Senate Calendar

WEDNESDAY, MARCH 28, 2012

SENATE CONVENES AT: 3:30 P.M.

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Second Reading

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ORDERS OF THE DAY

ACTION CALENDAR

CALLED UP FOR ACTION

Third Reading

S. 138.

An act relating to the record keeping of search warrants.

PENDING QUESTION: Shall the amendment proposed by Senators Benning and Baruth be substituted as moved by Sen. Sears on behalf of the Committee on Judiciary?

AMENDMENT TO S. 138 TO BE OFFERED BY SENATORS BENNING, BARUTH, SEARS AND ASHE BEFORE THIRD READING

Senators Benning, Baruth, Sears and Ashe move that the bill be amended in Sec. 9 [amending the Nonviolent Misdemeanor Sentence Review Committee established in Sec. 4 of No. 41 of the Acts of 2011] as follows:

First: In subsection (c), at the end of subdivision (1) by adding new subdivisions (E) and (F) to read as follows:

(E) Examine whether the state should decriminalize the possession of small amounts of marijuana and substitute a civil penalty administered through the judicial bureau.

(F) Review current state law and policy concerning minors possessing alcoholic beverages.

Second: By striking out subsection (d) in its entirety and inserting in lieu thereof the following:

(d) Report. By ~~December 1, 2011~~ November 15 annually, the committee shall report to the general assembly on its findings and any recommendations for legislative action.

UNFINISHED BUSINESS

Third Reading

S. 151.

An act relating to veterans' grave markers.

AMENDMENT TO S. 151 TO BE OFFERED BY SENATOR ASHE BEFORE THIRD READING

Senator Ashe moves to amend the bill by striking out all after the enacting

clause and inserting in lieu thereof the following:

Sec. 1. 9 V.S.A. chapter 86 is added to read:

CHAPTER 86. PURCHASE OF GRAVE MARKERS

§ 3221. GRAVE MARKERS AND ORNAMENTS

(a) A person shall not knowingly purchase, accept, or give anything of value in exchange for a metal grave marker, or any ornament or flag holder bearing a description or an emblem from any branch of the United States armed services or a police or fire department or which bears the designation "veteran."

(b) A person that violates this section shall be subject to a criminal fine of not more than $5,000.00 per violation.

S. 179.

An act relating to amending perpetual conservation easements.

S. 222.

An act relating to cost-sharing for employer-sponsored insurance assistance plans.

Second Reading

Favorable with Recommendation of Amendment

S. 183.

An act relating to the testing of potable water supplies.

Reported favorably with recommendation of amendment by Senator Brock for the Committee on Natural Resources and Energy.

The Committee recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds and declares that:

(1) The U.S. Environmental Protection Agency and the Vermont department of health estimate that 40 percent of Vermont residents obtain drinking water from groundwater sources.

(2) Property owners currently are not required to test groundwater sources that are a potable water supply serving one single-family residence.

(3) In adults and especially in children, consumption of contaminated groundwater can cause serious health effects, such as digestive problems, kidney problems, blue baby syndrome, and brain damage.

(4) The state lacks a comprehensive database or map identifying where groundwater contamination is prevalent in the state.

(5) To help mitigate the potential health effects of consumption of contaminated groundwater, the state should conduct education and outreach regarding the need for property owners to test the water quality of groundwater used as a potable water supply.

(6) The state should utilize tests of groundwater sources to identify groundwater contamination in the state so that the department of health can recommend treatment options to property owners in certain parts of the state.

Sec. 2. 10 V.S.A. 1396 is amended to read:

§ 1396. RECORDS AND REPORTS

(a) Each licensee shall keep accurate records and file a report with the department and well owner on each water well constructed or serviced, including but not limited to the name of the owner, location, depth, character of rocks or earth formations and fluids encountered, and other reasonable and appropriate information the department may, by rule, require.

(b) The reports required to be filed under subsection (a) of this section shall be on forms provided by the department as follows:

(1) Each licensee classified as a water well driller shall submit a well completion report within 90 days after completing the construction of a water well.

(2) Each licensee classified as a monitoring well driller shall submit a monitoring well completion or closure report or approved equivalent within 90 days after completing the construction or closure of a monitoring well. Reporting on the construction of a monitoring well shall be limited to information obtained at the time of construction and need not include the work products of others. The filing of a monitoring well completion or closure report shall be delayed for one or more six-month periods from the date of construction upon the filing of a request form provided by the department which is signed by both the licensee and well owner.

(3), (4) [Repealed.]

(c) No report shall be required to be filed with the department if the well is hand driven or is dug by use of a hand auger or other manual means.

(d) On or after January 1, 2013, a licensee drilling or developing a new water well for use as a potable water supply, as that term is defined in subdivision 1972(6) of this title, shall provide the owner of the property to be served by the groundwater source informational materials developed by the department of health regarding:

(1) the potential health effects of the consumption of contaminated groundwater; and

(2) recommended tests for specific contaminants.

Sec. 3. 18 V.S.A. § 501b is amended to read:

§ 501b. CERTIFICATION OF LABORATORIES

(a) The commissioner may certify a laboratory to perform the testing and monitoring required under 10 V.S.A. chapter 56 and the federal Safe Drinking Water Act, and of water supplies from a potable water supply, as that term is defined in 10 V.S.A. § 1972(6), if such laboratory meets the standards currently in effect of the National Environmental Laboratory Accreditation Conference and is accredited by an approved National Environmental Laboratory Accreditation Program accrediting authority or its equivalent.

(b)(1) The commissioner may by order suspend or revoke a certificate granted under this section, after notice and opportunity to be heard, if the commissioner finds that the certificate holder has:

(A) submitted materially false or materially inaccurate information; or

(B) violated any material requirement, restriction or condition of the certificate; or

(C) violated any statute, rule or order relating to this title.

(2) The order shall set forth what steps, if any, may be taken by the certificate holder to relieve the holder of the suspension or enable the certificate holder to reapply for certification if a previous certificate has been revoked.

(c) A person may appeal the suspension or revocation of the certificate to the board under section 128 of this title.

* * *

(f) A laboratory accredited to conduct testing of water supplies from a potable water supply, as that term is defined in 10 V.S.A. § 1972(6), shall submit the results of groundwater analyses to the department of health and the agency of natural resources in a format required by the department of health.

Sec. 4. 27 V.S.A. § 616 is added to read:

§ 616. GROUNDWATER SOURCE TESTING; DISCLOSURE OF EDUCATIONAL MATERIAL

(a) Disclosure of potable water supply. Prior to the time of a purchase and sale agreement for residential housing property executed on or after January 1, 2013, the seller shall provide the buyer with a disclosure form provided by the department of health indicating whether the property has a potable water supply, as that term is defined in 10 V.S.A. § 1972(6), that is used as the primary drinking water source for the residential housing on the property.

(b) Disclosure of health effects. The disclosure form required by subsection (a) of this section shall include informational materials regarding the potential health effects of the consumption of contaminated groundwater.

(c) Disclosure of opportunity to test. The disclosure form required by subsection (a) of this section shall include a statement regarding the buyer's opportunity under the purchase and sale agreement to test the potable water supply. The disclosure form shall also indicate that the buyer may obtain test kits from the department of the health.

(d) Marketability of title. Noncompliance with the requirements of this section shall not affect the marketability of title of a property.

Sec. 5. DEPARTMENT OF HEALTH; EDUCATION AND OUTREACH ON SAFE DRINKING WATER

The department of health, after consultation with the agency of natural resources, shall revise and update its education and outreach materials regarding the potential health effects of contaminants in groundwater sources of drinking water in order to improve citizen access to such materials and to increase awareness of the need to conduct testing of groundwater sources. In revising and updating its education and outreach materials, the department shall update the online safe water resource guide by incorporating the most current information on the health effects of contaminants, treatment of contaminants, and causes of contamination and by directly linking users to the department of health contaminant fact sheets.

Sec. 6. EFFECTIVE DATES

This act shall take effect on January 1, 2013.

(Committee vote: 5-0-0)

S. 223.

An act relating to extending health insurance coverage for autism spectrum disorders.

Reported favorably with recommendation of amendment by Senator Pollina for the Committee on Health and Welfare.

The Committee recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. § 4088i is amended to read:

§ 4088i. COVERAGE FOR DIAGNOSIS AND TREATMENT OF ~~AUTISM SPECTRUM~~ EARLY CHILDHOOD DEVELOPMENTAL DISORDERS

(a)(1) A health insurance plan shall provide coverage for the evidence-based diagnosis and treatment of ~~autism spectrum disorders~~ early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at 18 months of age and continuing until the child reaches age ~~six or enters the first grade, whichever occurs first~~ 21.

(2) Coverage provided pursuant to this section by Medicaid, the Vermont health access plan, or any other public health care assistance program shall comply with all federal requirements imposed by the Centers for Medicare and Medicaid Services.

(3) Any benefits required by this section that exceed the essential health benefits specified under Section 1302(b) of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended, shall not be required in a health insurance plan offered in the individual, small group, and large group markets on and after January 1, 2014.

(b) ~~A health insurance plan shall not limit in any way the number of visits an individual eligible for coverage under subsection (a) of this section may have with an autism services provider~~ The amount, frequency, and duration of treatment described in this section shall be based on medical necessity and may be subject to a prior authorization requirement under the health insurance plan. A private health insurance plan may limit coverage for applied behavior analysis treatment to a maximum benefit of $50,000.00 a year, but shall not apply payments for coverage unrelated to early childhood disorders to any maximum benefit established under this subsection.

(c) A health insurance plan shall not impose greater coinsurance, co-payment, deductible, or other cost-sharing requirements for coverage of the diagnosis or treatment of ~~autism spectrum~~ early childhood developmental

disorders than apply to the diagnosis and treatment of any other physical or mental health condition under the plan.

(d)(1) A health insurance plan shall provide coverage for applied behavior analysis when the services are provided or supervised by a licensed provider who is working within the scope of his or her license or who is a nationally board-certified behavior analyst.

(2) A health insurance plan shall provide coverage for services under this section delivered in the natural environment when the services are furnished by a provider working within the scope of his or her license or under the direct supervision of a licensed provider or, for applied behavior analysis, by or under the supervision of a nationally board-certified behavior analyst.

(e) Except for inpatient services, if an individual is receiving treatment for an early developmental delay, a health insurance plan may review the treatment plan for children under the age of eight no more frequently than once every six months. After the child reaches the age of eight, the health insurance plan may require treatment plan reviews based on the needs of the individual beneficiary, consistent with reviews for other diagnostic areas and with rules established by the department of banking, insurance, securities, and health care administration.

(f) As used in this section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) ~~"Autism services provider" means any licensed or certified person providing treatment of autism spectrum disorders.~~

~~(3)~~ "Autism spectrum disorders" means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger's disorder.

(3) "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that are:

(A) necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to his or her best functional level, or to ensure that an individual under the age of 21 achieves proper growth and development;

(B) provided or supervised by a nationally board-certified behavior analyst or by a licensed provider, so long as the services performed are within the provider's scope of practice and certifications.

(4) "Diagnosis of ~~autism spectrum disorder~~ early childhood developmental disorders" means medically necessary assessments~~;~~, evaluations, ~~including neuropsychological evaluations; genetic testing; or other testing~~ or tests to determine whether an individual has ~~one or more~~ an early childhood developmental delay, including an autism spectrum ~~disorders~~ disorder.

(5) ~~"Habilitative care" or "rehabilitative care" means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals the provider has identified~~ "Early childhood developmental disorder" means a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitations in major life activities, accompanied by a diagnosis defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease (ICD). The term includes autism spectrum disorders, but does not include a learning disability.

(6) "Evidence-based" means the same as in 18 V.S.A. § 4621.

(7) "Health insurance plan" means Medicaid, the Vermont health access plan, and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include benefit plans providing coverage for specific diseases or other limited benefit coverage.

~~(7)~~(8) "Medically necessary" ~~means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician licensed pursuant to chapter 23 of Title 26 or by a psychologist licensed pursuant to chapter 55 of Title 26 if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing~~ describes health care services that are appropriate in terms of type, amount, frequency, level, setting, and duration to the individual's diagnosis or condition, are informed by generally accepted medical or scientific evidence, and are consistent with generally accepted practice parameters. Such services shall be informed by the unique needs of

each individual and each presenting situation, and shall include a determination that a service is needed to achieve proper growth and development or to prevent the onset or worsening of a health condition.

(9) "Natural environment" means a home or child care setting.

(10) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need for or effectiveness of a medication.

(11) "Psychiatric care" means direct or consultative services provided by a licensed physician certified in psychiatry by the American Board of Medical Specialties.

(12) "Psychological care" means direct or consultative services provided by a psychologist licensed pursuant to 26 V.S.A. chapter 55.

~~(8)~~(13) "Therapeutic care" means services provided by licensed or certified speech language ~~pathologists~~ therapists, occupational therapists, or physical therapists~~, or social workers~~.

~~(9)~~(14) "Treatment ~~of disorders~~ for early developmental disorders" means ~~the following~~ evidence-based care and related equipment prescribed~~, provided,~~ or ordered for an individual ~~diagnosed with one or more autism spectrum disorders~~ by a licensed physician ~~licensed pursuant to chapter 23 of Title 26~~ or a licensed psychologist ~~licensed pursuant to chapter 55 of Title 26 if such physician or psychologist~~ who determines the care to be medically necessary, including:

(A) ~~habilitative or rehabilitative care~~ behavioral health treatment;

(B) pharmacy care;

(C) psychiatric care;

(D) psychological care; and

(E) therapeutic care.

~~(e)~~(g) Nothing in this section shall be construed to affect any obligation to provide services to an individual under an individualized family service plan, individualized education program, or individualized service plan. A health insurance plan shall not reimburse services provided under 16 V.S.A. § 2959a.

Sec. 2. REPORT

It is the intent of the general assembly to accept the offer of Autism Speaks to submit a report, in consultation with the agency of human services and health insurers, to the senate committee on health and welfare and the house committee on health care on or before January 15, 2014 regarding the

implementation of this act, including an assessment of whether eligible individuals are receiving evidence-based services, how such services may be improved, and the fiscal impact of these services.

Sec. 3. EFFECTIVE DATES

(a) This act shall take effect on July 1, 2012 and shall apply to Medicaid, the Vermont health access plan, and any other public health care assistance program on or after July 1, 2012.

(b) The provisions of this act shall apply to all other health insurance plans on or after October 1, 2012, on such date as a health insurer issues, offers, or renews the health insurance plan, but in no event later than October 1, 2013.

and that after passage the title of the bill be amended to read: "An act relating to health insurance coverage for early childhood developmental disorders, including autism spectrum disorders"

(Committee vote: 4-0-1)

Reported favorably with recommendation of amendment by Senator Fox for the Committee on Finance.

The Committee recommends that the bill be amended as recommended by the Committee on Health and Welfare with further amendment thereto in Sec. 1, in 8 V.S.A. § 4088i, subsection (b), by striking out the following: ". A private health insurance plan may limit coverage for applied behavior analysis treatment to a maximum benefit of $50,000.00 a year, but shall not apply payments for coverage unrelated to early childhood disorders to any maximum benefit established under this subsection"

(Committee vote: 7-0-0)

Reported favorably by Senator Kitchel for the Committee on Appropriations.

(Committee vote: 4-0-3)

Resolution for Action

J.R.S. 52.

Joint resolution relating to the issuance of a commemorative United States postage stamp in honor of former United States Senator George D. Aiken.

(For text of resolution, see Senate Journal of March 21, 2012, page 401.)

NEW BUSINESS

Third Reading

S. 89.

An act relating to Medicaid for Working Persons with Disabilities.

S. 209.

An act relating to naturopathic physicians.

Second Reading

Favorable with Proposal of Amendment

S. 200.

An act relating to the reporting requirements of health insurers.

Reported favorably with recommendation of proposal of amendment by Senator Pollina for the Committee on Health and Welfare.

The Committee recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. § 3561(a) is amended to read:

(a)(1) Each domestic, foreign, and alien insurance company doing business in this state shall annually submit to the commissioner a statement of its financial condition, verified by oath of two of its executive officers. The statement shall be prepared in accordance with the National Association of Insurance Commissioners' Instructions Handbook and Accounting Practices and Procedures Manual 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 with any useful or necessary modifications or adaptations thereof required or approved or accepted by the commissioner for the type of insurance and kinds of insurers to be reported upon, and as supplemented by additional information required by the commissioner.

(2)(A) In addition, a health insurance company with a minimum of 200 Vermont lives covered in the relevant reporting year or which offers a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803 shall provide the following information:

(i) the total number of claims submitted to the health insurance company;

(ii) the total number of denials of service by the health insurance company at the preauthorization level, including:

(I) the total number of denials of service at the preauthorization level appealed to the health insurance company at the first level grievance;

(II) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(III) the total number of denials of service at the preauthorization level appealed to the health insurance company at any second level grievance;

(IV) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(V) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(iii) the total number of service claims denied by the health insurance company, including:

(I) the total number of denied service claims appealed to the health insurance company at the first level grievance;

(II) the total number of denied service claims overturned at the first level grievance;

(III) the total number of denied service claims appealed to the health insurance company at any second level grievance;

(IV) the total number of denied service claims overturned at any second level grievance; and

(V) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(iv) the total number of claims denied by a health insurance company for reasons not related to network issue, medical necessity, or benefit coverage.

(B) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subdivision (2)(A) of this subsection (a), and a health insurance company shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(C)(i) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each health insurance company pursuant to subdivision (2)(B) of this subsection (a).

(ii) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (i) of this subdivision (2)(C).

(3) The statement of an alien insurer shall relate only to the insurer's transactions and affairs in the United States unless the commissioner requires otherwise.

(4) A foreign or alien company, upon withdrawing from the state of Vermont shall pay to the commissioner $25.00 for the filing of its final financial statement.

Sec. 2. 8 V.S.A. § 4516 is amended to read:

§ 4516. ANNUAL REPORT TO COMMISSIONER

(a) Annually, on or before March 15, a hospital service corporation shall file with the commissioner of banking, insurance, securities, and health care administration a statement sworn to by the president and treasurer of the corporation showing its condition on December 31. The statement shall be in such form and contain such matters as the commissioner shall prescribe, including for hospital service corporations with a minimum of 200 Vermont lives covered in the relevant reporting year or which offer a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803:

(1) the total number of claims submitted to the hospital service corporation;

(2) the total number of denials of service by the hospital service corporation at the preauthorization level, including:

(A) the total number of denials of service at the preauthorization level appealed to the hospital service corporation at the first level grievance;

(B) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(C) the total number of denials of service at the preauthorization level appealed to the hospital service corporation at any second level grievance;

(D) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(E) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(3) the total number of service claims denied by the hospital service corporation, including:

(A) the total number of denied service claims appealed to the hospital service corporation at the first level grievance;

(B) the total number of denied service claims overturned at the first level grievance;

(C) the total number of denied service claims appealed to the hospital service corporation at any second level grievance;

(D) the total number of denied service claims overturned at any second level grievance; and

(E) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(4) the total number of claims denied by a hospital service corporation for reasons not related to network issue, medical necessity, or benefit coverage.

(b)(1) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subsection (a) of this section, and a hospital service corporation shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(2)(A) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each hospital service corporation pursuant to subdivision (1) of this subsection (b).

(B) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (2)(A) of this subsection (b).

(c) To qualify for the tax exemption set forth in section 4518 of this title, the statement shall include a certification that the hospital service corporation operates on a nonprofit basis for the purpose of providing an adequate hospital service plan to individuals of the state, both groups and nongroups, without

discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

Sec. 3. 8 V.S.A. § 4588 is amended to read:

§ 4588. ANNUAL REPORT TO COMMISSIONER

(a) Annually, on or before March 15, a medical service corporation shall file with the commissioner of banking, insurance, securities, and health care administration a statement sworn to by the president and treasurer of the corporation showing its condition on December 31, which shall be in such form and contain such matters as the commissioner shall prescribe, including for medical service corporations with a minimum of 200 Vermont lives covered in the relevant reporting year or which offer a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803:

(1) the total number of claims submitted to the medical service corporation;

(2) the total number of denials of service by the medical service corporation at the preauthorization level, including:

(A) the total number of denials of service at the preauthorization level appealed to the medical service corporation at the first level grievance;

(B) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(C) the total number of denials of service at the preauthorization level appealed to the medical service corporation at any second level grievance;

(D) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(E) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(3) the total number of service claims denied by the medical service corporation, including:

(A) the total number of denied service claims appealed to the medical service corporation at the first level grievance;

(B) the total number of denied service claims overturned at the first level grievance;

(C) the total number of denied service claims appealed to the medical service corporation at any second level grievance;

(D) the total number of denied service claims overturned at any second level grievance; and

(E) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(4) the total number of claims denied by a medical service corporation for reasons not related to network issue, medical necessity, or benefit coverage.

(b)(1) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subsection (a) of this section, and a medical service corporation shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(2)(A) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each medical service corporation pursuant to subdivision (1) of this subsection (b).

(B) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (2)(A) of this subsection (b).

(c) To qualify for the tax exemption set forth in section 4590 of this title, the statement shall include a certification that the medical service corporation operates on a nonprofit basis for the purpose of providing an adequate medical service plan to individuals of the state, both groups and nongroups, without discrimination based on age, gender, geographic area, industry, and medical history, except as allowed by subdivisions 4080a(h)(2)(B) and 4080b(h)(2)(B) of this title.

Sec. 4. 8 V.S.A. § 5106(a) is amended to read:

(a)(1) Every organization subject to this chapter, annually, within 120 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, including for organizations with a minimum of 200 Vermont lives covered in the relevant reporting year or which offer a plan in the Vermont health benefit exchange pursuant to 33 V.S.A. § 1803:

(A) the total number of claims submitted to the organization;

(B) the total number of denials of service by the organization at the preauthorization level, including:

(i) the total number of denials of service at the preauthorization level appealed to the organization at the first level grievance;

(ii) the total number of denials of service at the preauthorization level overturned at the first level grievance;

(iii) the total number of denials of service at the preauthorization level appealed to the organization at any second level grievance;

(iv) the total number of denials of service at the preauthorization level overturned at any second level grievance; and

(v) the total number of denials of service at the preauthorization level for which external review is sought and the number overturned by external review;

(C) the total number of service claims denied by the organization, including:

(i) the total number of denied service claims appealed to the organization at the first level grievance;

(ii) the total number of denied service claims overturned at the first level grievance;

(iii) the total number of denied service claims appealed to the organization at any second level grievance;

(iv) the total number of denied service claims overturned at any second level grievance; and

(v) the total number of denied service claims for which external review is sought and the number overturned by external review; and

(D) the total number of claims denied by an organization for reasons not related to network issue, medical necessity, or benefit coverage.

(2)(A) The department of banking, insurance, securities, and health care administration shall create a standardized form for the purpose of collecting the information described in subdivision (1) of this subsection (a), and an organization shall use the standardized form for reporting the required information as an addendum to its annual report. Where possible, the standardized form shall require that reported information be divided into categories determined by the department, including categories for coding errors, services not covered, and out-of-network providers.

(B)(i) The department of banking, insurance, securities, and health care administration shall post on its website the standardized forms completed by each organization pursuant to subdivision (2)(A) of this subsection (a).

(ii) The department of Vermont health access shall post on the Vermont health benefit exchange an electronic link to the standardized forms posted by the department of banking, insurance, securities, and health care administration pursuant to subdivision (2)(B)(i) of this subsection (a).

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2012.

(Committee vote: 5-0-0)

Reported favorably by Senator Westman for the Committee on Finance.

(Committee vote: 7-0-0)

Favorable with Proposal of Amendment

H. 634.

An act relating to remedies for failure to pay municipal tickets.

Reported favorably with recommendation of proposal of amendment by Senator White for the Committee on Judiciary.

The Committee recommends that the Senate propose to the House to amend the bill by striking out Sec. 3 in its entirety and inserting in lieu thereof a new Sec. 3 to read as follows:

Sec. 3. EFFECTIVE DATES

(a) Sec. 1 of this act shall take effect on July 1, 2012.

(b) Sec. 2 of this act and this section shall take effect on passage.

(Committee vote: 4-0-1)

(For House amendments, see House Journal for March 21, 2012, page 297.)

CONFIRMATIONS

The following appointments will be considered by the Senate, as a group, under suspension of the Rules, as moved by the President *pro tempore*, for confirmation together and without debate, by consent thereby given by the Senate. However, upon request of any senator, any appointment may be singled out and acted upon separately by the Senate, with consideration given to the report of the Committee to which the appointment was referred, and with full debate; and further, all appointments for the positions of Secretaries of Agencies, Commissioners of Departments, Judges, Magistrates, and members of the Public Service Board shall be fully and separately acted upon.

David Luce of Waterbury Center – Member of the Community High School of Vermont Board- By Sen. Kittell for the Committee on Education. (1/13/12)

Patrick Flood of East Calais – Commissioner of the Department of Mental Health – By Sen. Mullin for the Committee on Health and Welfare. (2/8/12)

John Snow of Charlotte – Member of the Vermont Economic Development Authority – By Sen. Fox for the Committee on Finance. (2/8/12)

Martin Maley of Colchester – Superior Court Judge – By Sen. Sears for the Committee on Judiciary. (2/9/12)

Alison Arms of South Burlington – Superior Court Judge – By Sen. Snelli8lng for the Committee on Judiciary. (2/16/12)

Robert Bishop of St. Johnsbury – Member of the State Infrastructure Bank Board – By Sen. MacDonald for the Committee on Finance. (2/21/12)

John Valente of Rutland – Member of the Vermont Municipal Bond Bank – By Sen. McCormack for the Committee on Finance. (2/21/12)

James Volz of Plainfield – Chair of the Public Service Board – By Sen. Cummings for the Committee on Finance. (2/21/12)

Ed Amidon of Charlotte – Member of the Valuation Appeals Board – By Sen. Ashe for the Committee on Finance. (2/21/12)

Barry Peterson of East Fairfield – Family Division Magistrate – By Sen. White for the Committee on Judiciary. (3/29/12)

NOTICE OF JOINT ASSEMBLY

Thursday, March 29, 2012 – 1:00 P.M. – Retention of Superior Court Judges: Karen R. Carroll and Dennis R. Pearson. Retention of Magistrate: Barry Peterson.

JFO NOTICE

The following items were recently received by the Joint Fiscal Committee:

JFO #2555 – $790,018 grant from the U.S. Department of Health and Human Services to the Vermont Department of Mental Health. This grant will be used to provide regular crisis counseling services to survivors of Tropical Storm Irene in Addison, Bennington, Caledonia, Chittenden, Franklin, Lamoille, Orange, Rutland, Washington, Windham and Windsor Counties.

JFO #2556 – $159,776 grant from the Federal Emergency Management Agency (FEMA) to the Vermont Department of Public Safety. This grant is pass-through funding for hazard mitigation projects in the towns of Pawlet and Waitsfield in response to the December 2010 ice storm.

JFO #2557 – $10,000 grant from National Alcohol Beverage Control Association to the Vermont Department of Liquor Control. This grant will be used to create, produce and purchase community outreach and educational materials designed to prevent underage drinking.

JFO #2558 – $15,000 grant from National Historic Publications and Records Commission to the Vermont Secretary of State. This grant will be used to establish a program support local officials and other archives in the state to preserve and make accessible Vermont's historical records.