP ON PROTECTING IMMUNOCOMPROMISED STUDENTS AND STUDENTS WITH SPECIAL HEALTH NEEDS

(a) The departments of education and of health shall convene a working group on how to protect immunocompromised students and students with special health needs, which shall study the feasibility of allowing these students to enroll in a public school maintained by an adjoining school district, where the adjoining school district has a higher immunization rate than the

school maintained by the student's school district of residence. For the purpose of protecting immunocompromised students and students with special health needs, the working group shall also assess the necessity and practicability of requiring adults employed at schools to be fully immunized. The working group shall submit a report of its findings and recommendations to the senate committee on health and welfare and the house committee on health care on or before January 1, 2013.

(b) The working group shall be composed of the following members:

(1) the commissioner of education or designee, who shall serve as co-chair;

(2) the commissioner of health or designee, who shall serve as co-chair;

(3) one medical professional with training or experience treating immunocompromised patients, appointed by the commissioner of health;

(4) one medical professional specializing in pediatric care, appointed by the commissioner of health;

(5) the executive director of the Vermont Superintendents Association; and

(6) a member of the Vermont-National Education Association.

(c) For the purposes of its study, the working group shall have joint administrative support from the departments of education and of health.

(d) The working group on protecting immunocompromised students shall cease to exist on January 31, 2013.

Sec. 7. EFFECTIVE DATE

This act shall take effect on July 1, 2012.

Rep. Michael Fisher

Rep. Kristy Spengler

Rep. George Till

Committee on the part of the House

Sen. Kevin Mullin

Sen. Claire Ayer

Committee on the part of the Senate

NOTICE CALENDAR

Favorable

S. 180

An act relating to the universal service fund and establishment of a high-cost program

Rep. Shand of Weathersfield, for the Committee on **Commerce and Economic Development**, recommends that the bill ought to pass in concurrence.

(Committee Vote: 9-0-2)

(For text see Senate Journal 4/10/2012)

Senate Proposal of Amendment

H. 78

An act relating to wages for laid-off employees

The Senate proposes to the House to amend the bill by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 9 V.S.A. § 1971 is amended to read:

§ 1971. ~~EXTENT OF LIEN~~ UNPAID WAGES; STATUTORY LIEN; PRIORITY OVER SUBSEQUENT MORTGAGE OR LIEN

(a) A statutory lien is created on the real and personal property of a corporation for up to 30 days of unpaid wages.

(b) The liability of a corporation to ~~wage earners~~ an employee for unpaid wages which were earned ~~in the three months next~~ for a 30-day period prior to the filing of a new mortgage or other lien upon the property ~~and franchise of such corporation~~ of the corporation, in all cases, shall be a first lien thereon, notwithstanding any mortgage or other lien thereon recorded after such wages were earned. ~~An individual who works for wages, salary or hire at a rate of compensation not exceeding $3,000.00 a year shall be deemed to be a wage earner within the meaning of this section.~~ Notice of the lien if on personal property shall be filed with the secretary of state's office and, if on real property, in the land records, by the employee or the department of labor acting on behalf of one or more employees. An employee who is owed wages or the department of labor acting on behalf of one or more employees may file an action to execute on the lien in the civil division of the superior court in the county in which the corporation has its principal place of business in the state, or in the civil division of the Washington County superior court.

Sec. 2. 11A V.S.A. § 14.03 is amended to read:

§ 14.03. ARTICLES OF DISSOLUTION; CONTENT OF NOTICE; NOTICE TO DEPARTMENT OF LABOR REGARDING UNPAID WAGES

(a) At any time after dissolution is authorized, the corporation may dissolve by delivering to the secretary of state for filing articles of dissolution setting forth:

(1) the name of the corporation;

(2) the date dissolution was authorized;

(3) if dissolution was approved by the shareholders:

(A) the number of votes entitled to be cast on the proposal to dissolve; and

(B) either the total number of votes cast for and against dissolution or the total number of undisputed votes cast for dissolution and a statement that the number cast for dissolution was sufficient for approval;

(4) if voting by voting groups was required, the information required by subdivision (3) of this subsection ~~must be,~~ separately provided for each voting group entitled to vote separately on the plan to dissolve;

(5) a statement as to the settlement of debts, the distribution of property, and the status of pending litigation;

(6) a statement whether the corporation owes any unpaid wages to its employees.

(b) Subject to the provisions of section 14.09 of this title, a corporation is dissolved upon the effective date of its articles of dissolution.

(c) If a corporation owes unpaid wages to its employees, it shall also file a statement to that effect with the department of labor.

(For text see House Journal 3/20/2012)

Amendment to be offered by Rep. O'Sullivan of Burlington to H. 78

Rep. O'Sullivan of Burlington moves that the House concur in the Senate proposal of amendment with further amendment as follows:

First: By striking out Sec. 2 in its entirety and inserting in lieu thereof a new Sec. 2 to read:

Sec. 2. 11A V.S.A. § 14.03 is amended to read:

§ 14.03. ARTICLES OF DISSOLUTION

(a) At any time after dissolution is authorized, the corporation may dissolve

by delivering to the secretary of state for filing articles of dissolution setting forth:

(1) the name of the corporation;

(2) the date dissolution was authorized;

(3) if dissolution was approved by the shareholders:

(A) the number of votes entitled to be cast on the proposal to dissolve; and

(B) either the total number of votes cast for and against dissolution or the total number of undisputed votes cast for dissolution and a statement that the number cast for dissolution was sufficient for approval;

(4) if voting by voting groups was required, the information required by subdivision (3) of this subsection ~~must be~~, separately provided for each voting group entitled to vote separately on the plan to dissolve;

(5) a statement as to the settlement of debts, wages, the distribution of property, and the status of pending litigation.

(b) Subject to the provisions of section 14.09 of this title, a corporation is dissolved upon the effective date of its articles of dissolution.

(c) A corporation shall stipulate to the department of labor whether and in what amount it owes unpaid wages to its employees. The secretary of state shall certify the articles of dissolution only after receiving confirmation from the department of labor that the corporation has paid the stipulated wages.

Second: By adding a Sec. 3 to read:

Sec. 3. EFFECTIVE DATE

Sec. 2 of this act shall take effect on October 1, 2012.

H. 290

An act relating to adult protective services

The Senate proposes to the House to amend the bill by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. ADULT PROTECTIVE SERVICES REPORTS

(a) Beginning September 15, 2012 and by the 15th day of each month thereafter through September 2014, the commissioner of disabilities, aging, and independent living shall provide the information described in subsection (b) of this section to the general assembly. When the general assembly is in session, the commissioner shall provide the information to the house

committees on human services and on judiciary and to the senate committees on health and welfare and on judiciary. When the general assembly is not in session, the commissioner shall provide the information to the chairs of the committees of jurisdiction, the health access oversight committee, and the office of legislative council.

(b) The commissioner shall provide the following information relating to the department's adult protective services activities during the preceding calendar month and for the calendar year to date:

(1) The number of:

(A) unduplicated intakes.

(B) cases open and under investigation.

(C) cases in which there was no personal contact with the alleged victim.

(2) The number of times a reporter was not contacted by the department within 48 hours after making a report.

(3) The number of cases that were not investigated pursuant to 33 V.S.A. § 6906 because:

(A) the alleged victim did not meet the statutory definition of a vulnerable adult.

(B) the allegation did not meet the statutory definition of abuse, neglect, or exploitation.

(C) the report was based on self-neglect.

(D) the report was based on "resident on resident" abuse.

(4) Of the cases not investigated pursuant to 33 V.S.A. § 6906 because the alleged victim did not meet the statutory definition of a vulnerable adult, whether any involved an alleged victim who was a resident of a facility, as defined in 33 V.S.A. § 6902(14)(A); a resident of a psychiatric hospital, as defined in 33 V.S.A. § 6902(14)(B); or receiving personal care services, as defined in 33 V.S.A. § 6902(14)(C).

(5) Of the cases not investigated pursuant to 33 V.S.A. § 6906 because the report was based on self-neglect, the services to which the reporter was referred.

(6) Reasons other than those listed in subdivision (2) for which a case was not investigated pursuant to 33 V.S.A. § 6906, such as no allegation of mistreatment, and the number of reports in each category.

(7) The number of cases in which there was no contact with the alleged victim or the reporter after the initial screening.

(8) The number of substantiations, pending substantiations, unsubstantiations, and completed investigations.

(9) For cases in which a decision was made not to investigate, the number of times the required letters were not sent to the victim or the reporter within five business days.

(10) For cases in which an investigation was completed, the number of times the required letters were not sent to the alleged victim, reporter, or alleged perpetrator within five business days.

(11) The length of time between when:

(A) the department received a report and when a decision was made regarding whether or not to investigate.

(B) the department received a report and when the investigator contacted the alleged victim.

(C) the department received a report and when the investigation was completed.

(12) As of the last day of the month, the number of permanent full-time equivalent employees and vacancies, the number of temporary full-time equivalent employees and vacancies, the position titles of all employees and vacant positions, and the employees' caseloads.

(13) The number of:

(A) cases that resulted in a written coordinated treatment plan pursuant to 33 V.S.A. § 6907(a), protective services as defined in 33 V.S.A. § 6902(9), or a plan of care as defined in 33 V.S.A. § 6902(8).

(B) individuals put on the abuse and neglect registry as a result of a substantiation.

(C) referrals to law enforcement agencies.

(D) times a penalty was imposed pursuant to 33 V.S.A. § 6913.

(E) actions for intermediate sanctions brought pursuant to 33 V.S.A. § 7111.

(c) Beginning in September 2013, the commissioner shall also include in each monthly report all of the information described in subsection (b) of this section for the same month of the preceding calendar year in order to allow for year-to-year comparison.

Sec. 2. DATA ANALYSIS

The secretary of human services and the commissioner of disabilities, aging, and independent living shall examine the accuracy and consistency of the August 2012 data provided to the chairs of the committees of jurisdiction, the health access oversight committee, and the office of legislative council pursuant to Sec. 1 of this act. The secretary and commissioner shall submit a report to the chairs of the committees of jurisdiction, the health access oversight committee, and the office of legislative council by September 30, 2012 summarizing their findings regarding the accuracy of the data and the extent to which the data are internally consistent.

Sec. 3. ADULT PROTECTIVE SERVICES EVALUATION

(a) The secretary of human services and the commissioner of disabilities, aging, and independent living shall jointly issue a request for proposals to conduct an independent evaluation of the adult protective services provided by the department of disabilities, aging, and independent living's division of licensing and protection.

(b) The evaluation shall examine:

(1) the effectiveness of the adult protective services provided;

(2) the division's responsiveness to complaints;

(3) the appropriateness of the level of investigation into complaints;

(4) the adequacy of training for adult protective services staff;

(5) the ability of vulnerable adults to access adult protective services;

(6) the division's rules, protocols, and practices for prioritizing, responding to, and investigating complaints;

(7) the sufficiency of adult protective services staffing levels in the division;

(8) the number of reports, substantiations, and reversals by the commissioner or the human services board;

(9) the role that the division does or should play in assessing and providing emergency protective services to vulnerable adults;

(10) best practices from other states that would improve the division's ability to protect vulnerable adults from abuse and exploitation;

(11) the scope and effectiveness of current adult protective services public education efforts;

(12) public perception of and satisfaction with adult protective services;

(13) the relationship between the units of survey and certification and adult protective services in the division of licensing and protection in the department of disabilities, aging, and independent living with respect to investigations of abuse, exploitation, and neglect; and

(14) such other areas as the entity conducting the evaluation deems appropriate.

(c) No later than March 1, 2013, the entity conducting the evaluation shall provide an interim report regarding its work to date to the house committees on human services and on judiciary and the senate committees on health and welfare and on judiciary. No later than October 1, 2013, the entity conducting the evaluation shall provide the final report of its findings and recommendations to the chairs of the house committees on human services and on judiciary and the senate committees on health and welfare and on judiciary, to the health access oversight committee, and to the office of legislative council.

(d) The secretary of human services and the commissioner of disabilities, aging, and independent living shall report, upon request, on the status of the contract and the evaluation to the chairs of the house committees on human services and on judiciary and the senate committees on health and welfare and on judiciary and to the health access oversight committee.

Sec. 4. TRANSFER

A transfer of up to $75,000.00 is authorized from the department of Vermont health access long-term care program or the department of disabilities, aging, and independent living to the secretary of human services to implement the provisions of this act.

Sec. 5. REPEAL

Sec. 12 of No. 79 of the Acts of 2005 (adult protective services annual report) is repealed.

Sec. 6. EFFECTIVE DATE

This act shall take effect on passage.

(For text see House Journal 4/21/2012)

H. 753

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

The Senate proposes to the House to amend the bill by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. Sec. 2 of No. 153 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 2. SCHOOL DISTRICT MERGER INCENTIVE PROGRAM

* * *

(c) ~~Board vote. On or before October 1, 2012, each supervisory union board shall vote whether to perform a more comprehensive analysis of potential merger, and shall report the results of its vote to the commissioner of education and the voters of each member school district.~~ [Repealed.]

* * * Reimbursement; Initial Exploration of Joint Activity * * *

Sec. 2. REIMBURSEMENT OF FEES FOR CONSULTING SERVICES; INITIAL EXPLORATION OF JOINT ACTIVITY; SUPERVISORY UNIONS; SCHOOL DISTRICTS; SUNSET

(a) From the education fund, the commissioner of education shall reimburse up to $5,000.00 of fees paid by two or more supervisory unions or two or more school districts for facilitation, legal, and other consulting services necessary for initial exploration of the value of providing services or performing duties jointly, which may include community engagement and lead to the identification of possible joint action, including the provision of shared programming, the operation of a joint contract school, the merger of supervisory unions, or the creation of union school districts pursuant to 16 V.S.A. chapter 11, subchapter 4 or the variations authorized by Secs. 15, 16, and 17 of this act and by No. 153 of the Acts of the 2009 Adj. Sess. (2010).

(b) This section is repealed on July 1, 2017.

* * * Reimbursement; Joint Activity other than Merger * * *

Sec. 3. REPEAL

Sec. 9a of No. 153 of the Acts of the 2009 Adj. Sess. (2010) ($10,000.00 reimbursement of transitional costs for supervisory unions performing duties jointly) is repealed.

Sec. 4. REIMBURSEMENT OF FEES FOR CONSULTING SERVICES; JOINT ACTIVITY OTHER THAN MERGER; SUPERVISORY UNIONS; SCHOOL DISTRICTS; SUNSET

(a) From the education fund, the commissioner of education shall reimburse up to $10,000.00 of fees paid by two or more supervisory unions or two or more school districts for:

(1) legal and other consulting services necessary to analyze in detail the advisability of providing services or performing duties jointly that will result in

a measurable increase in opportunities for students and a decrease in costs; or

(2) transitional costs necessary to enter into and implement agreements to provide those services or perform those duties jointly; or

(3) both subdivisions (1) and (2) of this subsection.

(b) Each group of supervisory unions or school districts shall forward invoices to the commissioner on a quarterly basis. The commissioner shall reimburse one-half of the total amount reflected in each set of invoices and the remaining one-half upon submission to the commissioner of a written statement of the entities' analysis and conclusions, provided that no payment shall cause the total amount paid to exceed the $10,000.00 limit.

(c) A group of supervisory unions or school districts that receives reimbursement under this section shall not be eligible to receive additional reimbursement under Sec. 5 or 9 of this act for the same proposal.

(d) This section is repealed on July 1, 2017.

* * * Reimbursement and Incentives; Merger of Supervisory Unions * * *

Sec. 5. REIMBURSEMENT OF FEES FOR CONSULTING SERVICES; MERGER; SUPERVISORY UNIONS; SUNSET

(a) From the education fund, the commissioner of education shall reimburse up to $20,000.00 of fees paid by two or more supervisory unions for legal and other consulting services necessary to analyze the advisability of the merger into a fewer number of supervisory unions and to prepare a petition to the state board of education requesting adjustment of supervisory union boundaries.

(b) Each group of supervisory unions shall forward invoices to the commissioner on a quarterly basis. The commissioner shall reimburse one-half of the total amount reflected in each set of invoices and the remaining one-half upon submission of either a petition to the state board requesting that the boundaries be redrawn or a written statement of the entities' analysis supporting preservation of the current boundaries, provided that no payment shall cause the total amount paid to exceed the $20,000.00 limit.

(c) Any transition facilitation grant funds paid pursuant to Sec. 6 of this act shall be reduced by the total amount of reimbursement provided under this section.

(d) This section is repealed on July 1, 2017.

Sec. 6. TRANSITION FACILITATION GRANT; MERGER; SUPERVISORY UNIONS; SUNSET

(a) After state board of education approval of the petition of two or more supervisory unions to merge into a fewer number of supervisory unions, the commissioner of education shall pay to the new supervisory union board or the new group of boards a transition facilitation grant from the education fund of $150,000.00, less reimbursement funds received under Sec. 5 of this act.

(b) This section is repealed on July 1, 2017.

Sec. 7. APPLICABILITY; RUTLAND-WINDSOR AND WINDSOR SOUTHWEST SUPERVISORY UNIONS

If on or before July 1, 2012 the state board of education approves the petition of the Rutland-Windsor and Windsor Southwest Supervisory Unions to merge into a single, new supervisory union on or before July 1, 2013, then the new supervisory union shall be eligible to receive:

(1) the transition facilitation grant available under Sec. 6 of this act; and

(2) a one-time grant of $100,000.00 from the education fund for the purposes of reducing taxes in the affected towns during fiscal year 2014.

Sec. 8. SUPERVISORY UNION SIZE AND STRUCTURE

(a) The secretary of administration or designee, in consultation with the commissioner of education or designee, shall explore the purpose, structure, duties, and authority of supervisory unions and design a revised structure based roughly on existing technical center service regions that results in no more than three supervisory unions within each region. The primary purpose of any design shall be to improve education quality. The secretary shall analyze the feasibility of the revised structure and shall develop a plan of transition. Among other things, the secretary shall:

(1) consider the optimal size of supervisory unions, in terms of geography and numbers of students, technical centers, schools, and school districts served;

(2) consider structural elements, such as:

(A) management models;

(B) staffing, including the most appropriate way to address existing contracts, staff consolidation, and salary equalization;

(C) special education services;

(D) financial and other data collection and management systems;

(E) transportation, including ownership of buses, merger of systems, and consolidation of routes;

(F) supervisory union boards, including structure, selection of members, district representation, and the purpose, authority, and membership of executive committees;

(G) supervisory union budgets, including the manner in which they are adopted and the method by which costs are assessed to the member districts;

(H) ownership of real and personal property;

(I) ability to borrow money; and

(J) alignment of curricula and calendars;

(3) consider ways in which the department and state board of education would support transition to a proposed structure; and

(4) estimate both the financial cost of transitioning to and the potential savings in the proposed structure.

(b) By January 15, 2013, the secretary shall report to the senate and house committees on education on the work required by this section. The secretary shall also provide recommendations for legislative action necessary to implement its proposed plan.

* * * Reimbursement and Incentives; Merger of School Districts * * *

Sec. 9. REIMBURSEMENT OF FEES FOR CONSULTING SERVICES; MERGER; SCHOOL DISTRICTS; SUNSET

(a) From the education fund, the commissioner of education shall reimburse up to $20,000.00 of fees paid by a study committee established under 16 V.S.A. § 706 for legal and other consulting services necessary to analyze the advisability of creating a union school district or a unified union school district and to prepare the report required by 16 V.S.A. § 706b.

(b) The study committee shall forward invoices to the commissioner on a quarterly basis. The commissioner shall reimburse one-half of the total amount reflected in each set of invoices and the remaining one-half upon submission of the final report pursuant to 16 V.S.A. § 706c, provided that no payment shall cause the total amount paid to exceed the $20,000.00 limit.

(c) Any transition facilitation grant funds paid to the union school board pursuant to Sec. 11 of this act shall be reduced by the total amount of reimbursement provided under this section.

(d) A regional education district ("RED") receiving incentives pursuant to Sec. 4 of No. 153 of the Acts of the 2009 Adj. Sess. (2010) as amended by this act is not eligible to receive reimbursement under this section.

(e) This section is repealed on July 1, 2017.

Sec. 10. REPEAL

Sec. 168a of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as amended by Sec. 23 of No. 66 of the Acts of 2007 and further amended by Sec. 5 of No. 153 of the Acts of the 2009 Adj. Sess. (2010) ($150,000.00 or five-percent transition aid to merging school districts), is repealed.

Sec. 11. TRANSITION FACILITATION GRANT; MERGER; SCHOOL DISTRICTS; SUNSET

(a) After voter approval of the establishment of a union, unified union, or interstate school district, the commissioner of education shall pay to the district a transition facilitation grant from the education fund equal to the lesser of:

(1) five percent of the base education amount established in 16 V.S.A. § 4001(13) multiplied by the greater of either the combined enrollment or the average daily membership of the merging districts on October 1 of the year in which the successful vote is taken; or

(2) $150,000.00.

(b) A grant awarded under this section shall be reduced by the total amount of reimbursement paid under Sec. 9 of this act.

(c)(1) A RED receiving incentives pursuant to Sec. 4 of No. 153 of the Acts of the 2009 Adj. Sess. (2010) as amended by this act ("Act 153") is not eligible to receive a grant under this section.

(2) An interstate, union, or unified union school district, including a RED, that expands by merging with one or more additional school districts is not eligible to receive a grant under this section if the original merged district received a transition facilitation grant under this section, Act 153, or Sec. 168a of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as amended by Sec. 23 of No. 66 of the Acts of 2007, as further amended by Sec. 5 of No. 153 of the Acts of the 2009 Adj. Sess. (2010), and as repealed by Sec. 10 of this act.

(d) This section is repealed on July 1, 2017.

Sec. 12. APPLICABILITY; JOINT CONTRACT SCHOOL

A transition facilitation grant pursuant to Sec. 11 of this act shall be paid proportionally based on enrollment to any group of districts if in fiscal year 2012 or 2013 the voters of each district approve the issuance of bonds upon which establishment of a joint contract school is conditioned. The combined enrollment of the grades newly being offered jointly by the contracting districts shall be used to calculate the amount awarded.

* * * Incentives; Regional Education Districts * * *

Sec. 13. Sec. 4 of No. 153 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 4. VOLUNTARY SCHOOL DISTRICT MERGER; INCENTIVES

(a) Equalized homestead property tax rates or RED incentive grant. A RED's plan of merger shall provide whether, upon merger, the RED shall receive an equalization of its homestead property tax rates during the first four years following merger or an incentive grant during the first year following merger.

(1)(A) Equalized homestead property tax rates. Subject to the provisions of subdivision ~~(2)~~(C) of this ~~subsection~~ subdivision (1) and notwithstanding any other provision of law, the RED's equalized homestead property tax rate shall be:

(i) decreased by $0.08 in the first year after the effective date of merger;

(ii) decreased by $0.06 in the second year after the effective date of merger;

(iii) decreased by $0.04 in the third year after the effective date of merger; and

(iv) decreased by $0.02 in the fourth year after the effective date of merger.

(B) The household income percentage shall be calculated accordingly.

~~(2)~~(C) During the years in which a RED's equalized homestead property tax rate is decreased pursuant to this subsection, the rate for each town within the RED shall not increase or decrease by more than five percent in a single year. The household income percentage shall be calculated accordingly.

(2) RED incentive grant. During the first year after the effective date of merger, the commissioner of education shall pay to the RED board a RED incentive grant from the education fund equal to $400.00 per pupil based on the combined enrollment of the participating districts on October 1 of the year in which the successful vote was taken. The grant shall be in addition to funds received under 16 V.S.A. § 4028.

(3) ~~On~~ Common level of appraisal. Regardless of whether a RED chooses to receive an equalization of its homestead property tax rates or a RED incentive grant, on and after the effective date of merger, the common level of

appraisal shall be calculated independently for each town within the RED for purposes of determining the homestead property tax rate for each town.

* * *

(e) Consulting services reimbursement grant. From the education fund, the commissioner of education shall pay up to $20,000.00 to the merger study committee established under 16 V.S.A. § 706 to reimburse the participating districts for legal and other consulting fees necessary for the analysis and report required by 16 V.S.A. § 706b. The study committee shall forward invoices to the commissioner on a quarterly basis. The commissioner shall reimburse one-half of the total amount reflected in each set of invoices and the remaining one-half upon completion of the final report, provided that no payment shall cause the total amount paid to exceed the $20,000.00 limit. In addition, any transition facilitation grant funds paid to the RED pursuant to ~~Sec. 5 of this act~~ subsection (g) of this section shall be reduced by the total amount of ~~funds provided~~ reimbursement paid under this subsection (e).

* * *

(g) ~~Recent merger. If the Addison Northwest Unified Union School District becomes a body corporate and politic on or before July 1, 2010, then the merged district shall be entitled to receive any of the benefits set forth in this section that it elects and is otherwise eligible to receive if, on or before July 1, 2011:~~

~~(1) it notifies the commissioner of its election; and~~

~~(2) it provides the commissioner with a cost-benefit analysis as required by Sec. 3(h) of this act.~~ Transition facilitation grant.

(1) After voter approval of the plan of merger, the commissioner of education shall pay the RED a transition facilitation grant from the education fund equal to the lesser of:

(A) five percent of the base education amount established in 16 V.S.A. § 4001(13) multiplied by the greater of either the combined enrollment or the average daily membership of the merging districts on October 1 of the year in which the successful vote is taken; or

(B) $150,000.00.

(2) A transition facilitation grant awarded under this subsection (g) shall be reduced by the total amount of reimbursement paid under subsection (e) of this section.

(h) This section is repealed on July 1, 2017.

Sec. 14. Sec. 2(a) of No. 153 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

(a) Program created. There is created a school district merger incentive program under which the incentives outlined in Sec. 4 of this act shall be available to each new unified union school district created pursuant to Sec. 3 of this act ~~and;~~ to each new district created under ~~that section~~ Sec. 3 of this act by the merger of districts that provide education by paying tuition; and to the Vermont members of any new interstate school district if the Vermont members jointly satisfy the size criterion of Sec. 3(a)(1) of this act and the new, merged district meets all other requirements of Sec. 3 of this act. Incentives shall be available, however, only if the effective date of merger is on or before July 1, 2017.

* * * Other Types of Mergers Eligible for RED Incentives * * *

Sec. 15. TWO OR MORE MERGERS; REGIONAL EDUCATION DISTRICT INCENTIVES

(a) Notwithstanding Sec. 3(a)(1) of No. 153 of the Acts of the 2009 Adj. Sess. (2010) that requires a single regional education district ("RED") to have an average daily membership of at least 1,250 or result from the merger of at least four districts, or both, two or more new districts shall be eligible jointly for the incentives provided in Sec. 4 of No. 153 if:

(1) each new district is formed by the merger of at least two existing districts;

(2) each new district meets all criteria for RED formation other than the size criterion of Sec. 3(a)(1) of No. 153;

(3) one of the new districts provides education in all elementary and secondary grades by operating one or more schools and the other new district or districts pay tuition for students in one or more grades;

(4) each new district has the same effective date of merger;

(5) the new districts, when merged, are members of one supervisory union; and

(6) the new districts jointly satisfy the size criterion of Sec. 3(a)(1) of No. 153.

(b) This section is repealed on July 1, 2017.

Sec. 16. UNION ELEMENTARY SCHOOL DISTRICTS; REGIONAL EDUCATION DISTRICT INCENTIVES

(a) If a majority of the local elementary school districts in the member

towns of an existing union high school district merge to form a union elementary school district pursuant to 16 V.S.A. chapter 11 that operates all grades not offered by the union high school district, then, notwithstanding provisions of No. 153 of the Acts of the 2009 Adj. Sess. (2010) to the contrary, the new union elementary school district is eligible for the incentives provided to a regional education district ("RED") in Sec. 4 of that act, provided that the new district complies with the employment and labor relations provisions of Sec. 4(g) of that act and further provided that the effective date of the merger into the union elementary school district is within the period required for RED formation.

(b) This section is repealed on July 1, 2017.

Sec. 17. MODIFIED UNIFIED UNION SCHOOL DISTRICT

(a) Notwithstanding any provision of law to the contrary:

(1)(A) if all local elementary school districts in the member towns of an existing union high school or union middle school-high school district ("union high school district") vote whether to establish a unified union school district providing prekindergarten or kindergarten through grade 12, and

(B) if a majority but not all of the elementary school districts votes in favor of establishing the unified union school district, then

(2) a new modified union school district (the "modified union school district") shall be established that shall:

(A) provide to the students residing in the member towns of the union high school district education in those grades provided by the union high school district; and

(B) provide elementary education to the students residing in the current elementary school districts that voted in favor of the unified union school district.

(b) Establishment of the modified union school district shall:

(1) dissolve the union high school district, and any assets or liabilities held by the union high school district shall be transferred to the modified union school district; and

(2) dissolve the elementary school districts that voted in favor of establishing the unified union school district, and any assets or liabilities they hold as individual districts shall be transferred to the modified union school district.

(c) Notwithstanding provisions of No. 153 of the Acts of the 2009 Adj. Sess. (2010) as amended by this act to the contrary, the modified union school

district is eligible for the incentives provided to a regional education district ("RED") in Sec. 4 of that act, provided that the new district complies with the employment and labor relations provisions of Sec. 4(g) of that act and further provided that the effective date of the merger into the modified union school district is within the period required for RED formation.

(d) This section is repealed on July 1, 2017.

* * * Union School Districts Including REDs; Process * * *

Sec. 18. 16 V.S.A. § 706c is amended to read:

§ 706c. CONSIDERATION BY LOCAL SCHOOL DISTRICT BOARDS AND APPROVAL BY STATE BOARD OF EDUCATION

(a) If a study committee prepares a report under section 706b of this chapter, the committee shall transmit the report to the school boards of each school district that participated in the study committee and any other school districts that the report identifies as necessary or advisable to the establishment of the proposed union school district for the review and comment of each school board.

(b) The study committee shall transmit the report to the commissioner who shall submit the report with his or her recommendations to the state board of education. That board after notice to the study committee and after giving the committee an opportunity to be heard shall consider the report and the commissioner's recommendations, and decide whether the formation of such union school district will be for the best interest of the state, the students, and the school districts proposed to be members of the union. The board may request the commissioner and the study committee to make further investigation and may consider any other information deemed by it to be pertinent. If, after due consideration and any further meetings as it may deem necessary, the board finds that the formation of the proposed union school district is in the best interests of the state, the students, and the school districts, it shall approve the report submitted by the committee, together with any amendments, as a final report of the study committee, and shall give notice of its action to the committee. The chair of the study committee shall file a copy of the final report with the town clerk of each proposed member district at least 20 days prior to the vote to establish the union.

Sec. 19. 16 V.S.A. § 706n is amended to read:

§ 706n. AMENDMENTS TO AGREEMENTS REACHED BY ESTABLISHMENT VOTE, ORGANIZATION MEETING, OR FINAL REPORT

(a) ~~Any~~ A specific condition or agreement set forth as a distinct subsection

under Article 1 of the warning required by section 706f of this chapter and adopted by the member districts ~~pursuant to section 706f of this chapter~~ at the vote held to establish the union school district, or any amendment subsequently adopted pursuant to the terms of this section, may be amended only at a special or annual union district meeting; provided that the prior approval of the state board of education shall be secured if the proposed amendment concerns reducing the number of grades that the union is to operate. The warning for the meeting shall contain each proposed amendment as a separate article. The vote on each proposed amendment shall be by Australian ballot. Ballots shall be counted in each member district, and the clerks of each member district shall transmit the results of the vote in that district to the union school district clerk. ~~Results~~ Although the results shall be reported to the public by member district~~; however, no~~, an amendment is effective ~~unless~~ if approved by a majority of ~~those~~ the electorate of the union district voting at that meeting.

(b) Any decision at the organization meeting may be amended by a majority of those present and voting at a union district meeting duly warned for that purpose.

(c) Any provision of the final report ~~which was not contained in a separate article~~ that was included in the warning required pursuant to section 706f of this chapter for the vote to form the union by reference to or incorporation of the entire report but that was not set forth as a distinct subsection under Article 1 of the warning may be amended by a simple majority vote of the union board of school directors, or by any other majority of the board as is specified for a particular matter in the report.

* * * Special Education; Transition to Employment

by Supervisory Unions * * *

Sec. 20. Sec. 23(b) of No. 153 of the Acts of the 2009 Adj Sess. (2010), as amended by Sec. 1 of No. 30 of the Acts of 2011, is further amended to read:

(b) Secs. 9 through 12 of this act shall take effect on passage and shall be fully implemented on July 1, 2013, subject to the provisions of existing contracts; provided, however, that the special education provisions of Sec. 9, 16 V.S.A. § 261a(a)(6), and the transportation provisions of Sec. 9, 16 V.S.A. § 261a(a)(8)(E), shall be fully implemented on July 1, 2014.

Sec. 21. SUPERVISORY UNION EMPLOYEES; SPECIAL EDUCATION; WORKING GROUP

(a) On or before July 1, 2012, the commissioner of education or the commissioner's designee shall convene a working group to develop a detailed plan by which supervisory unions shall fully implement, by July 1, 2014, the

transition of special education staff employed by school districts to employment by supervisory unions as required by 16 V.S.A. § 261a(a)(6).

(b) The working group shall include department staff and representatives from at least the following constituencies: superintendents; school boards; principals; special educators; a teachers' organization as defined in 16 V.S.A. chapter 57; and business managers.

(c) The working group shall report to the advisory council on special education created by 16 V.S.A. § 2945 and to the house and senate committees on education during the first week of the 2013 and 2014 legislative sessions regarding the progress of the plan required by this section, including a description of the ways in which specific impediments to implementation are being addressed. The working group also shall identify any amendments to statute necessary to achieve implementation by July 1, 2014 of the requirements of 16 V.S.A. § 261a.

* * * Appropriation * * *

Sec. 22. APPROPRIATION

The sum of $650,000.00 is appropriated from the education fund to be used for the purposes of this act in fiscal year 2013.

* * * Excess Spending Provisions * * *

Sec. 23. 16 V.S.A. § 4001(6)(B) is amended to read:

(B) For purposes of calculating excess spending pursuant to 32 V.S.A. § 5401(12), "education spending" shall not include:

* * *

(viii) Tuition paid by a district that does not operate a school and pays tuition for all resident students in kindergarten through grade 12, except in a district in which the electorate has authorized payment of an amount higher than the statutory rate pursuant to subsection 823(b) or 824(c) of this title.

* * * Vermont Municipal Employees' Retirement System; Special Education Instructional Assistants and Transportation Employees; Transfer to Supervisory Union * * *

Sec. 24. 24 V.S.A. § 5051(10) and (11) are amended to read:

(10) "Employee" means the following persons employed on a regular basis by a school district or by a supervisory union for ~~not less~~ no fewer than 1,040 hours in a year and for ~~not less~~ no fewer than 30 hours a week for the school year, as defined in ~~section 1071 of Title~~ 16 V.S.A. § 1071, or for ~~not~~

~~less~~ no fewer than 1,040 hours in a year and for ~~not less~~ no fewer than 24 hours a week year-round; provided, however, that if a person who was employed on a regular basis by a school district as either a special education or transportation employee and who was transferred to and is working in a supervisory union in the same capacity pursuant to 16 V.S.A. § 261a(a)(6) or (8)(E) and if that person is also employed on a regular basis by a school district within the supervisory union, then the person is an "employee" if these criteria are met by the combined hours worked for the supervisory union and school district. The term shall also mean persons employed on a regular basis by a municipality other than a school district for ~~not less~~ no fewer than 1,040 hours in a year and for ~~not less~~ no fewer than 24 hours per week, including persons employed in a library at least ~~half~~ one-half of whose operating expenses are met by municipal funding:

* * *

(11) "Employer" means a municipality ~~or~~, a library at least ~~half~~ one-half of whose operating expenses are paid from municipal funds, or a supervisory union.

Sec. 25. 24 V.S.A. § 5053a is added to read:

§ 5053a. EMPLOYEES OF A SUPERVISORY UNION

(a) For purposes of this section, the term "transferred employee" means an employee under this chapter who transitioned from employment solely by a school district to employment, wholly or in part, by a supervisory union pursuant to 16 V.S.A. § 261a(a)(6) or (8)(E) as amended on June 3, 2010.

(b) A transferred employee from a participating school district shall remain an employee of the school district solely for the purpose of employer participation and employee membership in the system regardless of whether the supervisory union is a participant in the system on the date of transition. The membership and benefits of the transferred employee shall not be impaired or reduced by either negotiations with the supervisory union or school district under 21 V.S.A. chapter 22 or otherwise.

(c) If a supervisory union is a participant in the system on the date of transition, then:

(1) a transferred employee from a nonparticipating district shall not become a member of the system unless, through negotiations with the supervisory union under 21 V.S.A. chapter 22, the supervisory union becomes a participant in the system on the employee's behalf;

(2) an existing employee of the supervisory union on the date of transition shall be a member to the extent the supervisory union is or becomes

a participant in the system on the employee's behalf; and

(3) a new employee of the supervisory union after the date of transition shall be a member to the extent the supervisory union is or becomes a participant in the system on the employee's behalf.

(d) If a supervisory union is not a participant in the system on the date of transition, then:

(1) a transferred employee from a nonparticipating district shall not be a member of the system unless, through negotiations with the supervisory union under 21 V.S.A. chapter 22, the supervisory union becomes a participant in the system on the employee's behalf;

(2) an existing employee of the supervisory union on the date of transition shall not be a member of the system unless, through negotiations with the supervisory union under 21 V.S.A. chapter 22, the supervisory union becomes a participant in the system on the employee's behalf; and

(3) a new employee of the supervisory union after the date of transition shall not be a member of the system unless, through negotiations with the supervisory union under 21 V.S.A. chapter 22, the supervisory union becomes a participant in the system on the employee's behalf.

Sec. 26. TRANSITION; NEWLY MERGED DISTRICTS

(a) If two or more districts merge to form a union school district pursuant to 16 V.S.A. chapter 11, subchapter 4, or a regional education district pursuant to No. 153 of the Acts of the 2009 Adj. Sess. (2010) ("the new district") prior to the date on which employees covered by the municipal employees' retirement system provisions of 24 V.S.A. chapter 125 ("the system") transitioned from employment solely by a school district to employment, wholly or in part, by a supervisory union pursuant to 16 V.S.A. § 261a(a)(6) or (8)(E) as amended on June 3, 2010 ("the transition date"), then:

(1) on the first day of merger, the new district shall be a participant in the system on behalf of:

(A) an employee from a school district that merged to form the new district if the merging district was a participant in the system prior to merger; and

(B) a new employee hired by the new district after the effective date of merger into a job classification for which the new district is a participant in the system, if any;

(2) an employee from a school district that was not a participant in the system prior to merger shall not be a member of the system unless, through

negotiations with the new district under 21 V.S.A. chapter 22, the new district becomes a participant in the system on the employee's behalf.

(b) If a new district is formed after the transition date, then the new district shall assume the responsibilities of any one or more of the merging districts that participate in the system; provided, however, that this subsection shall not be construed to extend benefits to an employee who would not otherwise be a member of the system under any other provision of law.

(c) The existing membership and benefits of an employee shall not be impaired or reduced either by negotiations with the new district under 21 V.S.A. chapter 22 or otherwise.

(d) In addition to general responsibility for the operation of the Vermont municipal employees' retirement system pursuant to 24 V.S.A. § 5062(a), the responsibility for implementation of all sections of this act relating to the system is vested in the retirement board.

Sec. 26a. 16 V.S.A. § 1982 is amended to read:

§ 1982. RIGHTS

(a) Teachers shall have the right to or not to join, assist, or participate in any teachers' organization of their choosing. However, teachers ~~may be required to pay an agency fee~~ who choose not to join the teachers' organization, recognized pursuant to ~~an agreement negotiated under~~ section 1992 of this chapter as the exclusive representative, shall pay an agency fee in the same manner as teachers who choose to join the teachers' organization pay membership fees.

(b) Principals, assistant principals, and administrators other than superintendent and assistant superintendent shall have the right to or not to join, assist, or participate in any administrators' organization or as a separate unit of any teachers' organization of their choosing. However, administrators other than the superintendent and assistant superintendent ~~may be required to pay an agency fee~~ who choose not to join the administrators' organization, recognized pursuant to ~~an agreement negotiated under~~ section 1992 of this chapter as the exclusive representative, shall pay an agency fee in the same manner as administrators who choose to join the administrators' organization pay membership fees.

(c) Neither the school board nor any employee of the school board serving in any capacity, nor any other person or organization shall interfere with, restrain, coerce, or discriminate in any way against or for any teacher or administrator engaged in activities protected by this legislation.

Sec. 26b. 21 V.S.A. § 1726 is amended to read:

§ 1726. UNFAIR LABOR PRACTICES

(a) It shall be an unfair labor practice for an employer:

* * *

(8) Nothing in this chapter or any other statute of this state shall preclude a municipal employer from making an agreement with the exclusive bargaining agent ~~to require an agency service fee to be paid as a condition of employment, or~~ to require as a condition of employment membership in such employee organization on or after the 30th day following the beginning of such employment or the effective date of such agreement, whichever is the later. Absent such an agreement, an employee who does not become a member of the employee organization shall, in the same manner as employees who choose to join the employee organization pay membership fees, pay an agency service fee to that organization. No municipal employer shall discharge or discriminate against any employee for nonpayment of an agency service fee or for nonmembership in an employee organization:

(A) If the employer has reasonable grounds for believing that membership was not available to the employee on the same terms and conditions generally applicable to other members; or

(B) If the employer has reasonable grounds for believing that membership was denied or terminated for reasons other than the failure of the employee to tender the periodic dues and the initiation fees uniformly required as a condition of acquiring or retaining membership.

(b) It shall be an unfair labor practice for an employee organization or its agents:

* * *

(6) To require employees covered by an agency service fee ~~agreement~~ requirement or other union security agreement authorized under subsection (a) of this section to pay an initiation fee which the board finds excessive or discriminatory under all the circumstances, including the practices and customs of employee organizations representing municipal employees, and the wages paid to the employees affected.

* * *

(12) To charge an agency service fee unless the employee organization has established and maintained a procedure to provide nonmembers with all the following:

(A) An audited financial statement that identifies the major categories of expenses and divides them into chargeable and nonchargeable expenses.

(B) An opportunity to object to the amount of the fee requested and to place in escrow any amount reasonably in dispute.

(C) Prompt arbitration by an arbitrator selected jointly by the objecting fee payer and the labor organization or pursuant to the rules of the American Arbitration Association to resolve any objection over the amount of the agency service fee.

* * * Effective Dates * * *

Sec. 27. EFFECTIVE DATES

(a) This section and Secs. 7, 8, 12, 24, 25, and 26 of this act shall take effect on passage.

(b) All other sections of this act shall take effect on July 1, 2012.

(For text see House Journal 2/21/2012 and 2/22/2012)

H. 794

An act relating to the management of search and rescue operations

The Senate proposes to the House to amend the bill by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds:

(1) Several recent cases involving the search and rescue of persons lost in Vermont's outdoor recreation areas, including the tragic death of Levi Duclos on January 9, 2012 as he was hiking on the Emily Proctor Trail in Ripton, have raised questions concerning whether supervision of backcountry search and rescue operations should be maintained by the department of public safety or shared with or transferred to another governmental entity and whether regional protocols should be put into place to allow for a local or regional response utilizing a combination of qualified professional and qualified volunteer searchers and rescuers.

(2) Under current law and practice, the Vermont state police division of the department of public safety has primary responsibility for finding lost hikers and other missing people in areas of the state which do not have municipal police departments and has the authority to call out qualified professional and qualified volunteer services. This duty was assigned when the Vermont state police was first created in 1946 and has not changed since that time. According to Howard Paul, a public information officer and member of the board of directors of the National Association for Search and Rescue, Vermont is one of only five states that require their state police to find

and rescue people who are lost or missing outdoors.

(3) In other states in which a significant amount of outdoor recreational activity occurs, such as New Hampshire and Maine, state fish and game agencies are in charge of finding lost outdoor recreationalists. Most eastern states turn to park rangers and fish and game wardens for search and rescue.

(4) Many states collaborate with nonprofit organizations to aid in search and rescue. For example, the Maine Warden Service is in charge of search and rescue throughout that state, and it relies on the Maine Association for Search and Rescue, which is composed of approximately 15 approved member organizations.

(5) Vermont has an extensive number of first responders and emergency service personnel with specific training and experience conducting outdoor search and rescue operations. The Lincoln Fire Department, for example, has significant search and rescue experience, well-established strategies for conducting such operations, and the ability to have a team on the ground in sometimes 30 minutes or less on nights and weekends. Despite these resources, only four civilian organizations are approved by the department of public safety to provide search and rescue assistance in Vermont.

(6) In light of Vermont's minority status in charging the state police with responsibility for search and rescue of lost hikers and outdoor recreationalists and in light of the department's recent challenges in fulfilling this responsibility, it is an appropriate time to consider whether some other state entity, working with Vermont's extensive volunteer community, should assume responsibility for outdoor search and rescue operations.

Sec. 2. BACKCOUNTRY SEARCH AND RESCUE STUDY COMMITTEE

(a) Creation of committee. There is created a backcountry search and rescue study committee to determine whether the department of public safety or a different state agency should have lead or coauthority for supervising search and rescue operations for missing persons in Vermont's backcountry and outdoor recreational areas and to recommend an appropriate organizational structure to manage Vermont's various search and rescue resources. As used in the section, "backcountry search and rescue" means the search for and provision of aid to people who are lost or stranded in the outdoors on Vermont's land or inland waterways.

(b) Membership. The backcountry search and rescue study committee shall be composed of four members. The members of the committee shall be as follows:

(1) Two members of the house appointed by the speaker.

(2) Two members of the senate appointed by the committee on committees.

(c) For purposes of its study, the committee shall consult with and seek testimony from interested parties, including the following individuals and entities or their designees:

(1) The commissioner of public safety.

(2) The commissioner of fish and wildlife.

(3) The Vermont League of Cities and Towns.

(4) Stowe Mountain Rescue.

(5) Colchester Technical Rescue.

(6) A certified first responder with search and rescue experience.

(7) The Professional Firefighters of Vermont.

(8) A member of a volunteer fire department with search and rescue experience designated by the president of the Vermont State Firefighters Association.

(9) A sheriff designated by the department of sheriffs and state's attorneys.

(10) North Bennington Volunteer Fire Department.

(d) Powers and duties. The committee shall study whether the department of public safety or a different state agency should be responsible for supervising search and rescue operations for missing persons in Vermont's backcountry and outdoor recreational areas. The committee's study shall include:

(1) reviewing the existing method and responsibility for conducting backcountry search and rescue operations in Vermont and identifying the advantages and disadvantages of the current system;

(2) considering models in other states for supervision of backcountry search and rescue operations, including the New Hampshire approach of providing authority to the New Hampshire fish and game department;

(3) evaluating whether backcountry search and rescue operations would be conducted in a more timely and efficient manner if the authority for conducting such operations were held by one or more state or nongovernmental entities other than the department of public safety or whether there should be a shared or regional approach depending on the location of the search;

(4) considering and evaluating different organizational structures to determine how to most effectively manage Vermont's backcountry search and rescue processes and resources;

(5) considering whether minimum qualifications should be set for participation in backcountry search and rescue operations and whether backcountry search and rescue responders who are not state employees should be provided with insurance coverage;

(6) considering the feasibility of establishing an online database of missing persons that would provide automatic notice to first responders;

(7) developing methods of financing search and rescue operations, including consideration of methods used in other states such as:

(A) establishing an outdoor recreation search and rescue card available for purchase by users of outdoor recreation resources on a voluntary basis to help reimburse the expenses of search and rescue missions;

(B) imposing fees on recreational and outdoor licenses and permits; and

(C) permitting recovery of expenses from any person whose negligent conduct required a search and rescue response and, if so, who should bring such an action and who should be reimbursed; and

(8) proposing any statutory changes that the committee identifies as necessary to improve the conduct and supervision of backcountry search and rescue activities in Vermont.

(e) Report. The committee shall report its findings and recommendations, together with draft legislation if any legislative action is recommended, to the general assembly on or before January 15, 2013.

(f) The legislative council shall provide administrative and drafting support to the committee.

Sec. 3. 18 V.S.A. § 901 is amended to read:

§ 901. POLICY

It is the policy of the state of Vermont that all persons who suffer sudden and unexpected illness or injury should have access to the emergency medical services system in order to prevent loss of life or the aggravation of the illness or injury, and to alleviate suffering. The system should include competent emergency medical care provided by adequately trained, licensed, and equipped personnel acting under appropriate medical control. Persons involved in the delivery of emergency medical care should be encouraged to maintain and advance their levels of training and certification, and to upgrade

the quality of their vehicles and equipment.

Sec. 4. 18 V.S.A. § 903 is amended to read:

§ 903. AUTHORIZATION FOR PROVISION OF EMERGENCY MEDICAL SERVICES

Notwithstanding any other provision of law, including provisions of chapter 23 of Title 26, persons who are ~~certified~~ licensed to provide emergency medical care pursuant to the requirements of this chapter and implementing regulations are hereby authorized to provide such care without further certification, registration or licensing.

Sec. 5. 18 V.S.A. § 904 is amended to read:

§ 904. ADMINISTRATIVE PROVISIONS

(a) In order to carry out the purposes and responsibilities of this chapter, the department of health may contract for the provision of specific services.

(b) The secretary of human services, upon the recommendation of the ~~department~~ commissioner of health, may issue regulations to carry out the purposes and responsibilities of this chapter.

Sec. 6. 18 V.S.A. § 906 is amended to read:

§ 906. EMERGENCY MEDICAL SERVICES DIVISION; RESPONSIBILITIES

To implement the policy of section 901, the department of health shall be responsible for:

(1) Developing and implementing minimum standards for training emergency medical personnel in basic life support and advanced life support, and ~~certifying their~~ licensing emergency medical personnel according to their level of training and competence.

(2) Developing and implementing minimum standards for vehicles used in providing emergency medical care, designating the types and quantities of equipment that must be carried by these vehicles, and registering those vehicles according to appropriate classifications.

(3) Developing a statewide system of emergency medical services including but not limited to planning, organizing, coordinating, improving, expanding, monitoring and evaluating emergency medical services.

(4) Developing response time benchmarks for urban and rural requests for emergency services.

(5) Training, or assisting in the training of, emergency medical

personnel.

~~(5)~~(6) Assisting hospitals in the development of programs which will improve the quality of in-hospital services for persons requiring emergency medical care.

~~(6)~~(7) Developing and implementing procedures to insure that emergency medical services are rendered only with appropriate medical control. For the provision of advanced life support, appropriate medical control shall include at a minimum:

(A) written protocols between the appropriate officials of receiving hospitals and ~~ambulance services~~ emergency medical services districts defining their operational procedures;

(B) where necessary and practicable, direct communication between emergency medical personnel and a physician or person acting under the direct supervision of a physician;

(C) when such communication has been established, a specific order from the physician or person acting under the direct supervision of the physician to employ a certain medical procedure;

(D) use of advanced life support, when appropriate, only by emergency medical personnel who are certified by the department of health to employ advanced life support procedures.

~~(7)~~(8) Establishing requirements for the collection of data by emergency medical personnel and hospitals as may be necessary to evaluate emergency medical care.

~~(8)~~(9) Establishing, by rule, ~~levels of individual certification and application forms for advanced emergency medical care~~ license levels for emergency medical personnel. The commissioner shall use the guidelines established by the National Highway Traffic Safety Administration (NHTSA) in the U.S. Department of Transportation as a standard or other comparable standards, except that a felony conviction shall not ~~necessarily~~ disqualify an applicant unless the conviction is related to the delivery of emergency medical services. The rules shall also provide that:

(A) An individual may apply for and obtain one or more additional ~~certifications~~ licenses, including ~~certification~~ licensure as an advanced emergency medical technician or as a paramedic.

(B) An individual ~~certified~~ licensed by the commissioner as an emergency medical technician, advanced emergency medical technician, or a paramedic, who is affiliated with ~~a licensed ambulance service, fire department, or rescue service~~ an affiliated agency, shall be able to practice

fully within the scope of practice for such level of ~~certification~~ licensure as defined by NHTSA's National EMS Scope of Practice Model ~~notwithstanding any law or rule to the contrary~~ consistent with the license level of the affiliated agency, and subject to the medical direction of the ~~commissioner or designee~~ emergency medical services district medical advisor.

(C) Unless otherwise provided under this section, an individual seeking any level of ~~certification~~ licensure shall be required to pass an examination approved by the commissioner for that level of ~~certification~~ licensure. Written and practical examinations shall not be required for ~~recertification~~ relicensure; however, to maintain ~~certification~~ licensure, all individuals shall complete a specified number of hours of continuing education as established by rule by the commissioner. The commissioner shall ensure that continuing education classes are available online and provided on a regional basis to accommodate the needs of volunteers and part-time individuals, including those in rural areas of the state.

(D) If there is a hardship imposed on any applicant for a ~~certification~~ license under this section because of unusual circumstances, the applicant may apply to the commissioner for a temporary or permanent waiver of one or more of the ~~certification~~ licensure requirements, which the commissioner may grant for good cause.

(E) An applicant who has served as ~~an advanced emergency medical technician, such as~~ a hospital corpsman or a medic in the United States Armed Forces, or who is licensed as a registered nurse or a physician's assistant shall be granted a permanent waiver of the training requirements to become a ~~certified~~ licensed emergency medical technician, an advanced emergency medical technician, or a paramedic, provided the applicant passes the applicable examination approved by the commissioner for that level of ~~certification~~ licensure and further provided that the applicant is affiliated with ~~a rescue service, fire department, or licensed ambulance service~~ an affiliated agency.

(F) An applicant who is ~~certified~~ registered on the National Registry of Emergency Medical Technicians as an ~~EMT-basic, EMT-intermediate,~~ emergency medical technician, an advanced emergency medical technician, or a paramedic shall be granted ~~certification~~ licensure as a Vermont ~~EMT-basic, EMT-intermediate,~~ emergency medical technician, an advanced emergency medical technician, or a paramedic without the need for further testing, provided he or she is affiliated with ~~an ambulance service, fire department, or rescue service,~~ an affiliated agency or is serving as a medic with the Vermont National Guard.

~~(G) No advanced certification shall be required for a trainee in~~

~~established advanced training programs leading to certification as an advanced emergency medical technician, provided that the trainee is supervised by an individual holding a level of certification for which the trainee is training and the student is enrolled in an approved certification program.~~

Sec. 6a. 18 V.S.A. § 906a is added to read:

§ 906a. TRANSITION FROM CERTIFICATION TO LICENSURE

Every person certified as an emergency medical provider shall have his or her certification converted to the comparable level of licensure. Until such time as the department of health issues licenses in lieu of certificates, each certified emergency medical provider shall have the right to practice in accordance with his or her level of certification.

Sec. 6b. 18 V.S.A. § 906b is added to read:

§ 906b. RELICENSURE; GRACE PERIOD

A person certified or licensed as an emergency medical provider shall have six months after his or her certification or license has expired to resubmit the necessary information for renewal of the certificate or license.

Sec. 7. 18 V.S.A. § 908 is added to read:

§ 908. EMERGENCY MEDICAL SERVICES SPECIAL FUND

(a) The emergency medical services special fund is established pursuant to 32 V.S.A. chapter 7, subchapter 5 comprising revenues received by the department from public and private sources as gifts, grants, and donations together with additions and interest accruing to the fund. The commissioner of health shall administer the fund to the extent funds are available to support online and regional training programs, data collection and analysis, and other activities relating to the training of emergency medical personnel and delivery of emergency medical services and ambulance services in Vermont, as determined by the commissioner, after consulting with the EMS advisory committee established under section 909 of this title. Any balance at the end of the fiscal year shall be carried forward in the fund.

(b) The commissioner of health shall develop online training opportunities and offer regional classes to enable individuals to comply with the requirements of subdivision 906(9)(c) of this title.

Sec. 8. 18 V.S.A. § 909 is added to read:

§ 909. EMS ADVISORY COMMITTEE

(a) The commissioner shall establish an advisory committee to advise on matters relating to the delivery of emergency medical services (EMS) in

Vermont.

(b) The advisory committee shall be chaired by the commissioner or his or her designee and shall include the following 14 other members:

(1) four representatives of EMS districts. The representatives shall be selected by the EMS districts in four regions of the state. Those four regions shall correspond with the geographic lines used by the public safety districts pursuant to 20 V.S.A. § 5. For purposes of this subdivision, an EMS district located in more than one public safety district shall be deemed to be located in the public safety district in which it serves the greatest number of people;

(2) a representative from the Vermont Ambulance Association, or designee;

(3) a representative from the initiative for rural emergency medical services program at the University of Vermont, or designee;

(4) a representative from the professional firefighters of Vermont, or designee;

(5) a representative from the Vermont Career Fire Chiefs Association, or designee;

(6) a representative from the Vermont State Firefighters' Association, or designee;

(7) an emergency department director of a Vermont hospital appointed by the Vermont Association of Emergency Department Directors, or designee;

(8) an emergency department nurse manager of a Vermont hospital appointed by the Vermont Association of Emergency Department Nurse Managers, or designee;

(9) a pediatric emergency medicine specialist appointed by the American Academy of Pediatrics, Vermont Chapter, or designee;

(10) a representative from the Vermont Association of Hospitals and Health Systems, or designee; and

(11) a local government member not affiliated with emergency medical services, firefighter services, or hospital services, appointed by the Vermont League of Cities and Towns.

(c) The committee shall meet not less than quarterly in the first year and not less than twice annually each subsequent year and may be convened at any time by the commissioner or his or her designee or at the request of seven committee members.

(d) The first committee meeting shall be after January 1, 2013, and,

beginning January 1, 2014 and for the ensuing two years, the committee shall report annually on the emergency medical services system to the house committees on commerce and economic development and on human services and to the senate committees on economic development, housing and general affairs and on health and welfare. The committee's initial and ensuing reports shall include each EMS district's response times to 911 emergencies in the previous year based on information collected from the Vermont department of health's division of emergency medical services and recommendations on the following:

(1) whether Vermont EMS districts should be consolidated such as along the geographic lines used by the four public safety districts established under 20 V.S.A. § 5;

(2) whether every Vermont municipality should be required to have in effect an emergency medical services plan providing for timely and competent emergency responses; and.

(3) whether the state should establish directives addressing when an agency can respond to a nonemergency request for transportation of a patient if doing so will leave the service area unattended or unable to respond to an emergency call in a timely fashion.

Sec. 9. 24 V.S.A. § 2651 is amended to read:

§ 2651. DEFINITIONS

As used in this chapter:

(1) "Advanced emergency medical treatment" means those portions of emergency medical treatment as defined by the department of health, which may be performed by ~~certified~~ licensed emergency medical services personnel acting under the supervision of a physician within a system of medical control approved by the department of health.

* * *

(4) "Basic emergency medical treatment" means those portions of emergency medical treatment, as defined by the department of health, which may be exercised by ~~certified~~ licensed emergency medical services personnel acting under their own authority.

* * *

(6) "Emergency medical personnel" means persons, including volunteers, ~~certified~~ licensed by the department of health to provide emergency medical treatment ~~on behalf of an organization such as an ambulance service or first responder service~~ whose primary function is the provision of

emergency medical treatment. The term does not include duly licensed or registered physicians, dentists, nurses or physicians' assistants when practicing in their customary work setting.

* * *

(15) "Volunteer personnel" means persons who are ~~certified~~ licensed by the department of health to provide emergency medical treatment without expectation of remuneration for the treatment rendered other than nominal payments and reimbursement for expenses, and who do not depend in any significant way on the provision of such treatment for their livelihood.

(16) "Affiliated agency" means an ambulance service or first responder service licensed under this chapter, including a fire department, rescue squad, police department, ski patrol, hospital, or other entity licensed to provide rescue or emergency services under this chapter.

Sec. 10. 24 V.S.A. § 2657 is amended to read:

§ 2657. PURPOSES AND POWERS OF EMERGENCY MEDICAL SERVICES DISTRICTS

(a) It shall be the function of each emergency medical services district to foster and coordinate emergency medical services within the district, in the interest of affording adequate ambulance services within the district. Each emergency medical services district shall have powers which include, but are not limited to, the power to:

* * *

(3) Enter into agreements and contracts for furnishing technical, educational ~~or~~, and support services related to the provision of emergency medical treatment.

* * *

(8) Sponsor or approve programs of education approved by the department of health which lead to the ~~certification~~ licensure of emergency medical services personnel.

(9) ~~Cooperate~~ Establish medical control within the district with physicians or other licensed health care professionals and representatives of medical facilities ~~to establish medical control within the district~~, including written protocols with the appropriate officials of receiving hospitals defining their operational procedures.

(10) Assist the department of health in a program of testing for ~~certification~~ licensure of emergency medical services personnel.

(11) Develop protocols for providing appropriate response times to requests for emergency medical services.

* * *

Sec. 11. 24 V.S.A. § 2682 is amended to read:

§ 2682. POWERS OF STATE BOARD

(a) The state board shall administer this subchapter and shall have power to:

(1) Issue licenses for ambulance services and first responder services under this subchapter.

* * *

(3) Make, adopt, amend, and revise, as it deems necessary or expedient, reasonable rules in order to promote and protect the health, safety, and welfare of members of the public using, served by, or in need of, emergency medical treatment. Any rule may be repealed within 90 days of the date of its adoption by a majority vote of all the district boards. Such rules may cover or relate to:

(A) Age, training and physical requirements for emergency medical services personnel.

* * *

Sec. 12. REPEAL

Sec. 20(c) of No. 142 of the Acts of the 2009 Adj. Sess. (2010) (EMS services exceeding scope of practice of affiliated agency) is repealed.

Sec. 13. EFFECTIVE DATE

This act shall take effect July 1, 2012.

and that after passage the title of the bill be amended to read: "An act relating to a study of search and rescue operations and emergency medical services"

(For text see House Journal 4/19/2012 and 4/20/2012)

Senate Proposal of Amendment to House Proposal of Amendment

S. 99

An act relating to supporting mobile home ownership, strengthening mobile home parks and preserving affordable housing

The Senate concurs in the House proposal of amendment thereto as follows:

First: In Sec. 2, in 10 V.S.A. § 6242(a) following the first sentence, by inserting "If the notice is refused by a mobile home owner or is otherwise

undeliverable, the park owner shall send the notice by first class mail to the mobile home owner's last known mailing address.

Second: By adding a new section to be numbered Sec. 2a to read as follows:

Sec. 2a. LEGISLATIVE INTENT; AFFORDABLE HOUSING TAX CREDIT

It is the intent of the general assembly to increase the amount per year that may be awarded under 32 V.S.A. § 5930u(g) for the purposes of the mobile home financing program for owner-occupied mobile homes or alternative affordable structures. Accordingly, it is the intent of the general assembly that in House Bill 782 (2012) entitled "An act relating to miscellaneous tax changes for 2012," the award amount available for owner-occupied mobile homes or alternative affordable structures shall be increased from $100,000.00 to $300,000.00 and the total amount in any fiscal year of total first-year allocations plus succeeding-year deemed allocations shall be increased from $2,500,000.00 to $3,500,000.00.

Third: In Sec. 11, 9 V.S.A. § 4462(d), in subdivision (3) by striking "execution" and inserting in lieu thereof "service"

Fourth: By adding a new section to be numbered Sec. 12a to read as follows:

Sec. 12a. LEGISLATIVE INTENT; SALES AND USE TAX HOLIDAYS FOR MOBILE HOMES

It is the intent of the general assembly to provide tax relief from the sales and use tax, the local option sales tax, and the property transfer tax for a mobile home purchased to replace a mobile home that was damaged or destroyed as a result of damage incurred during the spring flooding or during Tropical Storm Irene in 2011. Accordingly, it is the intent of the general assembly that in House Bill 782 (2012) entitled "An act relating to miscellaneous tax changes for 2012," there shall be included a provision authorizing relief from the sales and use tax, the local option sales tax, and the property transfer tax for eligible mobile homes purchased during a qualifying period to replace homes that suffered flood and storm damage, authorizing reimbursement for eligible taxes paid for mobile homes purchased during the qualifying period, and authorizing the department of taxes to adopt standards and procedures necessary to achieve the goals of this section.

Fifth: By striking out Secs. 14–17 in their entirety and inserting in lieu thereof a new section Sec. 14 to read as follows:

Sec. 14. EFFECTIVE DATE

This act shall take effect on passage.

(For House Proposal of Amendment see House Journal 4/28/2012)

S. 106

An act relating to miscellaneous changes to municipal government law

The Senate concurs in the House proposal of amendment with the following proposal of amendment thereto:

First: In Sec. 24 (auditor website; audit findings), in subdivision (a)(1), after "a summary of all embezzlements and" by striking out "other financial fraud" and inserting in lieu thereof false claims, as that term is described in 13 V.S.A. § 3016,

Second: By adding a new section to be numbered Sec. 8a to read as follows:

Sec. 8a. PLAINFIELD TOWN MEETINGS

Notwithstanding any provision of law to the contrary, for three years subsequent to the effective date of this act, the polling place of the town of Plainfield may be located; any annual and special meetings may be conducted; and with the permission of the school, any other public meetings may be conducted at the Twinfield Union School in Marshfield, Vermont.

(For House Proposal of Amendment see House Journal 4/13/2012 and 4/18/2012)

S. 214

An act relating to customer rights regarding smart meters

The Senate concurs in the House proposal of amendment thereto by striking all after the enacting clause and inserting in lieu thereof the following:

* * * Renewable Energy Goals, Definitions * * *

Sec. 1. 30 V.S.A. § 8001 is amended to read:

§ 8001. RENEWABLE ENERGY GOALS

(a) The general assembly finds it in the interest of the people of the state to promote the state energy policy established in section 202a of this title by:

(1) Balancing the benefits, lifetime costs, and rates of the state's overall energy portfolio to ensure that to the greatest extent possible the economic benefits of renewable energy in the state flow to the Vermont economy in general, and to the rate paying citizens of the state in particular.

(2) Supporting development of renewable energy that uses natural

resources efficiently and related planned energy industries in Vermont, and the jobs and economic benefits associated with such development, while retaining and supporting existing renewable energy infrastructure.

* * *

(5) Protecting and promoting air and water quality ~~by means of renewable energy programs~~ in the state and region through the displacement of those fuels, including fossil fuels, which are known to emit or discharge pollutants.

(6) Contributing to reductions in global climate change and anticipating the impacts on the state's economy that might be caused by federal regulation designed to attain those reductions.

(7) ~~Supporting and providing incentives for small, distributed renewable energy generation, including~~ Providing support and incentives ~~that support locating such generation~~ to locate renewable energy plants of small and moderate size in a manner that is distributed across the state's electric grid, including locating such plants in areas that will provide benefit to the operation and management of ~~the state's electric~~ that grid through such means as reducing line losses and addressing transmission and distribution constraints.

(8) Promoting the inclusion, in Vermont's electric supply portfolio, of renewable energy plants that are diverse in plant capacity and type of renewable energy technology.

(b) The board shall provide, by order or rule, the regulations and procedures that are necessary to allow the board and the department to implement and supervise programs pursuant to this chapter.

Sec. 2. 30 V.S.A. § 8002 is amended to read:

§ 8002. DEFINITIONS

For purposes of this chapter:

* * *

(2) "Renewable energy" means energy produced using a technology that relies on a resource that is being consumed at a harvest rate at or below its natural regeneration rate.

(A) For purposes of this subdivision (2), methane gas and other flammable gases produced by the decay of sewage treatment plant wastes or landfill wastes and anaerobic digestion of agricultural products, byproducts, or wastes shall be considered renewable energy resources, but no form of solid waste, other than agricultural or silvicultural waste, shall be considered renewable.

(B) For purposes of this subdivision (2), no form of nuclear fuel shall be considered renewable.

(C) The only portion of electricity produced by a system of generating resources that shall be considered renewable is that portion generated by a technology that qualifies as renewable under this subdivision (2).

(D) After conducting administrative proceedings, the board may add technologies or technology categories to the definition of "renewable energy," provided that technologies using the following fuels shall not be considered renewable energy supplies: coal, oil, propane, and natural gas.

(E) For the purposes of this chapter, renewable energy refers to either "existing renewable energy" or "new renewable energy."

(3) "Existing renewable energy" means ~~all types of~~ renewable energy ~~sold from the supply portfolio of a Vermont retail electricity provider that is not considered to be from a new renewable energy source~~ produced by a plant that came into service prior to or on December 31, 2004.

(4) "New renewable energy" means renewable energy produced by a ~~generating resource~~ specific and identifiable plant coming into service after December 31, 2004.

(A) ~~With respect to~~ Energy from within a system of generating ~~resources~~ plants that includes renewable energy~~, the percentage of the system that constitutes~~ shall not constitute new renewable energy ~~shall be determined through dividing the plant capacity of the system's generating resources coming into service after December 31, 2004 that produce renewable energy by the total plant capacity of the system~~, regardless of whether the system includes specific plants that came or come into service after December 31, 2004.

(B) "New renewable energy" also may include the additional energy from an existing renewable ~~facility~~ energy plant retrofitted with advanced technologies or otherwise operated, modified, or expanded to increase the kWh output of the ~~facility~~ plant in excess of an historical baseline established by calculating the average output of that ~~facility~~ plant for the 10-year period that ended December 31, 2004. If the production of new renewable energy through changes in operations, modification, or expansion involves combustion of the resource, the system also must result in an incrementally higher level of energy conversion efficiency or significantly reduced emissions. ~~For the purposes of this chapter, renewable energy refers to either "existing renewable energy" or "new renewable energy."~~

(5) "~~Qualifying~~ SPEED resources" means contracts for ~~in-state~~ resources in the SPEED program established under section 8005 of this title that meet the definition of ~~new~~ renewable energy under this section, whether or not ~~renewable energy credits~~ environmental attributes are attached.

(6) ~~"Nonqualifying SPEED resources" means contracts for in-state resources in the SPEED program established under section 8005 of this title that are fossil fuel-based, combined heat and power (CHP) facilities that sequentially produce both electric power and thermal energy from a single source or fuel. In addition, at least 20 percent of a facility's fuel's total recovered energy must be thermal and at least 13 percent must be electric, the design system efficiency (the sum of full load design thermal output and electric output divided by the heat input) must be at least 65 percent, and the facility must meet air quality standards established by the agency of natural resources.~~

~~(7)~~ "Energy conversion efficiency" means the effective use of energy and heat from a combustion process.

(7) "Environmental attributes" means the characteristics of a plant that enable the energy it produces to qualify as renewable energy and include any and all benefits of the plant to the environment such as avoided emissions or other impacts to air, water, or soil that may occur through the plant's displacement of a nonrenewable energy source.

(8) "Tradeable renewable energy credits" means all of the environmental attributes associated with a single unit of energy generated by a renewable energy source where:

(A) those attributes are transferred or recorded separately from that unit of energy;

(B) the party claiming ownership of the tradeable renewable energy credits has acquired the exclusive legal ownership of all, and not less than all, the environmental attributes associated with that unit of energy; and

(C) exclusive legal ownership can be verified through an auditable contract path or pursuant to the system established or authorized by the board or any program for tracking and verification of the ownership of environmental attributes of energy legally recognized in any state and approved by the board.

(9) "Retail electricity provider" or "provider" means a company engaged in the distribution or sale of electricity directly to the public.

(10) "Board" means the public service board under section 3 of this title, except when used to refer to the clean energy development board.

(11) "Commissioned" or "commissioning" means the first time a plant

is put into operation following initial construction or modernization if the costs of modernization are at least 50 percent of the costs that would be required to build a new plant including all buildings and structures technically required for the new plant's operation. However, these terms shall not include activities necessary to establish operational readiness of a plant.

(12) "Plant" means ~~any~~ an independent technical facility that generates electricity from renewable energy. A group of newly constructed facilities, such as wind turbines, shall be considered one plant if the group is part of the same project and uses common equipment and infrastructure such as roads, control facilities, and connections to the electric grid.

* * *

(21) "Vermont composite electric utility system" means the combined generation, transmission, and distribution resources along with the combined retail load requirements of the Vermont retail electricity providers.

(22) "CPI" means the Consumer Price Index for all urban consumers, designated as "CPI-U," in the northeast region, as published by the U.S. Department of Labor, Bureau of Labor Statistics.

(23) "Greenhouse gas reduction credits" shall be as defined in section 8006a of this title.

* * * SPEED Program; General * * *

Sec. 3. 30 V.S.A. § 8005 is amended to read:

§ 8005. SUSTAINABLY PRICED ENERGY ENTERPRISE DEVELOPMENT (SPEED) PROGRAM; TOTAL RENEWABLES TARGETS

(a) ~~In order to~~ Creation. To achieve the goals of section 8001 of this title, there is created the Sustainably Priced Energy Enterprise Development (SPEED) program. ~~The SPEED program shall have two categories of projects: qualifying SPEED resources and nonqualifying SPEED resources.~~

(b) Board; powers and duties. The SPEED program shall be established, by rule, order, or contract, by the board. As part of the SPEED program, the board may, and in the case of subdivisions (1), (2), and (5) of this subsection, shall:

(1) Name one or more entities to become engaged in the purchase and resale of electricity generated within the state by means of ~~qualifying~~ SPEED resources ~~or nonqualifying SPEED resources, and shall implement the standard offer required by subdivision (2) of this subsection through this entity or entities~~. An entity appointed under this subdivision shall be known as a

SPEED facilitator.

(2) Issue standard offers for ~~qualifying~~ SPEED resources ~~with a plant capacity of 2.2 MW or less~~ in accordance with section 8005a of this title. ~~These standard offers shall be available until the cumulative plant capacity of all such resources commissioned in the state that have accepted a standard offer under this subdivision (2) equals or exceeds 50 MW; provided, however, that a plant owned and operated by a Vermont retail electricity provider shall count toward this 50 MW ceiling if the plant has a plant capacity of 2.2 MW or less and is commissioned on or after September 30, 2009. The term of a standard offer required by this subdivision (2) shall be 10 to 20 years, except that the term of a standard offer for a plant using solar power shall be 10 to 25 years. The price paid to a plant owner under a standard offer required by this subdivision shall include an amount for each kWh generated that shall be set as follows:~~

~~(A) Until the board determines the price to be paid to a plant owner in accordance with subdivision (2)(B) of this subsection, the price shall be:~~

~~(i) For a plant using methane derived from a landfill or an agricultural operation, $0.12 per kWh.~~

~~(ii) For a plant using wind power that has a plant capacity of 15 kW or less, $0.20 per kWh.~~

~~(iii) For a plant using solar power, $0.30 per kWh.~~

~~(iv) For a plant using hydropower, wind power with a plant capacity greater than 15 kW, or biomass power that is not subject to subdivision (2)(A)(i) of this subsection, a price equal, at the time of the plant's commissioning, to the average residential rate per kWh charged by all of the state's retail electricity providers weighted in accordance with each such provider's share of the state's electric load.~~

~~(B) In accordance with the provisions of this subdivision, the board by order shall set the price to be paid to a plant owner under a standard offer, including the owner of a plant described in subdivisions (2)(A)(i)-(iv) of this subsection.~~

~~(i) The board shall use the following criteria in setting a price under this subdivision:~~

~~(I) The board shall determine a generic cost, based on an economic analysis, for each category of generation technology that constitutes renewable energy. In conducting such an economic analysis the board shall:~~

~~(aa) Include a generic assumption that reflects reasonably available tax credits and other incentives provided by federal and state~~

governments and other sources applicable to the category of generation technology. For the purpose of this subdivision (2)(B), the term "tax credits and other incentives" excludes tradeable renewable energy credits.

(bb) Consider different generic costs for subcategories of different plant capacities within each category of generation technology.

(II) The board shall include a rate of return on equity not less than the highest rate of return on equity received by a Vermont investor-owned retail electric service provider under its board-approved rates as of the date a standard offer goes into effect.

(III) The board shall include such adjustment to the generic costs and rate of return on equity determined under subdivisions (2)(B)(i)(I) of this subsection as the board determines to be necessary to ensure that the price provides sufficient incentive for the rapid development and commissioning of plants and does not exceed the amount needed to provide such an incentive.

(ii) No later than September 15, 2009, the board shall open and complete a noncontested case docket to accomplish each of the following tasks:

(I) Determine whether there is a substantial likelihood that one or more of the prices stated in subdivision (2)(A) of this subsection do not constitute a reasonable approximation of the price that would be paid applying the criteria of subdivision (2)(B)(i).

(II) If the board determines that one or more of the prices stated in subdivision (2)(A) of this subsection do not constitute such an approximation, set interim prices that constitute a reasonable approximation of the price that would be paid applying the criteria of subdivision (2)(B)(i). Once the board sets such an interim price, that interim price shall be used in subsequent standard offers until the board sets prices under subdivision (2)(B)(iii) of this subsection.

(iii) Regardless of its determination under subdivision (2)(B)(ii) of this subsection, the board shall proceed to set, no later than January 15, 2010, the price to be paid to a plant owner under a standard offer applying the criteria of subdivision (2)(B)(i) of this subsection.

(C) On or before January 15, 2012 and on or before every second January 15 after that date, the board shall review the prices set under subdivision (2)(B) of this subsection and determine whether such prices are providing sufficient incentive for the rapid development and commissioning of plants. In the event the board determines that such a price is inadequate or excessive, the board shall reestablish the price, in accordance with the

~~requirements of subdivision (2)(B)(i) of this subsection, for effect on a prospective basis commencing two months after the price has been reestablished.~~

~~(D) Once the board determines, under subdivision (2)(B) or (C) of this subsection, the generic cost and rate of return elements for a category of renewable energy, the price paid to a plant owner under a subsequently executed standard offer contract shall comply with that determination.~~

~~(E) A plant owner who has executed a contract for a standard offer under this section prior to a determination by the board under subdivision (2)(B) or (C) of this subsection shall continue to receive the price agreed on in that contract.~~

~~(F) Notwithstanding any other provision of this section, on and after June 8, 2010, a standard offer shall be available for a qualifying existing plant.~~

~~(i) For the purpose of this subdivision, "qualifying existing plant" means a plant that meets all of the following:~~

~~(I) The plant was commissioned on or before September 30, 2009.~~

~~(II) The plant generates electricity using methane derived from an agricultural operation and has a plant capacity of 2.2 MW or less.~~

~~(III) On or before September 30, 2009, the plant owner had a contract with a Vermont retail electricity provider to supply energy or attributes, including tradeable renewable energy credits from the plant, in connection with a renewable energy pricing program approved under section 8003 of this title.~~

~~(ii) Plant capacity of a plant accepting a standard offer pursuant to this subdivision (2)(F) shall not be counted toward the 50 MW amount under this subsection (b).~~

~~(iii) Award of a standard offer under this subdivision (2)(F) shall be on condition that the plant owner and the retail electricity provider agree to modify any existing contract between them described under subdivision (i)(III) of this subdivision (2)(F) so that the contract no longer requires energy from the plant to be provided to the retail electricity provider. Those provisions of such a contract that concern tradeable renewable energy credits associated with the plant may remain in force.~~

~~(iv) The price and term of a standard offer contract under this subdivision (2)(F) shall be the same, as of the date such a contract is executed, as the price and term otherwise in effect under this subsection (b) for a plant that uses methane derived from an agricultural operation.~~

(G) Notwithstanding the requirement of this subsection (b) that a standard offer be available for qualifying SPEED resources, the board shall make a standard offer available under this subdivision (2) to an existing hydroelectric plant that does not exceed the 2.2 MW plant capacity limit of this subsection. To such plants, the board shall not allocate more of the cumulative 50 MW plant capacity under this subdivision (2) than exceeds the amount of such capacity that is unsubscribed as of January 1, 2012. Before making this standard offer available, the board shall notify potentially eligible plants known to it and shall publish broad public notice of the future availability of the standard offer. The notice shall direct that all potentially eligible plants shall file with the board a statement of interest in the standard offer by a date to be no less than 30 days from the date of the notice. No plant may participate in this standard offer unless it timely files such a statement. The filing of such a statement shall constitute the consent of the plant owner to produce such information as the board may reasonably require to carry out this subdivision (2)(G), including information the board deems necessary to determine a generic cost in setting the price. The board shall have authority to require the production of such information from a plant that files a statement of interest. For the purpose of this subdivision (2)(G):

(i) "Existing hydroelectric plant" means a hydroelectric plant located in the state that was in service as of January 1, 2009 and does not, as of the effective date of this subdivision (2)(G), have an agreement with the board's purchasing agent for the purchase of its power pursuant to subdivision 209(a)(8) of this title and board rules adopted under that subdivision. The term includes hydroelectric plants that have never had such an agreement and hydroelectric plants for which such an agreement expired prior to May 25, 2011.

(ii) The provisions of subdivisions (2)(B)(i)(I)-(III) of this subsection (standard offer pricing criteria) shall apply, except that:

(I) The term "generic cost," when applied by the board to determine the price of a standard offer for an existing hydroelectric plant, shall mean the cost to own, reliably operate, and maintain such a plant for the duration of the standard offer contract. In determining this cost, the board shall consider including a generic assumption with respect to rehabilitation costs based on relevant factors such as the age of the potentially eligible plants; recently constructed or currently proposed rehabilitations to such plants; the investment that a reasonably prudent person would have made in such a plant to date under the circumstances of the plant, including the price received for power; and the availability for such a plant of improved technology.

(II) The incentive described under subdivision (2)(B)(i)(III) of

~~this subsection shall be an incentive for continued safe, efficient, and reliable operation of existing hydroelectric plants.~~

* * *

(5) ~~Require~~ In accordance with section 8005a of this section, require all Vermont retail electricity providers to purchase from the SPEED facilitator~~, in accordance with subdivision (g)(2) of this section,~~ the power generated by the plants that accept the standard offer required to be issued under ~~subdivision (2) of this subsection~~ section 8005a. For the purpose of this subdivision (5), the board and the SPEED facilitator constitute instrumentalities of the state.

* * *

(7) ~~Create a mechanism by which a retail electricity provider may establish that it has a sufficient amount of renewable energy, or resources that would otherwise qualify under the provisions of subsection (d) of this section, in its portfolio so that equity requires that the retail electricity provider be relieved, in whole or in part, from requirements established under this subsection that would require a retail electricity provider to purchase SPEED power, provided that this mechanism shall not apply to the requirement to purchase power under subdivision (5) of this subsection. However, a retail electricity provider that establishes that it receives at least 25 percent of its energy from qualifying SPEED resources that were in operation on or before September 30, 2009, shall be exempt and wholly relieved from the requirements of subdivisions (b)(5) (requirement to purchase standard offer power) and (g)(2) (allocation of standard offer electricity and costs) of this section.~~ [Repealed.]

(8) Provide that in any proceeding under subdivision 248(a)(2)(A) of this title for the construction of a renewable energy plant, a demonstration of compliance with subdivision 248(b)(2) of this title, relating to establishing need for the ~~facility~~ plant, shall not be required if the ~~facility~~ plant is a SPEED resource and if no part of the ~~facility~~ plant is financed directly or indirectly through investments, other than power contracts, backed by Vermont electricity ratepayers.

(9) Take such other measures as the board finds necessary or appropriate to implement SPEED.

(c) VEDA; eligible facilities. Developers of ~~qualifying and nonqualifying~~ in-state SPEED resources shall be entitled to classification as an eligible facility under ~~chapter 12 of Title~~ 10 V.S.A. chapter 12, relating to the Vermont Economic Development Authority.

(d) Goals and targets. To advance the goals stated in section 8001 of this

title, the following goals and targets are established.

(1) 2012 SPEED goal. The board shall meet on or before January 1, 2012 and open a proceeding to determine the total amount of ~~qualifying~~ SPEED resources that have been supplied to Vermont retail electricity providers or have been issued a certificate of public good. If the board finds that the amount of ~~qualifying~~ SPEED resources coming into service or having been issued a certificate of public good after January 1, 2005 and before July 1, 2012 equals or exceeds total statewide growth in electric retail sales during that time, and in addition, at least five percent of the 2005 total statewide electric retail sales is provided by ~~qualified~~ SPEED resources or would be provided by ~~qualified~~ SPEED resources that have been issued a certificate of public good, or if it finds that the amount of ~~qualifying~~ SPEED resources equals or exceeds 10 percent of total statewide electric retail sales for calendar year 2005, the portfolio standards established under this chapter shall not be in force. The board shall make its determination by January 1, 2013. If the board finds that the goal established has not been met, one year after the board's determination the portfolio standards established under subsection 8004(b) of this title shall take effect.

(2) 2017 SPEED goal. A state goal is to assure that 20 percent of total statewide electric retail sales ~~before July 1, 2017~~ during the year commencing January 1, 2017 shall be generated by SPEED resources that constitute new renewable energy. ~~The board shall report to the house and senate committees on natural resources and energy and to the joint energy committee by December 31, 2011 with regard to the state's progress in meeting this goal. In addition, the board shall report to the house and senate committees on natural resources and energy and to the joint energy committee by December 31, 2013 with regard to the state's progress in meeting this goal and, if necessary, shall include any appropriate recommendations for measures that will make attaining the goal more likely.~~ On or before January 31, 2018, the board shall meet and open a proceeding to determine, for the calendar year 2017, the total amount of SPEED resources that were supplied to Vermont retail electricity providers and the total amount of statewide retail electric sales.

(3) Determinations. For the purposes of the ~~determination~~ determinations to be made under ~~this subsection,~~ subdivisions (1) and (2) of this subsection (d), the total amount of SPEED resources shall be the amount of electricity produced at ~~all facilities~~ SPEED resources owned by or under long-term contract to Vermont retail electricity providers~~, whether it is generated inside or outside Vermont,~~ that is new renewable energy ~~shall be counted in the calculations under subdivisions (1) and (2) of this subsection~~.

(4) Total renewables targets. This subdivision establishes, as

percentages of annual electric sales, target amounts of total renewable energy within the supply portfolio of each renewable electricity provider.

(A) The target amounts of total renewable energy established by this subsection shall be 55 percent of each retail electricity provider's annual electric sales during the year beginning January 1, 2017, increasing by an additional four percent each third January 1 thereafter, until reaching 75 percent on and after January 1, 2032.

(B) Each retail electricity provider shall manage its supply portfolio to be reasonably consistent with the target amounts established by this subdivision (2). The board shall consider such consistency during the course of reviewing a retail electricity provider's charges and rates under this title, integrated resource plans under section 218c of this title, and petitions under section 248 (new gas and electric purchases, investments, and facilities) of this title. However, nothing in this subdivision (2) shall relieve a retail electricity provider from the obligations of section 8004 (renewable portfolio standards) of this title.

(e) Regulations and procedures. The board shall provide, by order or rule, the regulations and procedures that are necessary to allow the board and the department to implement, and to supervise further the implementation and maintenance of the SPEED program. These rules shall assure that decisions with respect to certificate of public good applications for construction of SPEED resources shall be made in a timely manner.

(f) Preapproval. In order to encourage joint efforts on the part of regulated companies to purchase power that meets or exceeds the SPEED standards and to secure stable, long-term contracts beneficial to Vermonters, the board may establish standards for pre-approving the recovery of costs incurred on a SPEED project that is the subject of that joint effort.

(g) ~~With respect to executed contracts for standard offers under this section:~~

~~(1) Such a contract shall be transferable. The contract transferee shall notify the SPEED facilitator of the contract transfer within 30 days of transfer.~~

~~(2) The SPEED facilitator shall distribute the electricity purchased to the Vermont retail electricity providers at the price paid to the plant owners, allocated to the providers based on their pro rata share of total Vermont retail kWh sales for the previous calendar year, and the Vermont retail electricity providers shall accept and pay the SPEED facilitator for the electricity.~~

~~(3) The SPEED facilitator shall transfer any tradeable renewable energy credits attributable to electricity purchased under standard offer contracts to the~~

~~Vermont retail electricity providers in accordance with their pro rata share of the costs for such electricity as determined under subdivision (2) of this subsection, except that in the case of a plant using methane from agricultural operations, the plant owner shall retain such credits to be sold separately at the owner's discretion.~~

~~(4) The SPEED facilitator shall transfer all capacity rights attributable to the plant capacity associated with the electricity purchased under standard offer contracts to the Vermont retail electricity providers in accordance with their pro rata share of the costs for such electricity as determined under subdivision (2) of this subsection.~~

~~(5) All reasonable costs of a Vermont retail electricity provider incurred under this subsection shall be included in the provider's revenue requirement for purposes of ratemaking under sections 218, 218d, 225, and 227 of this title. In including such costs, the board shall appropriately account for any credits received under subdivisions (2) and (3) of this subsection. Costs included in a retail electricity provider's revenue requirement under this subdivision shall be allocated to the provider's ratepayers as directed by the board.~~

~~(h) With respect to standard offers under this section, the board shall by rule or order:~~

~~(1) Determine a SPEED facilitator's reasonable expenses arising from its role and the allocation of such expenses among plant owners and Vermont retail electricity providers.~~

~~(2) Determine the manner and timing of payments by a SPEED facilitator to plant owners for energy purchased under an executed contract for a standard offer.~~

~~(3) Determine the manner and timing of payments to the SPEED facilitator by the Vermont retail electricity providers for energy distributed to them under executed contracts for standard offers.~~

~~(4) Establish reporting requirements of a SPEED facilitator, a plant owner, and a Vermont retail electricity provider.~~

~~(i) With respect to standard offers under this section, the board shall determine whether its existing rules sufficiently address metering and the allocation of metering costs, and make such rule revisions as needed to implement the standard offer requirements of this section.~~

~~(j) Wood biomass resources that would otherwise constitute qualifying SPEED resources may receive a standard offer under subdivision (b)(2) of this section only if they have a design system efficiency (the sum of full load design thermal output and electric output divided by the heat input) of at least~~

~~50 percent.~~

~~(k) A Vermont retail electricity provider shall not be eligible for a standard offer contract under subdivision (b)(2) of this section. However, under subdivision (g)(1) of this section, a plant owner may transfer to such a provider all rights associated with a standard offer contract that has been offered to the plant without affecting the plant's status under the standard offer program. In the case of such a transfer of rights, the plant shall not be considered a utility-owned and -operated plant under subdivisions (b)(2) and (g)(2) of this section.~~

~~(l) The existence of a standard offer under subdivision (b)(2) of this section shall not preclude a voluntary contract between a plant owner and a Vermont retail electricity provider on terms that may be different from those under the standard offer. A plant owner who declines a voluntary contract may still accept a standard offer under this section.~~

~~(m)~~ State; nonliability. The state and its instrumentalities shall not be liable to a plant owner or retail electricity provider with respect to any matter related to SPEED, including costs associated with a standard offer contract under this section or section 8005a of this title or any damages arising from breach of such a contract, the flow of power between a plant and the electric grid, or the interconnection of a plant to that grid.

~~(n) On or before January 15, 2011 and every second January 15 afterward, the board shall report to the house and senate committees on natural resources and energy concerning the status of the standard offer program under this section. In its report, the board at a minimum shall:~~

~~(1) Assess the progress made toward attaining the cumulative statewide capacity ceiling stated in subdivision (b)(2) of this section.~~

~~(2) If that cumulative statewide capacity ceiling has not been met, identify the barriers to attaining that ceiling and detail the board's recommendations for overcoming such barriers.~~

~~(3) If that cumulative statewide capacity has been met or is likely to be met within a year of the date of the board's report, recommend whether the standard offer program under this section should continue and, if so, whether there should be any modifications to the program.~~

* * * SPEED Program; Standard Offer * * *

Sec. 4. 30 V.S.A. § 8005a is added to read:

§ 8005a. SPEED; STANDARD OFFER PROGRAM

(a) Establishment. A standard offer program is established within the SPEED program. To achieve the goals of section 8001 of this title, the board

shall issue standard offers for renewable energy plants that meet the eligibility requirements of this section. The board shall implement these standard offers through the SPEED facilitator.

(b) Eligibility. To be eligible for a standard offer under this section, a plant must constitute a qualifying small power production facility under 16 U.S.C. § 796(17)(C) and 18 C.F.R. part 292, must not be a net metering system under section 219a of this title, and must be a new standard offer plant. For the purpose of this section, "new standard offer plant" means a renewable energy plant that is located in Vermont, that has a plant capacity of 2.2 MW or less, and that is commissioned on or after September 30, 2009.

(c) Cumulative capacity. In accordance with this subsection, the board shall issue standard offers to new standard offer plants until a cumulative plant capacity amount of 127.5 MW is reached.

(1) Pace. Annually commencing April 1, 2013, the board shall increase the cumulative plant capacity of the standard offer program (the annual increase) until the 127.5-MW cumulative plant capacity of this subsection is reached.

(A) Annual amounts. The amount of the annual increase shall be five MW for the three years commencing April 1, 2013, 7.5 MW for the three years commencing April 1, 2016, and 10 MW commencing April 1, 2019.

(B) Blocks. Each year, a portion of the annual increase shall be reserved for new standard offer plants proposed by Vermont retail electricity providers (the provider block), and the remainder shall be reserved for new standard offer plants proposed by persons who are not providers (the independent developer block).

(i) The portion of the annual increase reserved for the provider block shall be 10 percent for the three years commencing April 1, 2013, 15 percent for the three years commencing April 1, 2016, and 20 percent commencing April 1, 2019.

(ii) If the provider block for a given year is not fully subscribed, any unsubscribed capacity within that block shall be added to the annual increase for each following year until that capacity is subscribed and shall be made available to new standard offer plants proposed by persons who are not providers.

(iii) If the independent developer block for a given year is not fully subscribed, any unsubscribed capacity within that block shall be added to the annual increase for each following year until that capacity is subscribed and:

(I) shall be made available to new standard offer plants proposed by persons who are not providers; and

(II) may be made available to a provider following a written request and specific proposal submitted to and approved by the board.

(C) Adjustment; greenhouse gas reduction credits. The board shall adjust the annual increase to account for greenhouse gas reduction credits by multiplying the annual increase by one minus the ratio of the prior year's greenhouse gas reduction credits to that year's statewide retail electric sales.

(i) The amount of the prior year's greenhouse gas reduction credits shall be determined in accordance with subdivision 8006a(a)(2) of this title.

(ii) During years in which the annual increase is 10 MW, the adjustment in the annual increase shall be applied proportionally to the independent developer block and the provider block.

(iii) Greenhouse gas reduction credits used to diminish a provider's obligation under section 8004 of this title may be used to adjust the annual increase under this subsection (c).

(2) Technology allocations. The board shall allocate the 127.5-MW cumulative plant capacity of this subsection among different categories of renewable energy technologies. These categories shall include at least each of the following: methane derived from a landfill; solar power; wind power with a plant capacity of 100 kW or less; wind power with a plant capacity greater than 100 kW; hydroelectric power; and biomass power using a fuel other than methane derived from an agricultural operation or landfill.

(d) Plants outside cumulative capacity. The following categories of plants shall not count toward the cumulative capacity amount of subsection (c) of this section, and the board shall make standard offers available to them provided that they are otherwise eligible for such offers under this section:

(1) Plants using methane derived from an agricultural operation.

(2) New standard offer plants that the board determines will have sufficient benefits to the operation and management of the electric grid or a provider's portion thereof because of their design, characteristics, location, or any other discernible benefit. To enhance the ability of new standard offer plants to mitigate transmission and distribution constraints, the board shall require Vermont retail electricity providers and companies that own or operate electric transmission facilities within the state to make sufficient information concerning these constraints available to developers who propose new standard offer plants.

(A) By March 1, 2013, the board shall develop a screening framework or guidelines that will provide developers with adequate information regarding constrained areas in which generation having particular characteristics is reasonably likely to provide sufficient benefit to allow the generation to qualify for eligibility under this subdivision (2).

(B) Once the board develops the screening framework or guidelines under subdivision (2)(A) of this subsection (d), the board shall require Vermont transmission and retail electricity providers to make the necessary information publically available in a timely manner, with updates at least annually.

(C) Nothing in this subdivision shall require the disclosure of information in contravention of federal law.

(e) Term. The term of a standard offer required by this section shall be 10 to 20 years, except that the term of a standard offer for a plant using solar power shall be 10 to 25 years.

(f) Price. The categories of renewable energy for which the board shall set standard offer prices shall include at least each of the categories established pursuant to subdivision (c)(2) of this section. The board by order shall determine and set the price paid to a plant owner for each kWh generated under a standard offer required by this section, with a goal of ensuring timely development at the lowest feasible cost. The board shall not be required to make this determination as a contested case under 3 V.S.A. chapter 25.

(1) Market-based mechanisms. For new standard offer projects, the board shall use a market-based mechanism, such as a reverse auction or other procurement tool, to obtain up to the authorized amount of a category of renewable energy, if it first finds that use of the mechanism is consistent with:

(A) applicable federal law; and

(B) the goal of timely development at the lowest feasible cost.

(2) Avoided cost.

(A) The price paid for each category of renewable energy shall be the avoided cost of the Vermont composite electric utility system if the board finds either of the following:

(i) Use of the pricing mechanism described in subdivision (1) (market-based mechanisms) of this subsection (f) is inconsistent with applicable federal law.

(ii) Use of the pricing mechanism described in subdivision (1) (market-based mechanisms) of this subsection (f) is reasonably likely to result

in prices higher than the prices that would apply under this subdivision (2).

(B) For the purpose of this subsection (f), the term "avoided cost" means the incremental cost to retail electricity providers of electric energy or capacity or both, which, but for the purchase through the standard offer, such providers would obtain from distributed renewable generation that uses the same generation technology as the category of renewable energy for which the board is setting the price. For the purpose of this subsection (f), the term "avoided cost" also includes the board's consideration of each of the following:

(i) The relevant cost data of the Vermont composite electric utility system.

(ii) The terms of the contract, including the duration of the obligation.

(iii) The availability, during the system's daily and seasonal peak periods, of capacity or energy purchased through the standard offer, and the estimated savings from mitigating peak load.

(iv) The relationship of the availability of energy or capacity purchased through the standard offer to the ability of the Vermont composite electric utility system or a portion thereof to avoid costs.

(v) The costs or savings resulting from variations in line losses and other impacts to the transmission or distribution system from those that would have existed in the absence of purchases through the standard offer.

(vi) The supply and cost characteristics of plants eligible to receive the standard offer.

(3) Price determinations. The board shall take all actions necessary to determine the pricing mechanism and implement the pricing requirements of this subsection (f) no later than March 1, 2013 for effect on April 1, 2013. Annually thereafter, the board shall review the determinations previously made under this subsection to decide whether they should be modified in any respect in order to achieve the goal and requirements of this subsection. Any such modification shall be effective on a prospective basis commencing one month after it has been made. Once a pricing determination made or modified under this subsection goes into effect, subsequently executed standard offer contracts shall comply with the most recently effective determination.

(4) Price stability. Once a plant owner has executed a contract for a standard offer under this section, the plant owner shall continue to receive the price agreed on in that contract regardless of whether the board subsequently changes the price applicable to the plant's category of renewable energy.

(g) Qualifying existing agricultural plants. Notwithstanding any other provision of this section, on and after June 8, 2010, a standard offer shall be available for a qualifying existing plant as defined in Sec. 3 of No. 159 of the Acts of the 2009 Adj. Sess. (2010) (Act 159). The provisions of 30 V.S.A. § 8005(b)(2), as they existed on June 4, 2010, the effective date of Act 159, shall govern a standard offer under this subsection. Standard offers for these plants shall not be subject to subsection (c) of this section (cumulative capacity; new standard offer plants).

(h) Application process. The board shall administer the process of applying for and obtaining a standard offer contract in a manner that ensures that the resources and capacity of the standard offer program are used for plants that are reasonably likely to achieve commissioning.

(i) Interconnection application. No contract under this section for a new standard offer plant shall be executed unless and until the plant owner submits a complete application to interconnect the plant to the subtransmission or distribution system of the applicable retail electricity provider.

(j) Termination; reallocation. In the event a proposed plant accepting a standard offer fails to meet the requirements of the program in a timely manner, the plant's standard offer contract shall terminate, and any capacity reserved for the plant within the program shall be reallocated to one or more eligible plants.

(1) For the purpose of this subsection, the requirements of the program shall include commissioning of all new standard offer plants, except plants using methane derived from an agricultural operation, within the following periods after execution of the plant's standard offer contract:

(A) 24 months if the plant is solar power or is wind power with a plant capacity of 100 kW or less; and

(B) 36 months if the plant uses a fuel source not described in subdivision 1(A) of this subsection (j) or is wind power of greater than 100 kW capacity.

(2) At the request of a plant owner, the board may extend a period described in subdivision (1) of this subsection (j) if it finds that the plant owner has proceeded diligently and in good faith and that commissioning of the plant has been delayed because of litigation or appeal or because of the need to obtain an approval the timing of which is outside the board's control.

(k) Executed standard offer contracts; transferability; allocation of benefits and costs. With respect to executed contracts for standard offers under this section:

(1) A contract shall be transferable. The contract transferee shall notify the SPEED facilitator of the contract transfer within 30 days of transfer.

(2) The SPEED facilitator shall distribute the electricity purchased to the Vermont retail electricity providers at the price paid to the plant owners, allocated to the providers based on their pro rata share of total Vermont retail kWh sales for the previous calendar year, and the Vermont retail electricity providers shall accept and pay the SPEED facilitator for the electricity. However, during any given calendar year:

(A) Calculation of pro rata shares under this subdivision (2) shall include an adjustment in the allocation to a provider if one or more of the provider's customers created greenhouse gas reduction credits under section 8006a of this title that are used to reduce the size of the annual increase under subdivision (c)(1)(D) (adjustment; greenhouse gas reduction credits) of this section. The adjustment shall ensure that any and all benefits or costs from the use of such credits flow to the provider whose customers created the credits. The savings that a provider realizes as a result of this application of greenhouse gas reduction credits shall be passed on proportionally to the customers that created the credits.

(B) A retail electricity provider shall be exempt and wholly relieved from the requirements of this subdivision and subdivision 8005(b)(5) (requirement to purchase standard offer power) of this title if, during the immediately preceding 12-month period ending October 31, the amount of renewable energy supplied to the provider by generation owned by or under contract to the provider, regardless of whether the provider owned the energy's environmental attributes, was not less than the amount of energy sold by the provider to its retail customers.

(3) The SPEED facilitator shall transfer the environmental attributes, including any tradeable renewable energy credits, of electricity purchased under standard offer contracts to the Vermont retail electricity providers in accordance with their pro rata share of the costs for such electricity as determined under subdivision (2) of this subsection (k), except that in the case of a plant using methane from agricultural operations, the plant owner shall retain such attributes and credits to be sold separately at the owner's discretion.

(4) The SPEED facilitator shall transfer all capacity rights attributable to the plant capacity associated with the electricity purchased under standard offer contracts to the Vermont retail electricity providers in accordance with their pro rata share of the costs for such electricity as determined under subdivision (2) of this subsection (k).

(5) All reasonable costs of a Vermont retail electricity provider incurred

under this subsection shall be included in the provider's revenue requirement for purposes of ratemaking under sections 218, 218d, 225, and 227 of this title. In including such costs, the board shall appropriately account for any credits received under subdivisions (3) and (4) of this subsection (k). Costs included in a retail electricity provider's revenue requirement under this subdivision shall be allocated to the provider's ratepayers as directed by the board.

(l) SPEED facilitator; expenses; payments. With respect to standard offers under this section, the board shall by rule or order:

(1) Determine a SPEED facilitator's reasonable expenses arising from its role and the allocation of the expenses among plant owners and Vermont retail electricity providers.

(2) Determine the manner and timing of payments by a SPEED facilitator to plant owners for energy purchased under an executed contract for a standard offer.

(3) Determine the manner and timing of payments to the SPEED facilitator by the Vermont retail electricity providers for energy distributed to them under executed contracts for standard offers.

(4) Establish reporting requirements of a SPEED facilitator, a plant owner, and a Vermont retail electricity provider.

(m) Metering. With respect to standard offers under this section, the board shall make rule revisions concerning metering and the allocation of metering costs as needed to implement the standard offer requirements of this section.

(n) Wood biomass. Wood biomass resources that would otherwise constitute qualifying SPEED resources may receive a standard offer under this section only if they have a design system efficiency (the sum of full load design thermal output and electric output divided by the heat input) of at least 50 percent.

(o) Voluntary contracts. The existence of a standard offer under this section shall not preclude a voluntary contract between a plant owner and a Vermont retail electricity provider on terms that may be different from those under the standard offer. A plant owner who declines a voluntary contract may still accept a standard offer under this section.

(p) Existing hydroelectric plants. Notwithstanding any contrary requirement of this section, no later than January 15, 2013, the board shall make a standard offer contract available to existing hydroelectric plants in accordance with this subsection.

(1) In this subsection:

(A) "Existing hydroelectric plant" means a hydroelectric plant of five MW plant capacity or less that is located in the state, that was in service as of January 1, 2009, that is a qualifying small power production facility under 16 U.S.C. § 796(17)(C) and 18 C.F.R. part 292, and that does not have an agreement with the board's purchasing agent for the purchase of its power pursuant to subdivision 209(a)(8) of this title and board rules adopted under subdivision (8). The term includes hydroelectric plants that have never had such an agreement and hydroelectric plants for which such an agreement has expired, provided that the expiration date is prior to December 31, 2015.

(B) "LIHI" means the Low-Impact Hydropower Institute of Portland, Maine.

(2) The term of a standard offer contract under this subsection shall be 10 or 20 years, at the election of the plant owner.

(3) Unless inconsistent with applicable federal law, the price of a standard offer contract shall be the lesser of the following:

(A) $0.08 per kWh, adjusted for inflation annually commencing January 15, 2013 using the CPI; or

(B) The sum of the following elements:

(i) a two-year rolling average of the ISO New England Inc. (ISO-NE) Vermont zone hourly locational marginal price for energy;

(ii) a two-year rolling average of the value of the plant's capacity in the ISO-NE forward capacity market;

(iii) the value of avoided line losses due to the plant as a fixed increment of the energy and capacity values;

(iv) the value of environmental attributes, including renewable energy credits; and

(v) the value of a 10- or 20-year contract.

(4) The board shall determine the price to be paid under this section no later than January 15, 2013.

(A) Annually by January 15 commencing in 2014, the board shall recalculate and adjust the energy and capacity elements of the price under subdivisions (3)(B)(i) and (ii) of this subsection (p). The recalculated and adjusted energy and capacity elements shall apply to all contracts executed under this subdivision, whether or not the contracts were executed prior to the adjustments.

(B) With respect to the price elements specified in subdivisions

(3)(B)(iii) (avoided line losses), (iv) (environmental attributes), and (v) (value of long-term contract) of this subsection (p):

(i) These elements shall remain fixed at their values at the time a contract is signed for the duration of the contract, except that the board may periodically adjust the value of environmental attributes that are applicable to an executed contract based upon whether the plant becomes certified by LIHI or loses such certification.

(ii) The board annually may adjust these elements for inclusion in contracts that are executed after the date any such adjustments are made.

(5) In addition to the limits specified in subdivision (3) of this subsection (p), in no event shall an existing hydroelectric plant receive a price in one year higher than its price in the previous year, adjusted for inflation using the CPI, except that if a plant becomes certified by LIHI, the board may add to the price any incremental increase in the value of the plant's environmental attributes resulting from such certification.

(6) Once a plant owner has executed a contract for a standard offer under this subsection (p), the plant owner shall continue to receive the pricing terms agreed on in that contract regardless of whether the board subsequently changes any pricing terms under this subsection.

(7) Capacity of existing hydroelectric plants executing a standard offer contract under this subsection shall not count toward the cumulative capacity amount of subsection (c) of this section.

(q) Allocation of regulatory costs. The board and department may authorize or retain legal counsel, official stenographers, expert witnesses, advisors, temporary employees, and research services in conjunction with implementing their responsibilities under this section. In lieu of allocating such costs pursuant to subsection 21(a) of this title, the board or department may allocate the expense in the same manner as the SPEED facilitator's costs under subdivision (l)(1) of this section.

Sec. 5. STANDARD OFFER; PRIOR CAPACITY; INTERCONNECTION APPLICATION; REPORT

(a) Prior capacity included. In Sec. 4 (SPEED; standard offer program) of this act, the cumulative capacity amount of 127.5 MW contained in 30 V.S.A. § 8005a(c) includes the 50 MW of capacity previously authorized for the standard offer program under 30 V.S.A. § 8005(b)(2) as it existed immediately prior to the effective date of Sec. 4. Portions of this previously authorized 50-MW capacity that become available after that effective date shall be made immediately available to other eligible new standard offer projects, as defined

in Sec. 4 of this act, in addition to the annual increase under 30 V.S.A. § 8005a(c)(1) (standard offer; pace). Such capacity:

(1) Shall be made available to new standard offer plants proposed by persons who are not providers; and

(2) May be made available to a provider following a written request and specific proposal submitted to and approved by the board.

(b) Prior capacity; pricing. In a standard offer contract under 30 V.S.A. chapter 89, the board shall use the price that would apply under 30 V.S.A. § 8005(b)(2) as it existed immediately prior to the effective date of Sec. 4 (SPEED; standard offer program) of this act, if both of the following apply:

(1) The contract pertains to capacity within the standard offer program as it existed immediately prior to that effective date.

(2) The capacity becomes available and the contract is executed prior to April 1, 2013.

(c) Interconnection application.

(1) No later than September 1, 2012, each owner of a new standard offer plant, as defined in Sec. 4 of this act, that executed or executes a standard offer contract under 30 V.S.A. chapter 89 prior to the effective date of this section shall submit a complete application to interconnect the plant to the subtransmission or distribution system of the applicable retail electricity provider. Failure to file such an application or to remit any required interconnection fees or deposits shall terminate the contract.

(2) The purpose of this subsection is to provide assurance that any reserved capacity within the standard offer program under 30 V.S.A. chapter 89 is allocated to proposed plants that are likely to be commissioned within the meaning of 30 V.S.A. § 8002.

(d) Prior to the first time that the pricing requirements under Sec. 4 of this act, 30 V.S.A. § 8005a(f) (SPEED; standard offer program; price), are implemented, the public service board in consultation with the department of public service shall review and publish a written report on any factors that have increased the cost to ratepayers, or caused delays in the commissioning, of projects that have accepted a standard offer, relative to other projects within the same category of renewable energy. The report shall include a corrective action plan to reduce costs by addressing these factors, and the implementation of those pricing requirements shall incorporate corrective actions contained in such plan as appropriate and otherwise authorized by law. Before final publication, the board shall conduct a process to receive public comment on the draft report.

* * * Renewable Energy; Reporting * * *

Sec. 6. 30 V.S.A. § 8005b is added to read:

§ 8005b. RENEWABLE ENERGY PROGRAMS; BIENNIAL REPORT

(a) On or before January 15, 2013 and no later than every second January 15 thereafter through January 15, 2033, the board shall file a report with the general assembly in accordance with this section. The board shall prepare the report in consultation with the department. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under this subsection.

(b) The report under this section shall include at least each of the following:

(1) The retail sales, in kWh, of electricity in Vermont during the preceding calendar year. The report shall include the statewide total and the total sold by each retail electricity provider.

(2) The amount of SPEED resources owned by the Vermont retail electricity providers, expressed as a percentage of retail kWh sales. The report shall include the statewide total and the total owned by each retail electricity provider and shall discuss the progress of each provider toward achieving the goals and targets of subsection 8005(d) (SPEED) of this title. The report to be filed under this subsection on or before January 15, 2019 shall discuss and attach the board's determination under subdivision 8005(d)(1) (2017 SPEED goal) of this title.

(3) A summary of the activities of the SPEED program under section 8005 of this title, including the name, location, plant capacity, and average annual energy generation, of each SPEED resource within the program.

(4) A summary of the activities of the standard offer program under section 8005a of this title, including the number of plants participating in the program, the prices paid by the program, and the plant capacity and average annual energy generation of the participating plants. The report shall present this information as totals for all participating plants and by category of renewable energy technology. The report also shall identify the number of applications received, the number of participating plants under contract, and the number of participating plants actually in service.

(5) An assessment of the energy efficiency and renewable energy markets and recommendations to the general assembly regarding strategies that may be necessary to encourage the use of these resources to help meet upcoming supply requirements.

(6) An assessment of whether Vermont retail electric rates are rising

faster than inflation as measured by the CPI, and a comparison of Vermont's electric rates with electric rates in other New England states. If statewide average rates have risen more than 0.2 percentage points per year faster than inflation over the preceding two or more years, the report shall include an assessment of the contributions to rate increases from various sources, such as the costs of energy and capacity, costs due to construction of transmission and distribution infrastructure, and costs due to compliance with the requirements of section 8005a (SPEED program; standard offer) of this title. Specific consideration shall be given to the price of renewable energy and the diversity, reliability, availability, dispatch flexibility, and full life cycle cost, including environmental benefits and greenhouse gas reductions, on a net present value basis of renewable energy resources available from suppliers. The report shall include any recommendations for statutory change that arise from this assessment. If electric rates have increased primarily due to cost increases attributable to nonrenewable sources of electricity or to the electric transmission or distribution systems, the report shall include a recommendation regarding whether to increase the size of the annual increase described in subdivision 8005a(c)(1) (standard offer; cumulative capacity; pace) of this title.

(7)(A) An assessment of whether strict compliance with the requirements of section 8005a (SPEED program; standard offer) of this title:

(i) Has caused one or more providers to raise its retail rates faster over the preceding two or more years than statewide average retail rates have risen over the same time period;

(ii) Will cause retail rate increases particular to one or more providers; or

(iii) Will impair the ability of one or more providers to meet the public's need for energy services in the manner set forth under subdivision 218c(a)(1) of this title (least-cost integrated planning).

(B) Based on this assessment, consideration of whether statutory changes should be made to grant providers additional flexibility in meeting requirements of section 8005a of this title.

(8) Any recommendations for statutory change related to sections 8005 and 8005a of this title.

* * * Renewable Energy; Further Study * * *

Sec. 7. RENEWABLE ENERGY; FURTHER STUDY; REPORT

(a) No later than January 15, 2013, the public service board, in consultation with the commissioner of public service, shall submit a further analysis and

report to the general assembly on the following issues related to renewable energy:

(1) Building on its study and report submitted pursuant to Sec. 13a of No. 159 of the Acts of the 2009 Adj. Sess. (2010), further analysis of whether and how to establish a renewable portfolio standard in Vermont, including consideration of allocating such a standard among different categories of renewable energy technologies and of creating, for renewable energy plants, a tiered system of tradeable renewable energy credits as defined under 30 V.S.A. § 8002 or other incentives that reward increasing levels of efficiency.

(2) Examination of whether and how, either as part of a renewable portfolio standard or through other means, to provide incentives for renewable energy generation that avoids, reduces, or defers transmission or distribution investments, provides baseload power, reduces the overall costs of meeting the public's need for electric energy, or has other beneficial impacts.

(b) The report shall state the board's recommendations and the reasons for those recommendations and shall include the mechanisms that would be required to implement those recommendations.

(c) Prior to completing the report, the board shall afford an opportunity to submit information and comment to affected and interested persons such as business organizations, consumer advocates, energy efficiency entities appointed under Title 30, energy and environmental advocates, relevant state agencies, and Vermont electric and gas utilities. The board may open an investigation in order to meet the requirements of this section and, if so, need not conduct that proceeding as a contested case under 3 V.S.A. chapter 25.

* * * Greenhouse Gas Reduction Credits * * *

Sec. 8. 30 V.S.A. § 8006a is added to read:

§ 8006a. GREENHOUSE GAS REDUCTION CREDITS

(a) Standard offer adjustment. In accordance with this section, greenhouse gas reduction credits generated by an eligible ratepayer shall result in an adjustment of the standard offer under subdivision 8005a(c)(1) of this title (cumulative capacity; pace). For the purpose of adjusting the standard offer under subdivision 8005a(c)(1) of this title, the amount of a year's greenhouse gas reduction credits shall be the lesser of the following:

(1) The amount of greenhouse gas reduction credits created by the eligible ratepayers served by all providers.

(2) The providers' annual retail electric sales during that year to those eligible ratepayers creating greenhouse gas reduction credits.

(b) Definitions. In this section:

(1) "Eligible ratepayer" means a customer of a Vermont retail electricity provider who takes service at 115 kilovolts and has demonstrated to the board that it has a comprehensive energy and environmental management program. Provision of the customer's certification issued under standard 14001 (environmental management systems) of the International Organization for Standardization (ISO) shall constitute such a demonstration.

(2) "Eligible reduction" means a reduction in non-energy-related greenhouse gas emissions from manufacturing processes at an in-state facility of an eligible ratepayer, provided that each of the following applies:

(A) The reduction results from a specific project undertaken by the eligible ratepayer at the in-state facility after January 1, 2012.

(B) The specific project reduces or avoids greenhouse gas emissions above and beyond any reductions of such emissions required by federal and state statutes and rules.

(C) The reductions are quantifiable and verified by an independent third party as approved by the board. Such independent third parties shall be certified by a body accredited by the American National Standards Institute (ANSI) as having a certification program that meets the ISO standards applicable to verification and validation of greenhouse gas assertions.

(3) "Greenhouse gas" shall be as defined under 10 V.S.A. § 552.

(4) "Greenhouse gas reduction credit" means a credit for eligible reductions, calculated in accordance with subsection (c) of this section and expressed as a kWh credit.

(c) Calculation. Greenhouse gas reduction credits shall be calculated as follows:

(1) Eligible reductions shall be quantified in metric tons of CO_2 equivalent, in accordance with the methodologies specified under 40 C.F.R. part 98, and may be counted annually for the life of the specific project that resulted in the reduction.

(2) Metric tons of CO_2 equivalent quantified under subdivision (1) of this subsection shall be converted into units of energy through calculation of the equivalent number of kWh of generation by renewable energy plants, other than biomass, that would be required to achieve the same level of greenhouse gas emission reduction through the displacement of market power purchases. For the purpose of this subdivision, the value of the avoided greenhouse gas emissions shall be based on the aggregate greenhouse gas emission characteristics of system power in the regional transmission area overseen by

the Independent System Operator of New England (ISO-NE).

(d) Reporting. An eligible ratepayer shall report to the board annually on each specific project undertaken to create eligible reductions. The board shall specify the required contents of such reports, which shall be publicly available.

(e) Savings. A provider shall pass on savings that it realizes through greenhouse gas reduction credits proportionally to the eligible ratepayers generating the credits.

* * * Renewable Energy Statutes; Technical Corrections * * *

Sec. 9. 30 V.S.A. § 8009 is amended to read:

§ 8009. BASELOAD RENEWABLE POWER PORTFOLIO REQUIREMENT

(a) In this section:

(1) "Baseload renewable power" means a plant that generates electricity from renewable energy; that, during normal operation, is capable of taking all or part of the minimum load on an electric transmission or distribution system; and that produces electricity essentially continuously at a constant rate.

(2) "Baseload renewable power portfolio requirement" means an annual average of 175,000 MWh of baseload renewable power from an in-state woody biomass plant that was commissioned prior to September 30, 2009, has a nominal capacity of 20.5 MW, and was in service as of January 1, 2011.

(3) "Biomass" means organic nonfossil material of biological origin constituting a source of renewable energy within the meaning of ~~30 V.S.A. §~~ subdivision 8002(2) of this title.

(4) ~~"Vermont composite electric utility system" means the combined generation, transmission, and distribution resources along with the combined retail load requirements of the Vermont retail electricity providers.~~

* * *

Sec. 10. STATUTORY REVISION

(a) The office of legislative council shall reorganize 30 V.S.A. § 8002 (definitions) so that the definitions are in alphabetical order.

(b) In the Vermont Statutes Annotated, the office of legislative council shall revise each cross-reference to a definition contained in 30 V.S.A. § 8002 so that it refers to the definition as reorganized under subsection (a) of this section.

* * * Utility Planning and Implementation; Consistency with Renewable

Energy Goals and Targets * * *

Sec. 11. 30 V.S.A. § 218c is amended to read:

§ 218c. LEAST COST INTEGRATED PLANNING

(a)(1) A "least cost integrated plan" for a regulated electric or gas utility is a plan for meeting the public's need for energy services, after safety concerns are addressed, at the lowest present value life cycle cost, including environmental and economic costs, through a strategy combining investments and expenditures on energy supply, transmission and distribution capacity, transmission and distribution efficiency, and comprehensive energy efficiency programs. Economic costs shall be ~~determined~~ assessed with due regard to:

(A) the greenhouse gas inventory developed under the provisions of 10 V.S.A. § 582;

(B) the state's progress in meeting its greenhouse gas reduction goals; ~~and~~

(C) the value of the financial risks associated with greenhouse gas emissions from various power sources; and

(D) consistency with section 8001 (renewable energy goals) of this title.

(2) "Comprehensive energy efficiency programs" shall mean a coordinated set of investments or program expenditures made by a regulated electric or gas utility or other entity as approved by the board pursuant to subsection 209(d) of this title to meet the public's need for energy services through efficiency, conservation or load management in all customer classes and areas of opportunity which is designed to acquire the full amount of cost effective savings from such investments or programs.

(b) Each regulated electric or gas company shall prepare and implement a least cost integrated plan for the provision of energy services to its Vermont customers. ~~Proposed plans shall be submitted~~ At least every third year on a schedule directed by the public service board, each such company shall submit a proposed plan to the department of public service and the public service board. The board, after notice and opportunity for hearing, may approve a company's least cost integrated plan if it determines that the company's plan complies with the requirements of subdivision (a)(1) of this section and is reasonably consistent with achieving the goals and targets of subsection 8005(d) (2017 SPEED goal; total renewables targets) of this title.

* * *

Sec. 12. 30 V.S.A. § 248 is amended to read:

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

* * *

(b) Before the public service board issues a certificate of public good as required under subsection (a) of this section, it shall find that the purchase, investment or construction:

* * *

(2) is required to meet the need for present and future demand for service which could not otherwise be provided in a more cost effective manner through energy conservation programs and measures and energy-efficiency and load management measures, including but not limited to those developed pursuant to the provisions of subsection 209(d), section 218c, and subsection 218(b) of this title. In determining whether this criterion is met, the board shall assess the environmental and economic costs of the purchase, investment, or construction in the manner set out under subdivision 218c(a)(1) (least cost integrated plan) of this title and, as to a generation facility, shall consider whether the facility will avoid, reduce, or defer transmission or distribution system investments;

* * *

(5) with respect to an in-state facility, will not have an undue adverse effect on esthetics, historic sites, air and water purity, the natural environment, the use of natural resources, and the public health and safety, with due consideration having been given to the criteria specified in 10 V.S.A. §§ 1424a(d) and 6086(a)(1) through (8) and (9)(K) and greenhouse gas impacts;

* * *

(9) with respect to a waste to energy facility, is included in a solid waste management plan adopted pursuant to 24 V.S.A. § 2202a, which is consistent with the state solid waste management plan; ~~and~~

(10) except as to a natural gas facility that is not part of or incidental to an electric generating facility, can be served economically by existing or planned transmission facilities without undue adverse effect on Vermont utilities or customers;

(11) with respect to an in-state generation facility that produces electric energy using woody biomass, will:

(A) comply with the applicable air pollution control requirements under the federal Clean Air Act, 42 U.S.C. § 7401 et seq.;

(B) incorporate commercially available and feasible designs to achieve a reasonable design system efficiency for the type and design of the proposed facility; and

(C) comply with harvesting guidelines and procurement standards that are consistent with the guidelines and standards developed by the secretary of natural resources pursuant to 10 V.S.A. § 2750 (harvesting guidelines and procurement standards).

* * *

(p) An in-state generation facility receiving a certificate under this section that produces electric energy using woody biomass shall annually disclose to the board the amount, type, and source of wood acquired to generate energy.

* * * Total Energy * * *

Sec. 13. TOTAL ENERGY; REPORT

(a) The general assembly finds that, in the comprehensive energy plan issued in December 2011, the department of public service recommends that Vermont achieve, by 2050, a goal that 90 percent of the energy consumed in the state be renewable energy. This goal would apply across all energy sectors in Vermont, including electricity consumption, thermal energy, and transportation (total energy).

(b) The commissioner of public service shall convene an interagency and stakeholder working group to study and report to the general assembly on policies and funding mechanisms that would be designed to achieve the goal described in subsection (a) of this section and the goals of 10 V.S.A. § 578(a) (greenhouse gas emissions) in an integrated and comprehensive manner.

(1) The study and report shall include consideration of:

(A) A total energy standard that would work with and complement the mechanisms enacted in Secs. 3 (SPEED; total renewables targets) and 4 (SPEED; standard offer program) of this act.

(B) The development of an ongoing science-based education and public information campaign for residents of the state at all ages on climate change due to anthropogenic global warming, the potential consequences of climate change, and the ability to reduce or prevent those consequences by replacing greenhouse-gas-emitting energy sources with energy efficiency and renewable energy resources. The study and report shall also consider what specific programs and activities such a campaign would undertake.

(2) The group's report shall include its recommended policy and funding mechanisms and the reasons for the recommendations. The report

shall be submitted to the general assembly by December 15, 2013.

(c) Prior to submitting the report to the general assembly, the group shall offer an opportunity to submit information and comment to affected and interested persons such as chambers of commerce or other groups representing business interests, consumer advocates, energy efficiency entities appointed under Title 30, energy and environmental advocates, fuel dealers, educational institutions, relevant state agencies, transportation-related organizations, and Vermont electric and gas utilities.

* * * Greenhouse Gas Accounting * * *

Sec. 14. 10 V.S.A. § 582 is amended to read:

§ 582. GREENHOUSE GAS INVENTORIES; REGISTRY; ACCOUNTING

* * *

(e) Rules. The secretary may adopt rules to implement the provisions of this section and shall review existing and proposed international, federal, and state greenhouse gas emission reporting programs and make reasonable efforts to promote consistency among the programs established pursuant to this section and other programs, and to streamline reporting requirements on greenhouse gas emission sources. ~~Nothing~~ Except as provided in subsection (g) of this section, nothing in this section shall limit a state agency from adopting any rule within its authority.

(f) Participation by government subdivisions. The state and its municipalities may participate in the inventory for purposes of registering reductions associated with their programs, direct activities, or efforts, including the registration of emission reductions associated with the stationary and mobile sources they own, lease, or operate.

(g) Greenhouse gas accounting. In consultation with the department of public service created under 30 V.S.A. § 1, the secretary shall research and adopt by rule greenhouse gas accounting protocols that achieve transparent and accurate life cycle accounting of greenhouse gas emissions, including emissions of such gases from the use of fossil fuels and from renewable fuels such as biomass. On adoption, such protocols shall be the official protocols to be used by any agency or political subdivision of the state in accounting for greenhouse gas emissions.

* * * Smart Meters * **

Sec. 15. 30 V.S.A. § 2811 is added to read:

§ 2811. SMART METERS; CUSTOMER RIGHTS; REPORTS

(a) Definitions. As used in this section, the following terms shall have the

following meanings:

(1) "Smart meter" means a wired smart meter or a wireless smart meter.

(2) "Wired smart meter" means an advanced metering infrastructure device using a fixed wire for two-way communication between the device and an electric company.

(3) "Wireless smart meter" means an advanced metering infrastructure device using radio or other wireless means for two-way communication between the device and an electric company.

(b) Customer rights. Notwithstanding any law, order, or agreement to the contrary, an electric company may install a wireless smart meter on a customer's premises, provided the company:

(1) provides prior written notice to the customer indicating that the meter will use radio or other wireless means for two-way communication between the meter and the company and informing the customer of his or her rights under subdivisions (2) and (3) of this subsection;

(2) allows a customer to choose not to have a wireless smart meter installed, at no additional monthly or other charge; and

(3) allows a customer to require removal of a previously installed wireless smart meter for any reason and at an agreed-upon time, without incurring any charge for such removal.

(c) Reports. On January 1, 2014 and again on January 1, 2016, the commissioner of public service shall publish a report on the savings realized through the use of smart meters, as well as on the occurrence of any breaches to a company's cyber-security infrastructure. The reports shall be based on electric company data requested by and provided to the commissioner of public service and shall be in a form and in a manner the commissioner deems necessary to accomplish the purposes of this subsection. The reports shall be submitted to the senate committees on finance and on natural resources and energy and the house committees on commerce and economic development and on natural resources and energy.

(d) Health report.

(1) On or before January 15, 2013, the commissioner of health and the commissioner of public service shall jointly submit a report to the senate committee on finance and the house committee on commerce and economic development. The report shall include: an update of the department of health's 2012 report entitled "Radio Frequency Radiation and Health: Smart Meters"; a summary of the department's activities monitoring the deployment of wireless smart meters in Vermont, including a representative sample of

postdeployment radio frequency level testing; and recommendations relating to evidence-based surveillance on the potential health effects of wireless smart meters.

(2) The commissioner of public service, in consultation with the commissioner of health, shall select and retain an independent expert, not an employee of the state, to perform the research and writing of the report identified in subdivision (1) of this subsection. The commissioner of public service may allocate the costs of retaining the independent expert to electric utilities in accordance with sections 20 and 21 of this title (particular proceedings; personnel; assessment of costs).

Sec. 15a. INSTALLED WIRELESS SMART METERS

If an electric company has installed a wireless smart meter as defined in 30 V.S.A. § 2811(a)(3) prior to the effective date of this act, the company shall provide notice of the installation to the applicable customers, and such notice shall include a statement of customer rights as described under 30 V.S.A. § 2811(b).

* * * Energy Efficiency * * *

Sec. 16. 30 V.S.A. § 209(d)(7) is amended to read:

(7) Net revenues above costs associated with payments from the New England Independent System Operator (ISO-NE) for capacity savings resulting from the activities of the energy efficiency utility designated under subdivision (2) of this subsection shall be deposited into the electric efficiency fund established by this section. Any such net revenues not transferred to the state PACE reserve fund under 24 V.S.A. § 3270(c) shall be used by the entity appointed under subdivision (2) of this subsection to deliver heating and process-fuel energy efficiency services to Vermont consumers of such fuel on a whole-buildings basis to help meet the state's building efficiency goals established by 10 V.S.A. § 581. In delivering such services with respect to heating systems, the entity shall give priority to incentives for the installation of ~~woody~~ high efficiency biomass heating systems and shall have a goal of offering an incentive that is equal to 25 percent of the installed cost of such a system. For the purpose of this subdivision (7), "~~woody~~ biomass" means organic nonfossil material ~~from trees or woody plants~~ constituting a source of renewable energy within the meaning of subdivision 8002(2) of this title. Provision of an incentive under this subdivision (7) for a woody biomass heating system shall not be contingent on the making of other energy efficiency improvements at the property on which the system will be installed.

* * * Harvesting; procurement * * *

Sec. 16a. 10 V.S.A. chapter 87 is added to read:

CHAPTER 87. HARVESTING GUIDELINES AND PROCUREMENT STANDARDS

§ 2750. HARVESTING GUIDELINES AND PROCUREMENT STANDARDS

(a) The secretary of natural resources shall develop voluntary harvesting guidelines that may be used by private landowners to help ensure long-term forest health. These guidelines shall address harvesting that is specifically for wood energy purposes, as well as other harvesting. The secretary may also recommend monitoring regimes as part of these guidelines.

(b) The commissioner of forests, parks and recreation (the commissioner) shall adopt rules or procedures to modify the process of approving forest management plans and forest practices for lands enrolled in the use value appraisal program, established under 32 V.S.A. chapter 124, in order to address long-term forest health and sustainability. These modifications shall include requirements for preapproval by the commissioner or designee of whole-tree harvesting and for applying the guidelines developed under subsection (a) of this section to harvesting on lands enrolled in the use value appraisal program.

(c) For contracts to harvest wood products on state lands, the commissioner of forests, parks and recreation shall ensure all such harvests are consistent with the purpose of the guidelines developed under subsection (a) of this section, with the objective being long-term forest health in addition to other management objectives.

(d) The secretary of natural resources shall develop a procurement standard that shall be used by the commissioner of buildings and general services in procuring wood products, including biomass for energy in state buildings. All state agencies and departments that use wood energy shall comply with this procurement standard. The procurement standard shall include the voluntary forest health guidelines developed pursuant to subsection (a) of this section. The procurement standard shall recommend methods to:

(1) assure compliance with those forest health guidelines and applicable laws; and

(2) obtain review of potential impacts to natural resources such as rare, threatened, or endangered species, wetlands, wildlife habitat, natural communities, and forest health and sustainability as defined by the commissioner of forest, parks and recreation in consultation with the commissioner of fish and wildlife.

(e) The procurement standard developed under subsection (d) of this section shall be made available to Vermont educational institutions and other users of biomass energy for their voluntary use.

(f) Working with regional governmental organizations, such as the New England Governors' Conference, Inc. and the Coalition of Northeastern Governors, the secretary of natural resources shall seek to develop and implement regional voluntary harvesting guidelines and a model procurement standard that can be implemented regionwide, consistent with the application of the guidelines, rules, procedures, and standards developed under subsections (a), (b), and (d) of this section.

Sec. 16b. INITIAL ADOPTION

(a) The secretary of natural resources and the commissioner of forests, parks and recreation respectively shall, by January 15, 2013, adopt initial guidelines, rules, procedures, and standards pursuant to Sec. 16m of this act, 10 V.S.A. § 2750(a) (voluntary forest health guidelines), (b) (forest management plans and practices; use value appraisal program), and (d) (procurement standards).

(b) In developing the initial voluntary harvesting guidelines and procurement standards under 10 V.S.A. § 2750(a) and (d), the secretary shall consider the recommendations outlined in the final report of the biomass energy working group, dated January 17, 2012.

(c) The procurement standard adopted under 10 V.S.A. § 2750(d) shall apply to wood product procurement by the commissioner of buildings and general services commencing with new or amended contracts executed after March 1, 2013.

Sec. 16c. 10 V.S.A. § 127 is added to read:

§ 127. RESOURCE MAPPING

(a) On or before January 15, 2013, the secretary of natural resources shall complete resource mapping based on the geographic information system (GIS). The mapping shall identify natural resources throughout the state that may be relevant to the consideration of energy projects. The center for geographic information shall be available to provide assistance to the secretary in carrying out the GIS-based resource mapping.

(b) The secretary of natural resources shall consider the GIS-based resource maps developed under subsection (a) of this section when providing evidence and recommendations to the public service board under 30 V.S.A. § 248(b)(5) and when commenting on or providing recommendations under chapter 151 of this title to district commissions on other projects.

Sec. 16d. DEMONSTRATION PROJECT; COMMUNITY-SUPPORTED BIOMASS

There is hereby authorized a biomass energy demonstration project to be implemented in Chittenden County by The Vermont Community Supported Biomass Energy Co-op Corporation in order to explore and showcase the development of community-supported wood pellet harvesting and production in Vermont. This demonstration project is subject to the following requirements:

(1) Purchased biomass shall be subject to forest harvesting guidelines no less stringent than those required for participation in the use value appraisal program authorized under 32 V.S.A. § 3755.

(2) Purchased biomass shall be subject to procurement standards no less stringent than those outlined in the final report of the Biomass Energy Development Working Group dated January 17, 2012.

(3) Pellets produced by the demonstration project shall be labeled as meeting appropriate harvesting guidelines and procurement standards.

(4) Pellets shall be sold to customers, including schools and other institutions, that employ high-efficiency heating appliances.

(5) The Biomass Energy Resource Center's publication from August 2011, titled "A Feasibility Study of Pellet Manufacturing in Chittenden County, Vermont," shall inform design and implementation of the demonstration project.

(6) The demonstration project shall provide pellets at a reduced cost to households that meet the income eligibility requirements found in 33 V.S.A. § 2604(a) for home heating fuel assistance in Vermont.

Sec. 16e. 24 V.S.A. § 4412(6) is amended to read:

(6) Heights of renewable energy resource structures. The height of wind turbines with blades less than 20 feet in diameter, or rooftop solar collectors less than 10 feet high on sloped roofs, any of which are mounted on complying structures, shall not be regulated unless the bylaws provide specific standards for regulation. For the purpose of this subdivision, a sloped roof means a roof having a slope of more than five degrees. In addition, the regulation of antennae that are part of a telecommunications facility, as defined in 30 V.S.A. § 248a, may be exempt from review under this chapter according to the provisions of that section.

Sec. 16f. 24 V.S.A. § 4413(g) is amended to read:

(g) Notwithstanding any provision of law to the contrary, a bylaw adopted

under this chapter shall not ~~prohibit~~:

(1) Regulate the installation, operation, and maintenance, on a flat roof of an otherwise complying structure, of a solar energy device that heats water or space or generates electricity. For the purpose of this subdivision, "flat roof" means a roof having a slope less than or equal to five degrees.

(2) Prohibit or have the effect of prohibiting the installation of solar collectors not exempted from regulation under subdivision (1) of this subsection, clotheslines, or other energy devices based on renewable resources.

Sec. 17. EFFECTIVE DATES; IMPLEMENTATION

(a) This section and Secs. 1 (renewable energy chapter; goals), 2 (renewable energy chapter; definitions), 3 (SPEED; total renewables targets), 4 (SPEED; standard offer program), 5 (standard offer; prior capacity; interconnection application; report), 7 (renewable energy; further study; report), 8 (greenhouse gas reduction credits), 12 (certificate of public good; findings), 13 (total energy; report), 15 (smart meters; customer rights; reports), 15a (installed wireless smart meters), 16a (harvesting and procurement standards), 16b (initial adoption), 16c (resource mapping) and 16d (community supported biomass) of this act shall take effect on passage.

(b) All sections of this act not referenced in subsections (a) and (e) of this section shall take effect on July 1, 2012.

(c) No later than March 1, 2013, the public service board shall adopt rules or orders sufficient to implement 30 V.S.A. § 8005a(d)(2) (new standard offer plants; transmission and distribution constraints).

(d) No later than September 1, 2013, the secretary of natural resources shall adopt rules pursuant to Sec. 14 of this act, 10 V.S.A. § 582(g) (greenhouse gas accounting).

(e) Secs. 16e (height of renewable energy structures) and 16f (bylaws; solar and other energy devices) of this act shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to the Vermont energy act of 2012"

(For House Proposal of Amendment see House Journal 4/27/2012)

S. 226

An act relating to combating illegal diversion of prescription opiates and increasing treatment resources for opiate addiction

The Senate concurs in the House proposal of amendment with the following proposal of amendment thereto:

By striking out the fifth proposal of amendment (adding Secs. 9a-d) in its entirety.

(For House Proposal of Amendment see House Journal 4/30/2012)

Senate Proposal of Amendment to House Proposal of Amendment to Senate Proposal of Amendment

H. 485

An act relating to establishing universal recycling of solid waste

The Senate concurs in the House proposal of amendment to the Senate proposal of amendment with the following proposal of amendment thereto:

First: In Sec. 2, 10 V.S.A. § 6604, in subdivision (a)(1), by adding a new subdivision (B) to read:

~~(ii)~~(B) materials management, which furthers the development of products that will generate less waste;

and by relettering the subsequent subdivisions of subdivision (a)(1) to be alphabetically correct

Second: In Sec. 12 (ANR report on solid waste), in subdivision (a)(1)(A) by striking out "and" after the semicolon and in subdivision (a)(1)(B), by striking out the period and inserting in lieu thereof ; and and by adding subdivision (a)(1)(C) to read:

(C) an analysis of the effectiveness of the existing, statutory beverage container deposit and return requirements and the effectiveness of the existing, statutory requirements in 10 V.S.A. chapters 164 (mercury management), 164A (collection and disposal of mercury containing lamps), and 166 (collection and recycling of electronic devices) in achieving the priorities and goals established by the state solid waste management plan.

(For House Proposal of Amendment see House Journal 3/1/2012 and 3/2/2012)

Committee of Conference Report

H. 464

An act relating to a moratorium on hydraulic fracturing wells for natural gas and oil production

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

H. 464 An act relating to a moratorium on hydraulic fracturing wells for natural gas and oil production

Respectfully report that they have met and considered the same and recommend that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds and declares that:

(1) The drilling practice of hydraulic fracturing for natural gas exploration and production uses a variety of chemicals that are pumped into natural gas or oil wells.

(2) During hydraulic fracturing, chemicals and waste fluid pumped into wells may be introduced into and contaminate drinking water aquifers.

(3) To ensure that the state's underground sources of drinking water remain free of contamination, the general assembly should prohibit hydraulic fracturing for the purpose of the recovery of oil or natural gas in order to:

(A) allow the state time to review, develop, and establish potential requirements for regulation of hydraulic fracturing; and

(B) allow the agency of natural resources to review the environmental impacts of hydraulic fracturing.

(4) When hydraulic fracturing can be conducted without risk of contamination to the groundwater of Vermont, the general assembly should repeal the prohibition on hydraulic fracturing for oil and natural gas recovery.

Sec. 2. 29 V.S.A. § 503 is amended to read:

§ 503. DEFINITIONS

As used in this chapter:

* * *

(8) "Gas" means all natural gas, whether hydrocarbon or nonhydrocarbon, including hydrogen sulfide, helium, carbon dioxide, nitrogen, hydrogen, casinghead gas, and all other fluid hydrocarbons not defined as oil.

* * *

(15) "Oil" means crude petroleum, oil, and all hydrocarbons, regardless of specific gravity, that are in the liquid phase in the reservoir and are produced at the wellhead in liquid form.

(16) "Oil and gas" means both oil and gas, or either oil or gas, as the

context may require to give effect to the purposes of this chapter.

* * *

(29) "Fluid" means any material or substance which flows or moves whether in semi-solid, liquid, sludge, gas, or any other form or state.

(30) "Hydraulic fracturing" means the process of pumping a fluid into or under the surface of the ground in order to create fractures in rock for the purpose of the production or recovery of oil or gas.

Sec. 3. 29 V.S.A. chapter 14, subchapter 8 is added to read:

Subchapter 8. Hydraulic Fracturing for Oil or Gas Recovery

§ 571. HYDRAULIC FRACTURING; PROHIBITION

(a) No person may engage in hydraulic fracturing in the state.

(b) No person within the state may collect, store, or treat wastewater from hydraulic fracturing.

Sec. 4. 10 V.S.A. § 1259 is amended to read:

§ 1259. PROHIBITIONS

(a) No person shall discharge any waste, substance, or material into waters of the state, nor shall any person discharge any waste, substance, or material into an injection well or discharge into a publicly owned treatment works any waste which interferes with, passes through without treatment, or is otherwise incompatible with those works or would have a substantial adverse effect on those works or on water quality, without first obtaining a permit for that discharge from the secretary. This subsection shall not prohibit the proper application of fertilizer to fields and crops, nor reduce or affect the authority or policy declared in joint house resolution 7 of the 1971 session of the general assembly.

* * *

(c) No person shall cause a direct discharge into Class A waters of any wastes that, prior to treatment, contained organisms pathogenic to human beings. Except within a waste management zone, no person shall cause a direct discharge into Class B waters of any wastes that prior to treatment contained organisms pathogenic to human beings.

(d) No person shall cause a discharge of wastes into Class A waters, except for on-site disposal of sewage from systems with a capacity of 1,000 gallons per day (gpd), or less, that are either exempt from or comply with the environmental protection rules, or existing systems, which shall require a permit according to the provisions of subsection 1263(f) of this title.

* * *

(j) No person shall discharge waste from hydraulic fracturing, as that term is defined in 29 V.S.A. § 503, into or from a pollution abatement facility, as that term is defined in section 1571 of this title.

Sec. 5. AGENCY OF NATURAL RESOURCES REPORT; REGULATION OF HYDRAULIC FRACTURING FOR OIL OR NATURAL GAS RECOVERY

(a) On or before January 15, 2015, the secretary of natural resources shall submit to the senate and house committees on natural resources and energy and the house committee on fish, wildlife and water resources a report recommending how hydraulic fracturing should be regulated in the state. The report shall include:

(1) A recommendation of what state agency, board, or instrumentality should be authorized by the general assembly to regulate hydraulic fracturing in the state;

(2) A summary of how the agency recommends that hydraulic fracturing be regulated in the state, including how hydraulic fracturing should be permitted, where and how hydraulic fracturing should be sited, how waste from the hydraulic fracturing should be disposed of, how groundwater and surface water withdrawal for hydraulic fracturing should be regulated, and how to regulate land use practices and traffic associated with hydraulic fracturing; and

(3) Whether the agency of natural resources recommends that additional statutory or regulatory authority be enacted or adopted for the regulation of hydraulic fracturing and, if additional authority is recommended, a summary of the recommended authority.

(b) In preparing the report required by this section, the secretary of natural resources shall consult with interested parties, including representatives of: environmental groups , the oil and gas board, the oil and gas industry, and the U.S. Environmental Protection Agency.

Sec. 6. ANR REPORT ON SAFETY OF HYDRAULIC FRACTURING

On or before January 15, 2016, the secretary of natural resources shall report to the senate and house committees on natural resources and energy and the house committee on fish, wildlife and water resources regarding the environmental impacts of hydraulic fracturing and the potential impact of the practice on the public health and environment of Vermont. The report shall include:

(1) A summary of the findings of the U.S. Environmental Protection

Agency studies of the environmental impacts of hydraulic fracturing, including the effects of hydraulic fracturing on ground water and air quality;

(2) A summary of additional relevant peer review studies related to the environmental impacts of hydraulic fracturing when, in the discretion of the secretary of natural resources, they are determined to be instructive or relevant to the potential environmental impacts of hydraulic fracturing in Vermont; and

(3) A recommendation as to whether the prohibition on hydraulic fracturing under 29 V.S.A § 571 should be repealed.

Sec. 7. AGENCY OF NATURAL RESOURCES; UNDERGROUND INJECTION CONTROL RULEMAKING

On or before July 15, 2015, the secretary of natural resources shall amend the rules regulating the discharge of waste into an injection well, including those discharges into an injection well for oil and gas recovery for which the agency of natural resources has jurisdiction, in order to update the rules to reflect existing requirements under federal and state law and to address practices not contemplated by the existing rules. In amending the rules regulating the discharge of waste into an injection well, the agency of natural resources shall provide that no permit shall be issued under 10 V.S.A. chapter 47 for a discharge of waste into an injection well when such a discharge would endanger an underground source of drinking water.

Sec. 8. EFFECTIVE DATE

This act shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to hydraulic fracturing wells for natural gas and oil production"

Rep. James McCullough

Rep. Kathryn Webb

Committee on the part of the House

Sen. Virginia Lyons

Sen. Joseph Benning

Sen. Mark MacDonald

Committee on the part of the Senate

H. 559

An act relating to health care reform implementation

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

H. 559 An act relating to health care reform implementation

Respectfully report that they have met and considered the same and recommend that 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 year, 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 year, 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 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. 2d. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

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

* * *

(17) Establishing procedures, including payment mechanisms and standard fee or compensation schedules, that allow licensed insurance agents and brokers to be appropriately compensated outside the navigator program established in section 1807 of this title for:

(A) assisting with the enrollment of qualified individuals and qualified employers in any qualified health plan offered through the exchange for which the individual or employer is eligible; and

(B) assisting qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health benefit plans purchased through the exchange.

Sec. 2e. 8 V.S.A. § 4085 is amended to read:

§ 4085. REBATES AND COMMISSIONS PROHIBITED FOR NONGROUP AND SMALL GROUP POLICIES AND PLANS OFFERED THROUGH THE VERMONT HEALTH BENEFIT EXCHANGE

(a) No insurer doing business in this state and no insurance agent or broker shall offer, promise, allow, give, set off, or pay, directly or indirectly, any rebate of or part of the premium payable on ~~the policy, or on any policy or agent's commission thereon~~ a plan issued pursuant to section 4080g of this title or 33 V.S.A. § 1811 or earnings, profits, dividends, or other benefits founded, arising, accruing or to accrue thereon or therefrom, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind or any other valuable consideration or inducement to or for insurance on any risk in this state, now or hereafter to be written, or for or upon any renewal of any such insurance, which is not specified in the policy contract of insurance, or offer, promise, give, option, sell, purchase any stocks, bonds, securities, or property or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever as inducement to insurance or in connection therewith, or any renewal thereof, which is not specified in the ~~policy~~ plan.

(b) No ~~insured~~ person insured under a plan issued pursuant to section § 4080g of this title or 33 V.S.A. § 1811 or party or applicant for ~~insurance~~ such plan shall directly or indirectly receive or accept~~,~~ or agree to receive or accept any rebate of premium or of any part thereof ~~or all or any part of any agent's or broker's commission thereon~~, or any favor or advantage, or share in any benefit to accrue under any ~~policy of insurance~~ plan issued pursuant to

section 4080g of this title or 33 V.S.A. § 1811, or any valuable consideration or inducement, other than such as is specified in the ~~policy~~ plan.

(c) Nothing in this section shall be construed as prohibiting ~~the payment of commission or other compensation to any duly licensed agent or broker; or as prohibiting~~ any insurer from allowing or returning to its participating policyholders dividends, savings, or unused premium deposits; or as prohibiting any insurer from returning or otherwise abating, in full or in part, the premiums of its policyholders out of surplus accumulated from nonparticipating insurance, or as prohibiting the taking of a bona fide obligation, with interest ~~at~~ not exceeding six percent per annum, in payment of any premium.

(d)(1) No insurer shall pay any commission, fee, or other compensation, directly or indirectly, to a licensed or unlicensed agent, broker, or other individual in connection with the sale of a health insurance plan issued pursuant to section 4080g of this title or 33 V.S.A. § 1811, nor shall an insurer include in an insurance rate for a health insurance plan issued pursuant to section 4080g of this title or 33 V.S.A. § 1811 any sums related to services provided by an agent, broker, or other individual. A health insurer may provide to its employees wages, salary, and other employment-related compensation in connection with the sale of health insurance plans, but may not structure any such compensation in a manner that promotes the sale of particular health insurance plans over other plans offered by that insurer.

(2) Nothing in this subsection shall be construed to prohibit the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 from structuring compensation for agents or brokers in the form of an additional commission, fee, or other compensation outside insurance rates or from compensating agents, brokers, or other individuals through the procedures and payment mechanisms established pursuant to 33 V.S.A. § 1805(17).

Sec. 2f. 8 V.S.A. § 4085a is added to read:

§ 4085a. REBATES PROHIBITED FOR GROUP INSURANCE POLICIES

(a) As used in this section, "group insurance" means any policy described in section 4079 of this title, except that it shall not include any small group policy issued pursuant to section 4080a or 4080g of this title or to 33 V.S.A. § 1811.

(b) No insurer doing business in this state and no insurance agent or broker shall offer, promise, allow, give, set off, or pay, directly or indirectly, any rebate of or part of the premium payable on a group insurance policy, or on any group insurance policy or agent's commission thereon or earnings, profits, dividends, or other benefits founded, arising, accruing or to accrue thereon or

therefrom, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind or any other valuable consideration or inducement to or for insurance on any risk in this state, now or hereafter to be written, or for or upon any renewal of any such insurance, which is not specified in the policy contract of insurance, or offer, promise, give, option, sell, purchase any stocks, bonds, securities, or property or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever as inducement to insurance or in connection therewith, or any renewal thereof, which is not specified in the policy.

(c) No insured person under a group insurance policy or party or applicant for group insurance shall directly or indirectly receive or accept or agree to receive or accept any rebate of premium or of any part thereof or all or any part of any agent's or broker's commission thereon, or any favor or advantage, or share in any benefit to accrue under any policy of insurance, or any valuable consideration or inducement, other than such as is specified in the policy.

(d) Nothing in this section shall be construed as prohibiting the payment of commission or other compensation to any duly licensed agent or broker; or as prohibiting any insurer from allowing or returning to its participating policyholders dividends, savings, or unused premium deposits; or as prohibiting any insurer from returning or otherwise abating, in full or in part, the premiums of its policyholders out of surplus accumulated from nonparticipating insurance, or as prohibiting the taking of a bona fide obligation, with interest not exceeding six percent per annum, in payment of any premium.

(e) An insurer that pays a commission, fee, or other compensation, directly or indirectly, to a licensed or unlicensed agent, broker, or other individual other than a bona fide employee of the insurer in connection with the sale of a group insurance policy shall clearly disclose to the purchaser of such group policy the amount of any such commission, fee, or compensation paid or to be paid.

Sec. 2g. DISCLOSURE OF COMMISSIONS FOR NONGROUP AND SMALL GROUP POLICIES

(a) An insurer that pays any commissions, fees, or other compensation, directly or indirectly, to licensed or unlicensed agents, brokers, or other individuals other than bona fide employees of the insurer in connection with the sale of nongroup or small group insurance policies, or both, shall clearly disclose to the purchaser of any nongroup or small group policy the amount of the premium for the policy attributable to the insurer's payment of commissions, fees, and other compensation.

(b) The disclosure requirement in subsection (a) of this section shall apply

to all health insurers offering nongroup or small group insurance policies, or both, beginning July 1, 2012, until the insurer no longer pays any commission, fee, or other compensation in connection with the sale of a nongroup or small group insurance policy in compliance with the provisions of 8 V.S.A. § 4085.

* * * Bronze plans * * *

Sec. 2h. 33 V.S.A. § 1806(g) is added to read:

(g) The Vermont health benefit exchange shall clearly indicate to any prospective purchaser of a bronze-level plan, and of other plans as appropriate, the potential for significant out-of-pocket costs, in addition to the premium, associated with the plan.

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 financial regulation 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 year, 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 year, 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 financial regulation 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 of financial regulation 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 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 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 limit community rating provisions accordingly as applicable 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.

(j) 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.

Sec. 5a. BILL-BACK REPORT

No later than February 1, 2013, the department of financial regulation 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. [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 financial regulation. 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 financial regulation, 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~~ BlueCross and BlueShield 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.

* * * Mental Health and Substance Abuse * * *

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 financial regulation 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.

Sec. 11c. PARITY FOR PRIMARY MENTAL HEALTH CARE SERVICES; RECOMMENDATIONS

No later than January 15, 2013, the commissioner of financial regulation or designee shall recommend to the house committee on health care and the senate committees on health and welfare and on finance guidelines for distinguishing between primary and specialty mental health services, taking into consideration factors such as mental health care providers' scope of practice and patterns of patient visitation. In addition, the commissioner or designee shall provide the committees with an estimate of the impact on health insurance premiums if such guidelines are enacted into law.

Sec. 11d. 8 V.S.A. § 4089b(c) is amended to read:

(c) A health insurance plan shall provide coverage for treatment of a mental health condition and shall:

(1) not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment for other health conditions, including no greater co-payment for primary mental health care or services than the co-payment applicable to care or services provided by a primary care provider under an insured's policy and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under an insured's policy;

* * *

Sec. 11e. PARITY FOR MENTAL HEALTH CO-PAYMENTS; RULEMAKING

No later than October 1, 2013, the commissioner of financial regulation

shall adopt rules pursuant to 3 V.S.A. chapter 25 establishing the guidelines for distinguishing between primary and specialty mental health services developed pursuant to Sec. 11c of this act, taking into account any recommendations received from the committees of jurisdiction.

Sec. 11f. 18 V.S.A. § 7259 is added to chapter 174 to read:

§ 7259. MENTAL HEALTH CARE OMBUDSMAN

(a) The department of mental health shall establish the office of the mental health care ombudsman within the agency designated by the governor as the protection and advocacy system for the state pursuant to 42 U.S.C. § 10801 et seq. The agency may execute the duties of the office of the mental health care ombudsman, including authority to assist individuals with mental health conditions and to advocate for policy issues on their behalf; provided, however, that nothing in this section shall be construed to impose any additional duties on the agency in excess of the requirements under federal law.

(b) The agency may provide a report annually to the general assembly regarding the implementation of this section.

(c) In the event the protection and advocacy system ceases to provide federal funding to the agency for the purposes described in this section, the general assembly may allocate sufficient funds to maintain the office of the mental health care ombudsman.

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

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

(a) Except as otherwise specified, as used in this subchapter:

* * *

(15) "Prior authorization" means the process used by a health plan to determine the medical necessity, medical appropriateness, or both, of otherwise covered drugs, medical procedures, medical tests, and health care services. The term "prior authorization" includes preadmission review, pretreatment review, and utilization review.

(16) "Procedure codes" means a set of descriptive codes indicating the procedure performed by a health care provider and includes the American Medical Association's Current Procedural Terminology codes (CPT), the Healthcare Common Procedure Coding System Level II Codes (HCPCS), the American Society of Anesthesiologists' (ASA) current procedural terminology, and the American Dental Association's current dental terminology.

~~(16)~~(17) "Product" means, to the extent permitted by state and federal law, one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

* * *

* * * Prior Authorization * * *

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

§ 9418b. PRIOR AUTHORIZATION

* * *

(g)(1)(A) Notwithstanding any provision of law to the contrary, on and after March 1, 2014, when requiring prior authorization for prescription drugs, medical procedures, and medical tests, a health plan shall accept for each prior authorization request either:

(i) The national standard transaction information, such as HIPAA 278 standards, for sending or receiving authorizations electronically; or

(ii) a uniform prior authorization form developed pursuant to subdivisions (2) and (3) of this subsection.

(B) A health plan shall have the capability to accept both the national standard transaction information and the uniform prior authorization forms developed pursuant to subdivisions (2) and (3) of this subsection.

(2)(A) No later than September 1, 2013, the department of financial regulation shall develop a clear, uniform, and readily accessible prior authorization form for prior authorization requests for medical procedures and medical tests.

(B) No later than September 1, 2013, the department of financial regulation shall develop clear, uniform, and readily accessible forms for prior authorization requests for prescription drugs after determining the appropriate number of forms.

(3) Each uniform prior authorization form developed pursuant to subdivision (2) of this subsection shall meet the following criteria, where applicable:

(A) The form shall include the core set of common data requirements for nonclinical information for prior authorization included in the HIPAA 278 standard transaction, national standards for prior authorization and electronic prescriptions, or both. The department shall revise the form as needed to ensure that national standards are adopted and incorporated as soon as such

standards are available and final.

(B) The form shall be made available electronically by the department and by the health plan.

(C) The completed form or its data elements may be submitted electronically from the prescribing health care provider to the health plan.

(D) The department shall develop the form in consultation with the department of Vermont health access and with input from interested parties from at least one public meeting.

(E) The department shall consider input on the proposed form from the national ASC X-12 workgroup, if available.

(F) In developing the uniform prior authorization forms, the department shall take into consideration the following:

(i) existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services, by the department of Vermont health access, and by insurance and Medicaid departments and agencies in other states; and

(ii) national standards related to electronic prior authorization.

(4) A health plan shall respond to a completed prior authorization request from a prescribing health care provider within 48 hours for urgent requests and within 120 hours for non-urgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If a health plan does not, within the time limits set forth in this section, respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information, the prior authorization request shall be deemed to have been granted.

* * * 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, within 10 business~~ Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of ~~such recommendations and~~ a request for approval from the commissioner of financial regulation, 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.

(12) Review data regarding mental health and substance abuse treatment reported to the department of financial regulation 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.

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~~ of financial regulation 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 certificates 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 disabilities, 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, 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.

* * * Medical Malpractice Reform * * *

Sec. 24a. 12 V.S.A. § 1051 is added to read:

§ 1051. CERTIFICATE OF MERIT

(a) No civil action shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after February 1, 2013, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action files a certificate of merit simultaneously with the filing of the complaint. In the certificate of merit, the attorney or plaintiff shall certify that he or she has consulted with a health care provider qualified pursuant to the requirements of Rule 702 of the Vermont Rules of Evidence and any other applicable standard, and that, based on the information reasonably available at the time the opinion is rendered, the health care provider has:

(1) Described the applicable standard of care;

(2) Indicated that based on reasonably available evidence, there is a reasonable likelihood that the plaintiff will be able to show that the defendant failed to meet that standard of care; and

(3) Indicated that there is a reasonable likelihood that the plaintiff will be able to show that the defendant's failure to meet the standard of care caused the plaintiff's injury.

(b) A plaintiff may satisfy this requirement through multiple consultations that collectively meet the requirements of subsection (a) of this section.

(c) A plaintiff must certify to having consulted with a health care provider as set forth in subsection (a) of this section with respect to each defendant identified in the complaint.

(d) Upon petition to the clerk of the court where the civil action will be filed, an automatic 90-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by this section.

(e) The failure to file the certificate of merit as required by this section shall be grounds for dismissal of the action without prejudice, except in the rare instances in which a court determines that expert testimony is not required to establish a case for medical malpractice.

(f) The requirements set forth in this section shall not apply to claims where the sole allegation against the health care provider is failure to obtain informed consent.

Sec. 24b. [DELETED.]

Sec. 24c. 12 V.S.A. chapter 215, subchapter 2 is added to read:

Subchapter 2. Mediation Prior to Filing a Complaint of Malpractice

§ 7011. PURPOSE

The purpose of mediation prior to filing a medical malpractice case is to identify and resolve meritorious claims and reduce areas of dispute prior to litigation, which will reduce the litigation costs, reduce the time necessary to resolve claims, provide fair compensation for meritorious claims, and reduce malpractice-related costs throughout the system.

§ 7012. PRE-SUIT MEDIATION; SERVICE

(a) A potential plaintiff may serve upon each known potential defendant a request to participate in pre-suit mediation prior to filing a civil action in tort or in contract alleging that an injury or death resulted from the negligence of a health care provider and to recover damages resulting from the personal injury or wrongful death.

(b) Service of the request required in subsection (a) of this section shall be in letter form and shall be served on all known potential defendants by certified mail. The date of mailing such request shall toll all applicable statutes of limitations.

(c) The request to participate in pre-suit mediation shall name all known potential defendants, contain a brief statement of the facts that the potential plaintiff believes are grounds for relief, and be accompanied by a certificate of merit prepared pursuant to section 1051 of this title, and may include other documents or information supporting the potential plaintiff's claim.

(d) Nothing in this chapter precludes potential plaintiffs and defendants from pre-suit negotiation or other pre-suit dispute resolution to settle potential claims.

§ 7013. MEDIATION RESPONSE

(a) Within 60 days of service of the request to participate in pre-suit mediation, each potential defendant shall accept or reject the potential plaintiff's request for pre-suit mediation by mailing a certified letter to counsel or if the party is unrepresented to the potential plaintiff.

(b) If the potential defendant agrees to participate, within 60 days of the service of the request to participate in pre-suit mediation, each potential defendant shall serve a responsive certificate on the potential plaintiff by mailing a certified letter indicating that he or she, or his or her counsel, has consulted with a qualified expert within the meaning of section 1643 of this title and that expert is of the opinion that there are reasonable grounds to defend the potential plaintiff's claims of medical negligence. Notwithstanding the potential defendant's acceptance of the request to participate, if the potential defendant does not serve such a responsive certificate within the 60-day period, then the potential plaintiff need not participate in the pre-suit mediation under this title and may file suit. If the potential defendant is willing to participate, pre-suit mediation may take place without a responsive certificate of merit from the potential defendant at the plaintiff's election.

§ 7014. PROCESS; TIME FRAMES

(a) The mediation shall take place within 60 days of the service of all potential defendants' acceptance of the request to participate in pre-suit mediation. The parties may agree to an extension of time. If in good faith the mediation cannot be scheduled within the 60-day time period, the potential plaintiff need not participate and may proceed to file suit.

(b) If pre-suit mediation is not agreed to, the mediator certifies that mediation is not appropriate, or mediation is unsuccessful, the potential plaintiff may initiate a civil action as provided in the Vermont Rules of Civil Procedure. The action shall be filed:

(1) within 90 days of the potential plaintiff's receipt of the potential defendant's letter refusing mediation, the failure of the potential defendant to file a responsive certificate of merit within the specified time period, or the mediator's signed letter certifying that mediation was not appropriate or that the process was complete; or

(2) prior to the expiration of the applicable statute of limitations, whichever is later.

(c) If pre-suit mediation is attempted unsuccessfully, the parties shall not be required to participate in mandatory mediation under Rule 16.3 of the Vermont Rules of Civil Procedure.

§ 7015. CONFIDENTIALITY

All written and oral communications made in connection with or during the mediation process set forth in this chapter shall be confidential. The mediation process shall be treated as a settlement negotiation under Rule 408 of the Vermont Rules of Evidence.

Sec. 24d. SUNSET

12 V.S.A. chapter 215, subchapter 2 shall be repealed on February 1, 2015.

Sec. 24e. REPORT

On or before September 1, 2014, the secretary of administration or designee shall report to the senate committees on health and welfare and on judiciary and the house committees on health care and on judiciary on the impacts of Secs. 24a (certificate of merit) and 24c (pre-suit mediation) of this act. The report shall address the impacts that these reforms have had on:

(1) consumers, physicians, and the provision of health care services;

(2) the rights of consumers to due process of law and to access to the court system; and

(3) any other service, right, or benefit that was or may have been affected by the establishment of the medical malpractice reforms in Secs. 24a and 24c of this act.

Sec. 24f. 18 V.S.A. § 1919 is amended to read:

§ 1919. INCLUSION OF DATA IN HOSPITAL COMMUNITY REPORTS

The commissioner shall consult with the commissioner of ~~banking, insurance, securities, and health care administration~~ financial regulation, and with patient safety experts, hospitals, health care professionals, and members of the public and shall make recommendations to the commissioner of ~~banking, insurance, securities, and health care administration~~ financial regulation concerning which data should be included in the hospital community reports required by section 9405b of this title. Beginning in 2013, the community reports shall include at a minimum data from all Vermont hospitals of reportable adverse events aggregated in a manner that protects the privacy of the patients involved and does not identify the individual hospitals in which an event occurred together with analysis and explanatory comments about the information contained in the report to facilitate the public's understanding of the data. The commissioner shall make such

recommendations no more than 18 months after data collection is initiated.

* * * 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~~ financial regulation; ~~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, modify, 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 subdivision (2).

(B) The Green Mountain Care board shall review rate requests forwarded by the commissioner pursuant to subdivision (A) of this subdivision (2) and shall approve, modify, 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.

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

(b) 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. For premium rates, such withdrawal may occur at any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section. ~~Such disapproval~~ Disapproval pursuant to this subsection 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)~~(c) 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) of this section 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. 25a. 8 V.S.A. § 5104 is amended to read:

§ 5104. FILING AND APPROVAL OF RATES AND FORMS; SUPPLEMENTAL ORDERS

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title.

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

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

(b) In connection with a rate decision, the commissioner may also, with the prior approval of the Green Mountain Care board established in 18 V.S.A. chapter 220, make reasonable supplemental orders and may attach reasonable conditions and limitations to such orders as the commissioner finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at reasonable cost under efficient and economical management of the organization. The commissioner shall not set the rate of payment or reimbursement made by the organization to any physician, hospital or health care provider.

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

§ 9381. APPEALS

(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 financial regulation pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.

* * *

(c) 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 pursuant to subsection (b) of this section, 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. 26a. CONSUMER PROTECTION REPORT

No later than January 15, 2013, the department of financial regulation, in collaboration with the state health care ombudsman 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:

(1) recommendations on how best to represent the public interest before the Green Mountain Care board and other regulatory agencies and estimates of resource needs;

(2) recommendations on how best to coordinate, consolidate, or both the consumer protection efforts of the ombudsman's office, the department, and the agency; and

(3) the ombudsman's current and projected funding and resource needs to meet existing statutory responsibilities and suggestions for funding mechanisms to meet those needs.

* * * Payment Reform Pilots * * *

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

§ 9377. PAYMENT REFORM; PILOTS

* * *

(b)(1) The board shall be responsible for payment and delivery system reform, including ~~setting the overall policy goals for~~ the pilot projects established in ~~chapter 13, subchapter 2 of this title~~ 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 financial regulation 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 financial regulation. 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 ~~and the commissioner~~, of mental health, 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~~ financial regulation 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 mental health professional with clinical experience in Vermont; a representative of the Vermont council of developmental and mental health services; 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) Health insurer and Medicaid payments for a community health team and access by patients and medical practices to the team should begin at least six months prior to the scheduled date to score a medical practice 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, 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 or life insurance.

(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 on and after July 1, 2012, 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 on and after July 1, 2012, 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 dollar limit on

prescription drug benefits.

(c) A health insurance or other health benefit 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 for self-only and family coverage per year than the minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively.

(d) For prescription drugs benefits offered in conjunction with a high-deductible health plan (HDHP), the plan may not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles in effect for self-only and family coverage under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection (c) of this section.

(e) 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.

(f) The department of financial regulation 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), but shall not include prescription eyeglasses, prescription sunglasses, or other prescription eyewear.

* * *

(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, a nonprescription medical device, ~~or~~ an item of nonprescription durable medical equipment, an item of medical food as defined in the federal Orphan Drug Act, as amended, 21 U.S.C. § 360ee(b)(3), or infant formula as defined in Section 201(z) of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321, 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;

(v) combination products;

(vi) medical food;

(vii) infant formula; or

(viii) medical equipment or supplies.

* * *

(d) The attorney general may bring an action in ~~Washington superior court~~ the civil division of the Washington unit of the 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, medical food, and infant formula 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, combination products, medical food, infant formula, or supplies to a free clinic shall not include information that allows for the identification of individual recipients of such products or that 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, medical food, and infant formula shall be presented in aggregate form.

* * *

(c) The attorney general may bring an action in ~~Washington superior court~~ the civil division of the Washington unit of the 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 through 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 that are more restrictive than those for individuals not enrolled in the consolidated program.

(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) if the agency contracts with an integrated care provider (ICP) then, at a minimum, as required under 42 U.S.C. § 1395a(a), guarantees individuals a choice of health care providers who offer the same service or services within the individual's ICP and a choice of providers for services that are not offered through the individual's ICP.

(G) unless otherwise appropriated by the general assembly, and after reconciling savings as required by the federal government, invests at least 50 percent of the remaining funds at the end of the state fiscal year to enhance 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;

(III) rate negotiations between the integrated care provider and the public managed care organization; or

(IV) meeting or failing to meet specified performance measures.

(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) If the agency of human services contracts with an ICP on a risk-sharing basis for services other than care coordination, the following provisions shall be included in the ICP contract:

(A) A broad range of services for individuals, to be provided by the ICP or through contracts between the ICP and other service providers, and coordination between the ICP and other service or health care providers who are not participants in the ICP, as appropriate. Examples of entities that are

unlikely to be part of an ICP include the individual's medical home and the Blueprint for Health community health teams.

(B) An enforcement mechanism to ensure that the ICP 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 ICP 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 shall 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.

(8) Ensure affordable coverage for individuals who are eligible for Medicare but who are responsible for paying the full cost of Medicare coverage due to inadequate work history or for another reason. The agency shall align the upper income eligibility limitation with other populations, such as individuals receiving state assistance in the Vermont health benefit exchange or individuals receiving coverage as part of a Medicaid expansion population.

(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 and transition planning 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, 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 care oversight committee upon request. The secretary or designee shall be available to the health care oversight committee on a monthly basis to provide an update in person or by telephone on the status of the waiver and transition planning, applications, and negotiations, including updates on the substantive provisions and issues provided for in Secs. 33–35a of this act. If the health care oversight committee elects not to meet in person or by telephone during any one 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 AND TRANSITION PLANNING; INTENT

(a) It is the intent of the general assembly to ensure continued legislative oversight after adjournment through the health care oversight committee and the committees of jurisdiction of the transition from Vermont's current

Medicaid expansion programs to new coverage options, including the Vermont health benefit exchange, for individuals and families in 2014. Because of federal time lines and the need to negotiate a waiver with the Centers for Medicare and Medicaid Services, continued development of the transition plan by the administration is expected during the summer and fall of 2012. It is the intent of the general assembly that the secretary of human services or designee not implement a basic health program without the approval of the general assembly. It is also the intent of the general assembly to continue to oversee the development of the transition plan during the 2013 legislative session.

(b) 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 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; ensures that health care providers receive compensation that is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably; and recognizes the need to limit the financial exposure of the state of Vermont.

(c) The department of Vermont health access, in consultation with the Medicaid and exchange advisory committee established by 33 V.S.A. § 402, shall evaluate the options available under Section 1115 of the Social Security Act and under 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), for ensuring affordable coverage for individuals above 133 percent of the federal poverty level. The department shall consider financial implications to Vermonters, health care providers, and the state; administrative simplification of health care; continuity of coverage and reduction of churn; consistency with and promotion of other state health care reform efforts; and the likelihood of receiving approval from the U.S. Department of Health and Human Services, where necessary.

Sec. 35b. 33 V.S.A. § 402(b) is amended to read:

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

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

advisory committee.

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

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

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

(iii) advocates for consumer organizations.

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

* * *

Sec. 35c. EXCHANGE IMPLEMENTATION AND TRANSITION PLANNING; UPDATES

(a) The house committee on health care and the senate committees on health and welfare and on finance may meet while the legislature is not in session during 2012 to receive updates on issues related to health care reform, including waivers, transition planning, health information technology, the Vermont Information Technology Leaders, Inc., and implementation of the Vermont health benefit exchange. The committees shall meet at the call of the chairs of the committees, with the approval of the speaker of the house of representatives and the president pro tempore of the senate. To the extent practicable, such meetings shall coincide with scheduled meetings of the health care oversight committee.

(b) If the secretary of human services or designee receives the results of the federal government's review of Vermont's plan to implement its health benefit exchange while the general assembly is not in session, the members of the administration team responsible for exchange implementation shall present the results to the health care oversight committee and to a joint meeting of the standing committees pursuant to subsection (a) of this section. If the secretary or designee receives the results of the federal review when the general assembly is in session, the members of the administration team shall present the results to the house committees on health care and on appropriations and the senate committees on health and welfare, on finance, and on appropriations.

(c) No later than February 1, 2013, the administration team responsible for exchange implementation shall present to the house committees on health care and on appropriations and the senate committees on health and welfare, on finance, and on appropriations the exchange certification application the

secretary of human services or designee submitted to the federal government.

* * * 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.

* * * Preconditions for Green Mountain Care * * *

Sec. 36a. 33 V.S.A. § 1822 is amended to read:

§ 1822. IMPLEMENTATION; WAIVER

(a) Green Mountain Care shall be implemented 90 days following the last to occur of:

* * *

(5) A determination by the Green Mountain Care ~~Board~~ board, as the result of a detailed and transparent analysis, that each of the following conditions will be met:

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

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy. This determination shall include an analysis of the impact of implementation on economic growth.

(C) The financing for Green Mountain Care is sustainable. In this analysis, the board shall consider at least a five-year revenue forecast using the consensus process established in 32 V.S.A. § 305a, projections of federal and other funds available to support Green Mountain Care, and estimated expenses for Green Mountain Care for an equivalent time period.

(D) Administrative expenses in Vermont's health care system for which data are available will be reduced below 2011 levels, adjusted for inflation and other factors as necessary to reflect the present value of 2011 dollars at the time of the analysis.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending without reducing access to necessary care or resulting in excessive wait times for services.

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

* * *

(c) The Green Mountain Care board's analysis prepared pursuant to subdivision (a)(5) of this section shall be made available to the general assembly and the public and shall include:

(1) a complete fiscal projection of revenues and expenses, as described in subdivision (a)(5) of this section, including reserves, if recommended, and other costs in addition to the cost of services, over at least a five-year period for a public-private universal health care system providing benefits with an actuarial value of 80 percent or greater;

(2) the financing plans provided to the general assembly in January 2013 pursuant to Sec. 9 of No. 48 of the Acts of 2011;

(3) an analysis of how implementing Green Mountain Care will further the principles of health care reform expressed in 18 V.S.A. § 9371 beyond the reforms established through the Blueprint for Health; and

(4) a comparison of best practices for reducing health care costs in self-funded plans, if available.

Sec. 36b. JOINT FISCAL OFFICE REVIEW

(a) Within 90 days following a determination by the Green Mountain Care board pursuant to 33 V.S.A. § 1822 that the preconditions for Green Mountain Care have been met, the joint fiscal committee shall direct the legislative joint fiscal office to prepare a review of the board's findings, including an evaluation of the assumptions that formed the basis for the board's analysis. The joint fiscal office shall present its review to the house committees on health care and on appropriations, the senate committees on health and welfare and on appropriations, the governor, and the Green Mountain Care board; provided, however, that if the general assembly is not in session at the time the office completes its review, the office shall present the review to the joint fiscal committee in lieu of the committees of jurisdiction.

(b) The joint fiscal office may hire consultants as necessary to carry out its duties under this section.

* * * 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 financial regulation, 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 financial regulation 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 Care Oversight Committee * * *

Sec. 40d. 2 V.S.A. chapter 24 is amended to read:

CHAPTER 24. HEALTH ~~ACCESS~~ CARE OVERSIGHT COMMITTEE

§ 851. CREATION OF COMMITTEE

(a) A legislative health ~~access~~ care oversight committee is created. The committee shall be appointed biennially and consist of ten members: five members of the house appointed by the speaker, not all from the same political party, and five members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include ~~two members~~ one member from the house committee on human services, ~~two members~~ one member from the house committee on health care, ~~and~~ one member from the house committee on appropriations, and two at-large members. The senate appointees shall include ~~three members~~ one member from the senate committee on health and welfare, one member from the senate committee on finance, ~~and~~ one member from the senate committee on appropriations, and two at-large members.

(b) The committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The health ~~access~~ care 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, including programs and initiatives related to mental health, substance abuse treatment, and health care reform.

(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 agency of human services.~~

~~(6) The attorney general.~~

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

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

~~(9) Any other person or entity as determined by the committee~~ with consumers, providers, advocates, administrative agencies and departments, and other interested parties.

(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~~ committees of jurisdiction.

§ 853. MEETINGS AND STAFF SUPPORT

(a) The committee may meet during a session of the general assembly at the call of the chair or by a majority of the members of the committee. The committee may meet during adjournment subject to the approval of the speaker of the house and the president pro tempore of the senate.

(b) For attendance at meetings which are held when the general assembly is not in session, the members of the committee shall be entitled to the same per diem compensation and reimbursement for necessary expenses as those provided to members of standing committees under section 406 of this title.

(c) The staff of the legislative council and the joint fiscal office shall provide professional and administrative support to the committee. The department of ~~banking, insurance, securities, and health care administration~~ financial regulation, the agency of human services, and other agencies of the state shall provide information, assistance, and support upon request of the committee.

* * * 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) 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.

(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), 4077 (industrial policies), and 4078 (franchise plan policies) are repealed on July 1, 2012.

Sec. 41a. TRANSITIONAL PROVISIONS; IMPLEMENTATION

(a)(1) 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 that took effect prior to January 1, 2014.

(2) Notwithstanding subdivision (1) of this subsection, the commissioner of financial regulation may, in his or her discretion, allow for the extension of a small group or association plan beyond the plan's renewal date in order to ensure a smooth and orderly transition from health plans offered in the small group and association markets in 2013 to health plans offered in the small group market through the Vermont health benefit exchange in 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 March 31, 2014, pursuant to

federal law.

(c) Notwithstanding Sec. 41(i) of this act, repealing 8 V.S.A. §§ 4080a and 4080b, the department of financial regulation 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 financial regulation may allow individuals and small employers to extend coverage under an existing health insurance plan. The department of financial regulation 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 financial regulation 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.

41b. MEDICARE SUPPLEMENTAL INSURANCE; WEB PORTAL

Nothing in this act shall be construed to prohibit the department of Vermont health access from allowing Medicare supplemental insurance to be offered on the web portal for the Vermont health benefit exchange, nor to require that the cost of providing such offerings on the web portal be paid in whole or in part with federal funds. Prior to allowing Medicare supplemental insurance to be offered on the Vermont health benefit exchange web portal, the department shall seek the input of consumers, insurers, and other stakeholders.

Sec. 41c. STATUTORY REVISION

The legislative council, in its statutory revision authority under 2 V.S.A. § 424, is directed to replace the term "health access oversight committee" in the Vermont Statutes Annotated wherever it appears with the term "health care oversight committee."

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), 11c (parity for primary mental health care services), 12–14 (Green Mountain Care board duties, health care administration), 23 (hospital budgets), 24 (provider bargaining groups), 25–26 (insurance rate reviews), 26a (consumer protection report), 27 (payment reform pilot projects, 28 (Blueprint for Health), 28a (Blueprint intent), 29 (HMO reporting requirements), 33–35a (waivers), 35c (transition planning and exchange updates), 36 (health access eligibility unit), 36a (preconditions for Green Mountain Care), 36b (JFO review), 37–39 (technical/clarifying changes), 40b (transfer of position), 40c (maximizing federal funds), 41 (repeals), 41a (transitional provisions), and 41b (Medicare supplemental policies) 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), 2c (exchange options), 2d (brokers and agents), 2f and 2g (brokers' fee disclosure), and 2h (bronze plan disclosures) 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 July 1, 2012 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), (e), and (f) (prescription drug coverage); 32a and 32b (prescribed products); 35b (Medicaid and exchange advisory committee); 39a (sports injuries); 40d (health care oversight committee); and 41c (statutory revision) shall take effect on July 1, 2012.

(2) Sec. 32(b), (c), and (d) (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 financial regulation 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.

(i) Secs. 11b (mental health and substance abuse quality assurance), 11e (rulemaking; mental health co-payment parity), 11f (mental health care ombudsman), 11g (payment; definitions), and 11h (prior authorization) of this act shall take effect on July 1, 2012.

(j) Secs. 24a–24f (medical malpractice reform) shall take effect on February 1, 2013.

(k) Sec. 11d (parity for mental health co-payments) of this act shall take effect on January 1, 2014, and shall apply to health insurance plans on and after January 1, 2014 on such date as a health insurer issues, offers, or renews the health insurance plan, but in no event later than January 1, 2015.

(l) Sec. 2e (ban on brokers' fees inside insurance rates) of this act shall take effect on January 1, 2014 and shall apply to all health insurers on and after January 1, 2014 on such date as a health insurer issues, offers, or renews a health insurance policy, but in no event later than January 1, 2015.

Rep. Michael Fisher

Rep. Sarah Copeland-Hanzas

Rep. Leigh Dakin

Committee on the part of the House

Sen. Claire Ayer

Sen. Kevin Mullin

Sen. Sally Fox

Committee on the part of the Senate

H. 771

An act relating to making technical corrections and other miscellaneous changes to education law

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

H. 771 An act relating to making technical corrections and other miscellaneous changes to education law

Respectfully reports that it has met and considered the same and recommends that the House accede to the Senate proposal of amendment with the following amendment thereto:

First: By striking out Secs. 33 and 34 in their entirety and inserting in lieu thereof the following:

Sec. 33. [Deleted.]

Sec. 34. 16 V.S.A. § 822a is added to read:

§ 822a. PUBLIC HIGH SCHOOL CHOICE

(a) Definitions. In this section:

(1) "High school" means a public school or that portion of a public school that offers grades 9 through 12 or some subset of those grades.

(2) "Student" means a student's parent or guardian if the student is a minor or under guardianship and means a student himself or herself if the student is not a minor.

(b) Limits on transferring students. A sending high school board may limit the number of resident students who transfer to another high school under this section in each year; provided that in no case shall it limit the potential number

of new transferring students to fewer than five percent of the resident students enrolled in the sending high school as of October 1 of the academic year in which the calculation is made or 10 students, whichever is fewer; and further provided that in no case shall the total number of transferring students in any year exceed 10 percent of all resident high school students or 40 students, whichever is fewer.

(c) Capacity. On or before February 1 each year, the board of a high school district shall define and announce its capacity to accept students under this section. The commissioner shall develop, review, and update guidelines to assist high school district boards to define capacity limits. Guidelines may include limits based on the capacity of the program, class, grade, school building, measurable adverse financial impact, or other factors, but shall not be based on the need to provide special education services.

(d) Lottery.

(1) Subject to the provisions of subsection (f) of this section, if more than the allowable number of students wish to transfer to a school under this section, then the board of the receiving high school district shall devise a nondiscriminatory lottery system for determining which students may transfer.

(2) Subject to the provisions of subsection (f) of this section, if more than the allowable number of students wish to transfer from a school under this section, then the board of the sending high school district shall devise a nondiscriminatory lottery system for determining which students may transfer; provided, however:

(A) a board shall give preference to the transfer request of a student whose request to transfer from the school was denied in a prior year; and

(B) a board that has established limits under subsection (b) of this section may choose to waive those limits in any year.

(e) Application and notification.

(1) A high school district shall accept applications for enrollment until March 1 of the school year preceding the school year for which the student is applying.

(2) A high school district shall notify each student of acceptance or rejection of the application by April 1 of the school year preceding the school year for which the student is applying.

(3) An accepted student shall notify both the sending and the receiving high schools of his or her decision to enroll or not to enroll in the receiving high school by April 15 of the school year preceding the school year for which the student has applied.

(4) After sending notification of enrollment, a student may enroll in a school other than the receiving high school only if the student, the receiving high school, and the high school in which the student wishes to enroll agree. If the student becomes a resident of a different school district, the student may enroll in the high school maintained by the new district of residence.

(5) If a student who is enrolled in a high school other than in the school district of residence notifies the school district of residence by July 15 of the intent to return to that school for the following school year, the student shall be permitted to return to the high school in the school district of residence without requiring agreement of the receiving district or the sending district.

(f) Continued enrollment. An enrolled nonresident student shall be permitted to remain enrolled in the receiving high school without renewed applications in subsequent years unless:

(1) the student graduates;

(2) the student is no longer a Vermont resident; or

(3) the student is expelled from school in accordance with adopted school policy.

(g) Tuition and other costs.

(1) Unless the sending and receiving schools agree to a different arrangement, no tuition or other cost shall be charged by the receiving district or paid by the sending district for a student transferring to a different high school under this section; provided, however, a sending high school district shall pay special education and technical education costs for resident students pursuant to the provisions of this title.

(2) A student transferring to a different high school under this section shall pay no tuition, fee, or other cost that is not also paid by students residing in the receiving district.

(3) A district of residence shall include within its average daily membership any student who transfers to another high school under this section; a receiving school district shall not include any student who transfers to it under this section.

(h) Special education. If a student who is eligible for and receiving special education services chooses to enroll in a high school other than in the high school district of residence, then the receiving high school shall carry out the individualized education plan, including placement, developed by the sending high school district. If the receiving high school believes that a student not on an individualized education plan may be eligible for special education services or that an existing individualized education plan should be altered, it shall

notify the sending high school district. When a sending high school district considers eligibility, development of an individualized education plan, or changes to a plan, it shall give notice of meetings to the receiving high school district and provide an opportunity for representatives of that district to attend the meetings and participate in making decisions.

(i) Suspension and expulsion. A sending high school district is not required to provide services to a resident student during a period of suspension or expulsion imposed by another high school district.

(j) Transportation. Jointly, the superintendent of each supervisory union shall establish and update a statewide clearinghouse providing information to students about transportation options among the high school districts.

(k) Nonapplicability of other laws. The provisions of subsections 824(b) and (c) (amount of tuition), 825(b) and (c) (maximum tuition rate), and 826(a) (notice of tuition change) and section 836 (tuition overcharge and undercharge) of this chapter shall not apply to enrollment in a high school pursuant to this section.

(l) Waiver. If a high school board determines that participation under this section would adversely affect students in its high school, then it may petition the commissioner for an exemption. The commissioner's decision shall be final.

(m) Report. Notwithstanding 2 V.S.A. § 20(d), the commissioner shall report annually in January to the senate and house committees on education on the implementation of public high school choice as provided in this section, including a quantitative and qualitative evaluation of the program's impact on the quality of educational services available to students and the expansion of educational opportunities.

Second: By striking out Sec. 38 in its entirety and inserting in lieu thereof a new Sec. 38 to read:

Sec. 38. EFFECTIVE DATE; IMPLEMENTATION

(a) Secs. 18–31 (audits) of this act shall take effect on July 1, 2013.

(b) Secs. 34, 35, and 37 of this act (statewide high school choice) shall take effect on July 1, 2012; provided, however, that Sec. 34 shall apply to enrollment in the 2013–2014 academic year and after.

(c) Sec. 36 (repeal of regional high school choice) of this act shall take effect on July 1, 2013; provided, however, that 16 V.S.A. § 1622 shall apply to enrollment in the 2012–2013 academic year and shall not apply to the process for determining enrollment in the 2013–2014 academic year.

(d) This section and all other sections of this act shall take effect on passage.

Rep. Johannah Donovan

Rep. Howard Crawford

Rep. Peter Peltz

Committee on the part of the House

Sen. Kevin Mullin

Sen. Robert Starr

Sen. William Doyle

Committee on the part of the Senate

S. 116

An act relating to probate proceedings

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

S. 116 An act relating to probate proceedings

Respectfully report that they have met and considered the same and recommend that the House recede from its proposal of amendment and the bill be further amended as follows:

by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. Rule 4(e) of the Vermont Rules of Probate Procedure is amended to read:

(e) Service by publication. When service by publication is required by this rule or by order of the court, the person directed by the court shall cause the substance of the notice prescribed by subdivision (a) of this rule, and a brief statement of the object of the petition, to be published ~~once a week for two successive weeks and at least seven days apart~~ in a ~~designated~~ newspaper of general circulation in the probate district where the petition was filed, or such other location as the court may direct. The ~~first~~ publication of the notice shall be made within 20 days after the petition is filed or the order is granted. Service by publication is complete on the day of ~~the last~~ publication.

Sec. 2. Rule 17 of the Vermont Rules of Probate Procedure is amended to read:

Rule 17. PARTIES GENERALLY

(a) Parties at commencement. At the commencement of a probate proceeding all interested persons shall be considered parties and shall be served with notice pursuant to Rule 4.

(1)(A) Decedent's estates. At commencement of a probate proceeding involving a decedent's estate, the term "interested person" includes heirs, devisees, legatees, children, spouses, and such other persons as the court directs. The term "interested person" also includes the trustees of any trusts to which assets of the decedent's estate may be distributed. Notice to a trustee shall be sufficient to notify the trust's beneficiaries. It also includes persons having priority for appointment as executor or administrator, and other fiduciaries representing interested persons.

(B) The court, on motion, may order that an interested party need not be served with notice pursuant to Rule 4:

(i) if after due diligence the interested party cannot be located; or

(ii) for other good cause shown if the court finds that not providing such notice serves the interests of justice and the efficient administration of the estate.

* * *

Sec. 3. 14 V.S.A. § 3504 is amended to read:

§ 3504. SCOPE OF AUTHORITY

(a)(1) The agent shall have the authority to act on the principal's behalf as to all lawful subjects and purposes, but only to the extent such authority is given under the terms of the power of attorney, subject to section 3506 of this title and subsections (b) through (g) of this section.

(2) A general power of attorney created under this subchapter shall be construed to grant powers that are not expressly delineated in the terms of the power of attorney if it appears from the relevant facts and circumstances that the principal intended the agent to have general authority to act on the principal's behalf with respect to all lawful subjects and purposes. The specific inclusion or exclusion of one or more powers shall not, by itself, prevent a determination that the principal intended to grant general authority to the agent with respect to subjects not specifically included or excluded.

* * *

Sec. 4. 14 V.S.A. § 3516 is amended to read:

§ 3516. EFFECTIVE DATE; EFFECT ON EXISTING POWERS OF

ATTORNEY

(a) A power of attorney shall be valid if it:

(1) complies with the terms of this subchapter; or

(2) is executed before July 1, 2002 and valid under common law or statute existing at the time of execution.

(b) If a power of attorney executed before July 1, 2002 was valid under common law or statute existing at the time of execution, any exercise of authority under the power of attorney, whether before or after July 1, 2002, shall be deemed valid if the exercise complies with common law or statute existing at the time of execution.

Sec. 5. 24 V.S.A. § 133 is amended to read:

§ 133. COUNTY TAX; AMOUNT; ASSESSMENT

* * *

(e) The proposed budget shall contain any cost estimates and preliminary plans for capital construction in the county pursuant to subchapter 2 of chapter 3 of this title, estimates of the indebtedness of the county, estimates of the probable ordinary expenses of the county for the ensuing year, and any and all other expenses and obligations of the county. The budget may contain provision for additions to ~~a~~ an operations reserve fund and the accumulated total reserve fund shall not at any time exceed an amount equal to ~~ten~~ 15 percent of the current budget presented. Pursuant to a capital program, as described in section 4426 of this title, the budget may also include a provision for a separate reserve fund for capital construction, reconstruction, remodeling, repairs, renovation, design, or redesign which shall not at any time exceed an amount equal to ~~50~~ 75 percent of the current budget presented. However, if capital construction, reconstruction, remodeling, repairs, renovation, design, or redesign is necessitated by an insured loss or damage to a county building, the separate reserve fund may also include the amount of insurance proceeds received as a result of the loss or damage. All county budgets shall be presented on the form prescribed by the auditor of accounts, after consultation with the association of assistant judges, and shall include the amounts currently budgeted for each item included in the proposed budget.

Sec. 6. MINOR GUARDIANSHIP STUDY COMMITTEE

The minor guardianship study committee created by Sec. 23 of No. 56 of the Acts of 2011 shall continue to meet during 2012 and shall report any additional findings and recommendations to the house and senate committees on judiciary, the house committee on human services, and the senate committee on health and welfare on or before December 15, 2012, whereupon

it shall cease to exist.

Sec. 7. EFFECTIVE DATE

This act shall take effect on passage.

and that after passage the title of the bill be amended to read: "An act relating to probate proceedings, powers of attorney, and county budget reserve funds"

Rep. Thomas Koch

Rep. William Lippert

Rep. Richard Marek

Committee on the part of the House

Sen. Alice Nitka

Sen. Richard Sears

Sen. Margaret Flory

Committee on the part of the Senate

S. 200

An act relating to the reporting requirements of health insurers

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

S. 200 An act relating to the reporting requirements of health insurers

Respectfully report that they have met and considered the same and recommend that the Senate accede to the House proposal of amendment and the House proposal be further amended as follows:

First: In Sec. 1, 18 V.S.A. § 9414a, subsection (a), in the first sentence, by striking the number "5,000" and inserting in lieu thereof "2,000"

Second: In Sec. 1, 18 V.S.A. § 9414a, subdivision (a)(9)(A), by striking "names, positions," and inserting in lieu thereof "titles"

Rep. Sarah Copeland- Hanzas

Rep. Christopher Pearson

Rep. Patricia Komline

Committee on the part of the House

Sen. Richard McCormack

Sen. Anthony Pollina

Committee on the part of the Senate

S. 217

An act relating to closely held benefit corporations

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

S. 217 An act relating to closely held benefit corporations

Respectfully report that they have met and considered the same and recommend that the House recede from its proposal of amendment and the bill be further amended as follows:

in Sec. 1, in 11A V.S.A. § 21.10(e)(1), by striking "one million dollars" and inserting in lieu thereof "five million dollars"

Rep. Michele Kupersmith

Rep. Eileen Dickinson

Rep. Samuel Young

Committee on the part of the House

Sen. Randolph Brock

Sen. Richard McCormack

Sen. William Carris

Committee on the part of the Senate

S. 245

An act relating to requiring cardiovascular care instruction in public and independent schools

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

S. 245 An act relating to requiring cardiovascular care instruction in public and independent schools

Respectfully report that they have met and considered the same and recommend that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 16 V.S.A. § 131 is amended to read:

§ 131. DEFINITIONS

For the purposes of this subchapter, "comprehensive health education" means a systematic and extensive elementary and secondary educational program designed to provide a variety of learning experiences based upon knowledge of the human organism as it functions within its environment. The term includes the study of:

* * *

(3) Safety including:

(A) first aid, disaster prevention, and accident prevention; and

(B) information regarding and practice of compression-only cardiopulmonary resuscitation and the use of automated external defibrillators;

* * *

Sec. 2. 16 V.S.A. § 212 is amended to read:

§ 212. COMMISSIONER'S DUTIES GENERALLY

The commissioner shall execute those policies adopted by the state board in the legal exercise of its powers and shall:

* * *

(18) Annually inform superintendents and principals of regional resources available to assist schools to provide instruction in cardiopulmonary resuscitation and the use of automated external defibrillators and provide updated information to the education community regarding the provision of a comprehensive health education.

Sec. 3. REPORT

The commissioner of education shall electronically query superintendents and principals regarding whether and to what extent the instruction of cardiopulmonary resuscitation and the use of automated external defibrillators is offered in the schools of the state. Specifically, the commissioner shall determine in what grades, for what periods of time, and in connection with what underlying courses instruction is offered. The commissioner shall report the results of this data collection to the senate and house committees on education on or before February 1, 2013.

Sec. 4. EFFECTIVE DATE

This act shall take effect on passage.

Rep. Johanna Donovan

Rep. Kevin Christie

Rep. Brian Campion

Committee on the part of the House

Sen. William Doyle

Sen. Virginia Lyons

Sen. Philip Baruth

Committee on the part of the Senate

S. 251

An act relating to miscellaneous amendments to laws pertaining to motor vehicles

TO THE SENATE AND HOUSE OF REPRESENTATIVES:

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

S. 251 An act relating to miscellaneous amendments to laws pertaining to motor vehicles

Respectfully report that they have met and considered the same and recommend that the bill be amended as follows:

that the Senate accede to the House's proposal of amendment to add Sec. 12 to the bill and to renumber the remaining section to be numerically correct, and that the House recede from its proposal of amendment to add Secs. 13–15 to the bill.

Rep. Diane Lanpher

Rep. Clement Bissonnette

Rep. Charles Bohi

Committee on the part of the House

Sen. Robert Hartwell

Sen. Richard Westman

Sen. Richard Mazza

Committee on the part of the Senate

Ordered to Lie

H. 775

An act relating to allowed interest rates for installment loans.

Pending Action: Second Reading of the bill.