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Second Reading

Favorable with Recommendation of Amendment

S. 169.

An act relating to workers' compensation liens.

Reported favorably with recommendation of amendment by Senator Illuzzi for the Committee on Appropriations.

The Committee recommends that the bill be amended as recommended by the Committee on Economic Development, Housing and General Affairs with the following amendments thereto:

First: In Sec. 2, in subsection (b) (Membership), in subdivisions (1) and (2), by striking out "Three" where it appears and inserting in lieu thereof the following: Two

Second: In Sec. 2, by striking out subsection (f) (Reimbursement) in its entirety and by relettering subsection (g) to be subsection (f)

(Committee vote: 5-0-2)

AMENDMENT TO S. 169 TO BE OFFERED BY SENATOR ILLUZZI ON BEHALF OF THE COMMITTEE ON ECONOMIC DEVELOPMENT, HOUSING AND GENERAL AFFAIRS

Senator Illuzzi, on behalf of the Committee on Economic Development, Housing and General Affairs, moves to amend the bill by adding Secs. 3 – 15 as follows:

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) Establishing by rule minimum standards for the credentialing of emergency medical personnel by their affiliated agency, which shall be required in addition to the licensing requirements of this chapter.

(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. 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~~ credentialed by 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.

(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~~ credentialed by 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,~~ credentialed by 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.~~

(10) The commissioner shall adopt rules related to expenditures authorized from the special fund created in section 908 of this chapter.

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

§ 908. EMERGENCY MEDICAL SERVICES SPECIAL FUND

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 training programs, injury prevention, 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. Any balance at the end of the fiscal year shall be carried forward in the fund.

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;

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

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

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

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

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

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

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

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

(11) one public member not affiliated with emergency medical services, firefighter services, or hospital services, appointed by the governor.

(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) Beginning January 1, 2013, 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 report shall include 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; and

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

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~~ and credentialed by an affiliated agency 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 and credentialed by an affiliated agency 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 agency so licensed.

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 and credentialing 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 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) Assure that each affiliated agency in the district has implemented a system for the credentialing of all its licensed emergency medical personnel.

* * *

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, credentialing, 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 on passage.

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.

UNFINISHED BUSINESS

Third Reading

H. 550.

An act relating to the Vermont administrative procedure act.

Second Reading

Favorable

H. 157.

An act relating to restrictions on tanning beds.

PENDING QUESTION: Shall the bill be read the Third time?

H. 327.

An act relating to the uniform principal and income act .

Reported favorably by Senator Cummings for the Committee on Judiciary.

(Committee vote: 4-0-1)

(For House amendments, see House Journal for February 2, 2012, page 168.)

Favorable with Recommendation of Amendment

S. 20.

An act relating to financing campaigns for elected office.

Reported favorably with recommendation of amendment by Senator White for the Committee on Government Operations.

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 that:

(1) Large campaign contributions reduce public confidence in the electoral process and increase the risk and the appearance that candidates and elected officials may be beholden to contributors and not act in the best interests of all Vermont citizens.

(2) In Vermont, contributions greater than the amounts specified in this act are considered by the general assembly, candidates, and elected officials to be large contributions.

(3) In Vermont, candidates can raise sufficient monies to fund effective, competitive campaigns from contributions no larger than the amounts specified in this act.

(4) Limiting large contributions will encourage direct and small group contact between candidates and the electorate and will encourage the personal

involvement of a larger number of citizens in campaigns, both of which are crucial to public confidence and the robust debate of issues.

(5) Identification of persons who publish political advertisements and electioneering communications provides the public with important information to evaluate advertising messages during an election campaign.

(6) Individuals who and companies which wish to influence voters but do not want to be particularly visible to the public during an election campaign often make contributions to political committees rather than sponsor campaign advertisements themselves. Disclosure of the identity of contributors to political committees provides the public with important information to evaluate the political committees' advertising messages and to illuminate the potential influence of contributors.

(7) Contributors who wish to influence candidates make contributions not only to candidates, but also to political committees and political parties that are associated with those candidates.

(8) Political committees make independent expenditures for the purpose of influencing the conduct of candidates and officeholders. Candidates and officeholders may feel beholden to political committees that produce advertising supportive of them. In addition, the conduct of candidates and officeholders may be influenced by a desire to avoid the effects of negative advertising by political committees that oppose them.

(9) As the line between independent and related expenditures is difficult to detect and enforce, the limit on contributions to political committees assists in preventing circumvention of the limits on contributions to candidates.

(10) Aggregate contribution limitations are necessary to limit the influence of a single source, political committee, or political party in an election. Large contributors to political committees and political parties are known to candidates and can exert undue influence over those candidates. Contributors who wish to circumvent the limits on contributions to candidates have been known to give large contributions to political committees that also support the same candidates.

(11) There is an extensive record supporting the need for the regulation of campaign finance in Vermont that was compiled during the consideration of No. 64 of the Acts of 1997 and that was considered by the courts during the litigation of Landell v. Sorrell, 118 F.Supp.2d 459 (D.Vt. 2000), aff'd in part and vacated in part, 382 F.3d 91 (2d Cir. 2004), rev'd and remanded sub nom. Randall v. Sorrell, 126 S. Ct. 2479 (2006), and during the general assembly's consideration of S.164 during the 2007 legislative session, S.278 during the 2008 legislative session, and S.92 during the 2009–2010 legislative sessions.

(12) This act is necessary in order to implement more fully the provisions of Article 8 of Chapter I of the Constitution of the State of Vermont, which declares "That all elections ought to be free and without corruption, and that all voters, having a sufficient, evident, common interest with, and attachment to the community, have a right to elect officers, and be elected into office, agreeably to the regulations made in this constitution."

Sec. 2. 17 V.S.A. § 2801 is amended to read:

§ 2801. DEFINITIONS

As used in this chapter:

(1) "Candidate" means an individual who has taken affirmative action to become a candidate for state, county, local, or legislative office in a primary, special, general, or local election. An affirmative action shall include one or more of the following:

(A) accepting contributions or making expenditures totaling $500.00 or more; or

(B) filing the requisite petition for nomination under this title or being nominated by primary or caucus; or

(C) announcing that he or she seeks an elected position as a state, county, or local officer or a position as representative or senator in the general assembly.

(2) "Clearly identified," with respect to a candidate, means that:

(A) The name of the candidate appears;

(B) A photograph or drawing of the candidate appears; or

(C) The identity of the candidate is apparent by unambiguous reference.

(3) "Contribution" means a payment, distribution, advance, deposit, loan, or gift of money or anything of value, paid or promised to be paid ~~to a person~~ for the purpose of influencing an election, advocating a position on a public question, or supporting or opposing one or more candidates in any election~~, but shall not include services provided without compensation by individuals volunteering their time on behalf of a candidate, political committee or political party~~. For purposes of this chapter, "contribution" shall not include ~~a personal loan from a lending institution.~~ any of the following:

(A) a personal loan of money to a candidate from a lending institution;

(B) services provided without compensation by individuals volunteering their time on behalf of a candidate, political committee, or political party;

(C) unreimbursed travel expenses paid for by an individual for himself or herself who volunteers personal services to a candidate;

(D) unreimbursed campaign-related travel expenses paid for by the candidate or the candidate's spouse or civil union partner;

(E) the payment by a political party of the costs of preparation, display, or mailing or other distribution of a party candidate listing;

(F) documents, in printed or electronic form, including party platforms, single copies of issue papers, information pertaining to the requirements of this title, lists of registered voters, and voter identification information created, obtained, or maintained by a political party for the general purpose of party building and provided to a candidate who is a member of that party or to another political party;

(G) compensation paid by a political party to its employees whose job responsibilities are not for the specific and exclusive benefit of a single candidate in any election;

(H) campaign training sessions provided to three or more candidates;

(I) costs paid for by a political party in connection with a campaign event at which three or more candidates are present;

(J) the use of a political party's offices, telephones, computers, and similar equipment;

(K) the use by a candidate or volunteer of his or her own personal property, including offices, telephones, computers, and similar equipment;

(L) compensation paid by a political party to its employees or consultants for the purpose of providing assistance to another political party;

(M) activity or communication designed to encourage individuals to register to vote or to vote if that activity or communication does not mention or depict a clearly identified candidate.

~~(3)~~(4) "Expenditure" means a payment, disbursement, distribution, advance, deposit, loan, or gift of money or anything of value, paid or promised to be paid, for the purpose of influencing an election, advocating a position on a public question, or supporting or opposing one or more candidates. For the purposes of this chapter, "expenditure" shall not include any of the following:

(A) a personal loan of money to a candidate from a lending institution;

(B) services provided without compensation by individuals volunteering their time on behalf of a candidate, political committee, or political party;

(C) unreimbursed travel expenses paid for by an individual for himself or herself who volunteers personal services to a candidate;

(D) unreimbursed campaign-related travel expenses paid for by the candidate or the candidate's spouse or civil union partner.

(5) "Party candidate listing" means any communication by a political party that:

(A) lists the names of at least three candidates for election to public office;

(B) is distributed through public advertising such as broadcast stations, cable television, newspapers, and similar media or through direct mail, telephone, electronic mail, a publicly accessible site on the Internet, or personal delivery;

(C) treats all candidates in the communication in a substantially similar manner; and

(D) is limited to:

(i) the identification of each candidate, with which pictures may be used;

(ii) the offices sought;

(iii) the offices currently held by the candidates;

(iv) the party affiliation of the candidates and a brief statement about the party or the candidates' positions, philosophy, goals, accomplishments, or biographies;

(v) encouragement to vote for the candidates identified; and

(vi) information about voting, such as voting hours and locations.

~~(4)~~(6) "Political committee" or "political action committee" means any formal or informal committee of two or more individuals, or a corporation, labor organization, public interest group, or other entity, not including a political party, which receives contributions of more than $500.00 and makes expenditures of more than $500.00 in any one calendar year for the purpose of supporting or opposing one or more candidates, influencing an election, or advocating a position on a public question in any election or affecting the outcome of an election.

~~(5)~~(7) "Political party" means a political party organized under chapter 45 of this title ~~or~~ and any committee established, financed, maintained, or controlled by the party, including any subsidiary, branch, or local unit thereof ~~and including national or regional affiliates of the party~~ and shall be considered a single, unified political party. The national affiliate of the political party shall be considered a separate political party.

~~(6)~~(8) "Single source" means an individual, partnership, corporation, association, labor organization, or any other organization or group of persons which is not a political committee or political party.

~~(7)~~(9) "Election" means the procedure whereby the voters of this state or any of its political subdivisions ~~select~~ or caucus selects a person to be a candidate for public office or fill a public office, or to act on public questions including voting on constitutional amendments. Each primary, general, special, ~~run-off~~ or local election shall constitute a separate election.

~~(8)~~(10) "Public question" means an issue that is before the voters for a binding decision.

~~(9)~~(11) "Two-year general election cycle" means the 24-month period that begins 38 days after a general election. ~~Expenditures related to a previous campaign and contributions to retire a debt of a previous campaign shall be attributed to the earlier campaign cycle.~~

~~(10)~~(12) "Full name" means an individual's full first name, middle name or initial, if any, and full legal last name, making the identity of the person who made the contribution apparent by unambiguous reference.

~~(11)~~(13) "Telephone bank" means more than 500 telephone calls of an identical or substantially similar nature that are made to the general public within any 30-day period.

Sec. 3. 17 V.S.A. § 2801a is amended to read:

§ 2801a. EXCEPTIONS

The definitions of "contribution," "expenditure," and "electioneering communication" shall not apply to:

(1) any news story, commentary, or editorial distributed through the facilities of any broadcasting station, newspaper, magazine, or other periodical publication which has not been paid for, or such facilities are not owned or controlled, by any political party, committee, or candidate; or

(2) any communication distributed through a public access television station if the communication complies with the laws and rules governing the station and if all candidates in the race have an equal opportunity to promote their candidacies through the station.

Sec. 4. 17 V.S.A. § 2803 is amended to read:

§ 2803. CAMPAIGN REPORTS; FORMS; FILING

(a) The secretary of state shall prescribe and provide a uniform reporting form for all campaign finance reports. The reporting form shall be designed to show the following information, which shall be reported by a candidate or the candidate's treasurer:

(1) the full name, town of residence, and mailing address of each contributor who contributes an amount in excess of $100.00 for any election, the date of the contribution, and the amount contributed, as well as a space on the form for the occupation and employer of each contributor, which the candidate shall make a reasonable effort to obtain;

* * *

Sec. 5. 17 V.S.A. § 2805 is amended to read:

§ 2805. LIMITATIONS OF CONTRIBUTIONS

(a) A candidate for state representative or local office shall not accept contributions totaling more than ~~$200.00~~ $500.00 from a single source~~,~~ or political committee ~~or political party in~~ for any two-year general election cycle.

(b) A candidate for state senator or county office shall not accept contributions totaling more than ~~$300.00~~ $1,000.00 from a single source~~,~~ or political committee ~~or political party in~~ for any two-year general election cycle.

(c) A candidate for the office of governor, lieutenant governor, secretary of state, state treasurer, auditor of accounts, or attorney general shall not accept contributions totaling more than ~~$400.00~~ $2,000.00 from a single source~~,~~ or political committee ~~or political party in~~ for any two-year general election cycle. ~~A political committee, other than a political committee of a candidate, or a political party shall not accept contributions totaling more than $2,000.00 from a single source, political committee or political party in any two-year general election cycle.~~

~~(b)~~(d) A single source~~, political committee or political party~~ shall not contribute more ~~to a candidate, political committee or political party than the candidate, political committee or political party is permitted to accept under subsection (a) of this section~~ than an aggregate of $20,000.00 to candidates in any two-year general election cycle. A single source shall not contribute more than an aggregate of $20,000.00 to political committees and political parties in any two-year general election cycle.

~~(c)~~(e) A candidate~~, political party or political committee~~ shall not accept~~,~~ from a political party contributions totaling more than the following amounts in any two-year general election cycle~~, more than 25 percent of total contributions from contributors who are not residents of the state of Vermont or from political committees or parties not organized in the state of Vermont~~:

(1) For the office of governor, lieutenant governor, secretary of state, state treasurer, auditor of accounts, or attorney general, $30,000.00;

(2) For the office of state senator or county office, $2,000.00;

(3) For the office of state representative or local office, $1,000.00.

(f) A single source, political committee, or political party shall not contribute more to a candidate, political committee, or political party than the candidate, political committee, or political party is permitted to accept under subsections (a) through (c) and (e) of this section.

~~(d)~~(g) A candidate shall not accept a monetary contribution in excess of $50.00 unless made by check, credit or debit card, or other electronic transfer.

~~(e)~~(h) A candidate, political party, or political committee shall not knowingly accept a contribution which is not directly from the contributor, but was transferred to the contributor by another person for the purpose of transferring the same to the candidate, or otherwise circumventing the provisions of this chapter. It shall be a violation of this chapter for a person to make a contribution with the explicit or implicit understanding that the contribution will be transferred in violation of this subsection.

~~(f)~~(i) This section shall not be interpreted to limit the amount a candidate or his or her immediate family may contribute to his or her own campaign. For purposes of this subsection, "immediate family" means ~~individuals related to the candidate in the first, second or third degree of consanguinity~~ a candidate's spouse or civil union partner, parent, grandparent, child, grandchild, sister, brother, stepparent, step-grandparent, stepchild, step-grandchild, stepsister, stepbrother, mother-in-law, father-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, legal guardian, or former legal guardian.

~~(g)~~(j) The limitations on contributions established by this section shall not apply to contributions made for the purpose of advocating a position on a public question, including a constitutional amendment.

~~(h)~~(k) For purposes of this section, the term "candidate" includes the candidate's political committee.

(l) The contribution limitations contained in this section shall be adjusted for inflation by increasing them based on the Consumer Price Index. Increases shall be rounded to the nearest $10.00. Increases shall be effective for the first two-year general election cycle beginning after the general election held in

2010. On or before July 1, 2011, the secretary of state shall calculate and publish the amount of each limitation that will apply to the election cycle in which July 1, 2011 falls. On July 1 of each subsequent odd-numbered year, the secretary shall publish the amount of each limitation for the election cycle in which that publication falls.

(m) A candidate's expenditures related to a previous two-year general election cycle and contributions used to retire a debt of a previous two-year general election cycle shall be attributed to the earlier two-year general election cycle.

(n) A candidate accepts a contribution when the contribution is deposited in the candidate's campaign account.

Sec. 6. 17 V.S.A. § 2805b is added to read:

§ 2805b. LIMITATIONS ON CONTRIBUTIONS; POLITICAL COMMITTEES; POLITICAL PARTIES

(a) In any two-year general election cycle:

(1) A political committee, other than a political committee of a candidate, shall not accept contributions totaling more than $2,000.00 from a single source, political committee, or political party.

(2) A political party shall not accept contributions totaling more than $2,000.00 from a single source or political committee.

(3) A political party shall not accept contributions totaling more than $30,000.00 from another political party.

(b) The contribution limitations contained in this section shall be adjusted for inflation by increasing them based on the Consumer Price Index. Increases shall be rounded to the nearest $10.00. Increases shall be effective for the first two-year general election cycle beginning after the general election held in 2010. On or before July 1, 2011, the secretary of state shall calculate and publish the amount of each limitation that will apply to the election cycle in which July 1, 2011 falls. On July 1 of each subsequent odd-numbered year, the secretary shall publish the amount of each limitation for the election cycle in which that publication falls.

(c) In any two-year general election cycle:

(1) A single source, political committee, or political party shall not contribute more than $2,000.00 to a political committee other than a political committee of a candidate.

(2) A single source or political committee shall not contribute more than $2,000.00 to a political party.

(3) A political party shall not contribute more than $30,000.00 to another political party.

(d) The limitations on contributions established by this section shall not apply to contributions made for the purpose of advocating a position on a public question, including a constitutional amendment.

Sec. 7. 17 V.S.A. § 2806(a) is amended to read:

(a) A person who knowingly and intentionally violates a provision of ~~subchapters 2 through 4~~ subchapter 2, 3, 4, or 8 of this chapter shall be fined not more than $1,000.00 or imprisoned not more than six months or both. If the person is not a natural person, each individual responsible for knowingly and intentionally authorizing a violation shall be liable under this subsection.

Sec. 8. 17 V.S.A. § 2806a is amended to read:

§ 2806a. CIVIL INVESTIGATION

(a) The attorney general or a state's attorney, whenever he or she has reason to believe any person to be or to have been in violation of this chapter or of any rule or regulation made pursuant to this chapter, may examine or cause to be examined by any agent or representative designated by him or her for that purpose any books, records, papers, memoranda, and physical objects of any nature bearing upon each alleged violation and may demand written responses under oath to questions bearing upon each alleged violation. The attorney general or state's attorney may require the attendance of such person or of any other person having knowledge in the premises in the county where such person resides or has a place of business or in Washington County if such person is a nonresident or has no place of business within the state and may take testimony and require proof material for his or her information and may administer oaths or take acknowledgment in respect of any book, record, paper, or memorandum. The attorney general or a state's attorney shall serve notice of the time, place, and cause of such examination or attendance or notice of the cause of the demand for written responses personally or by certified mail upon such person at his or her principal place of business, or, if such place is not known, to his or her last known address. Any book, record, paper, memorandum, or other information produced by any person pursuant to this section shall not, unless otherwise ordered by a court of this state for good cause shown, be disclosed to any person other than the authorized agent or representative of the attorney general or a state's attorney or another law enforcement officer engaged in legitimate law enforcement activities, unless with the consent of the person producing the same, except that any transcript of oral testimony, written responses, documents, or other information produced pursuant to this section may be used in the enforcement of this chapter, including in connection with any civil action brought under section 2806 of

this title or subsection (c) of this section. Nothing in this subsection is intended to prevent the attorney general or a state's attorney from disclosing the results of an investigation conducted under this section, including the grounds for his or her decision as to whether to bring an enforcement action alleging a violation of this chapter or of any rule or regulation made pursuant to this chapter. This subsection shall not be applicable to any criminal investigation or prosecution brought under the laws of this or any state.

(b) A person upon whom a notice is served pursuant to the provisions of this section shall comply with the terms thereof unless otherwise provided by the order of a court of this state. Any person who is served with such notice within the state shall bear the complete cost of compliance with the terms thereof. Any person who, with intent to avoid, evade, or prevent compliance, in whole or in part, with any civil investigation under this section, removes from any place, conceals, withholds, or destroys, mutilates, alters, or by any other means falsifies any documentary material in the possession, custody, or control of any person subject to such notice, or mistakes or conceals any information, shall be fined not more than $5,000.00.

* * *

Sec. 9. 17 V.S.A. § 2809 is amended to read:

§ 2809. ACCOUNTABILITY FOR RELATED EXPENDITURES

* * *

(b) ~~A related campaign expenditure made on a candidate's behalf shall be considered an expenditure by the candidate on whose behalf it was made. However, if the expenditure did not exceed $50.00, the expenditure shall not be considered an expenditure by the candidate on whose behalf it was made.~~

(c) For the purposes of this section, a "related campaign expenditure made on the candidate's behalf" means any expenditure intended to promote the election of a specific candidate or group of candidates, or the defeat of an opposing candidate or group of candidates, if intentionally facilitated by, solicited by, or approved by the candidate or the candidate's ~~political~~ committee.

(d)(1) An expenditure made by a political party or by a political committee that recruits or endorses candidates, that primarily benefits six or fewer candidates who are associated with the political party or political committee making the expenditure, is presumed to be a related expenditure made on behalf of those candidates. An expenditure made by a political party or by a political committee that recruits or endorses candidates, that substantially benefits more than six candidates and facilitates party or political committee functions, voter turnout, platform promotion or organizational capacity shall

not be presumed to be a related expenditure made on a candidate's behalf. In addition, an expenditure shall not be considered a "related campaign expenditure made on the candidate's behalf" if all of the following apply:

~~(1)~~(A) The ~~expenditures were~~ expenditure was made in connection with a campaign event whose purpose was to provide a group of voters with the opportunity to meet the candidate personally.

~~(2)~~(B) The ~~expenditures were~~ expenditure was made only for refreshments and related supplies that were consumed at that event.

~~(3)~~(C) The amount of the ~~expenditures~~ expenditure for the event was less than $100.00.

(2) For the purposes of this section, a "related campaign expenditure made on the candidate's behalf" does not mean:

(A) the cost of invitations and postage and of food and beverages voluntarily provided by an individual in conjunction with an opportunity for a group of voters to meet a candidate, if the cumulative value of these items provided by the individual on behalf of any candidate does not exceed $500.00 per election; or

(B) the sale of any food or beverage by a vendor at a charge less than the normal comparable charge for use at a campaign event providing an opportunity for a group of voters to meet a candidate, if the charge to the candidate is at least equal to the cost of the food or beverages to the vendor and if the cumulative value of the food or beverages does not exceed $500.00 per election.

* * *

Sec. 10. 17 V.S.A. § 2891 is amended to read:

§ 2891. DEFINITIONS

As used in this chapter, "electioneering communication" means any communication that refers to a clearly identified candidate for office and that promotes or supports a candidate for that office or attacks or opposes a candidate for that office, regardless of whether the communication expressly advocates a vote for or against a candidate, including communications published in any newspaper or periodical or broadcast on radio or television or over any public address system, placed on any billboards, outdoor facilities, buttons, or printed material attached to motor vehicles, window displays, posters, cards, pamphlets, leaflets, flyers, or other circulars, or in any direct mailing, robotic phone calls, or mass e-mails ~~that refers to a clearly identified candidate for office and that promotes or supports a candidate for that office, or attacks or opposes a candidate for that office, regardless of whether the communication expressly advocates a vote for or against a candidate~~.

Sec. 11. 17 V.S.A. § 2892 is amended to read:

§ 2892. IDENTIFICATION

(a) All electioneering communications shall contain the name and address of the person, political committee, ~~or campaign~~ political party, or candidate who or which paid for the communication, except that:

(1) an electioneering communication transmitted through radio and paid for by a candidate does not need to contain the candidate's address; and

(2) an electioneering communication paid for by a person acting as an agent or consultant on behalf of another person, political committee, political party, or candidate shall clearly designate the name and address of the person, political committee, political party, or candidate on whose behalf the communication is published or broadcast. ~~The communication shall clearly designate the name of the candidate, party, or political committee by or on whose behalf the same is published or broadcast.~~

(b) If an electioneering communication is a related campaign expenditure made on a candidate's behalf pursuant to section 2809 of this title, then in addition to other requirements of this section, the communication shall also clearly designate the candidate on whose behalf it was made by including language such as "on behalf of" such candidate.

(c) The identification requirements of this section shall not apply to lapel stickers or buttons, nor shall they apply to electioneering communications made by a single individual acting alone who spends, in a single two-year general election cycle, a cumulative amount of no more than $150.00 on those electioneering communications, adjusted for inflation pursuant to the Consumer Price Index.

Sec. 12. 17 V.S.A. § 2892a is added to read:

§ 2892a. SPECIFIC IDENTIFICATION REQUIREMENTS FOR CERTAIN ELECTIONEERING COMMUNICATIONS

(a) A person, political committee, political party, or candidate who makes an expenditure for an electioneering communication shall include in any communication which is transmitted through radio or television, in a clearly spoken manner, an audio statement by the person who paid for the communication stating his or her name and title, that the person paid for the communication, and that the person approves of the content of the communication. Moreover, for electioneering communications transmitted through television, this statement shall be made while the person, candidate, or representative of the political committee or political party that made the expenditure appears in a full-screen, unobscured view in the televised electioneering communication. If the person who paid for the communication

is not a natural person, a statement required by this subsection shall be made by the principal officer of the person and shall include the name of the person who paid for the communication, the principal officer's name and title, and a statement that the officer approves of the content of the communication.

(b) For electioneering communications using media other than radio or television, the name and mailing address of the person who paid for the communication shall appear prominently such that a reasonable person would clearly understand by whom the expenditure has been made.

Sec. 13. 17 V.S.A. § 2893 is amended to read:

§ 2893. NOTICE OF EXPENDITURE

(a) For purposes of this section, "mass media activities" ~~includes~~ means any communication that includes the name or likeness of a clearly identified candidate for office including television commercials, radio commercials, mass mailings, mass electronic or digital communications, literature drops, newspaper and periodical advertisements, robotic phone calls, and telephone banks ~~which include the name or likeness of a clearly identified candidate for office~~.

(b) In addition to any other reports required to be filed under this chapter, a person who makes expenditures for any one mass media activity totaling $500.00 or more, adjusted for inflation pursuant to the Consumer Price Index, within 30 days ~~of~~ before a primary or general election shall, for each activity, file within 12 hours of the expenditure or activity, whichever occurs first, a mass media report by e-mail with the secretary of state and send a copy of the mass media report by e-mail to each candidate who has provided the secretary of state with an e-mail address on the consent form and whose name or likeness is included in the activity ~~within 24 hours of the expenditure or activity, whichever occurs first~~ without that candidate's knowledge. For the purposes of this section, a person shall be treated as having made an expenditure if the person has executed a contract to make the expenditure. The report shall identify the person who made the expenditure ~~with~~ and the name of ~~the~~ each candidate ~~involved~~ whose name or likeness was included in the activity and any other information relating to the expenditure that is required to be disclosed under the provisions of subsections 2803(a) and (b) of this title. If the activity occurs within 30 days before the election and the expenditure was previously reported, an additional report shall be required under this section.

Sec. 14. EVALUATION OF 2012 PRIMARY AND GENERAL ELECTIONS

The house and senate committees on government operations shall evaluate the 2012 primary and general elections to determine whether the major provisions of this act are accomplishing their intended purposes.

Sec. 15. REPEAL

17 V.S.A. § 2805a (campaign expenditure limitations) is repealed.

Sec. 16. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: 3-2-0)

AMENDMENT TO S. 20 TO BE OFFERED BY SENATORS GALBRAITH, ASHE, POLLINA AND BARUTH

Senators Galbraith, Ashe, Pollina and Baruth move that the bill be amended as follows:

First: In Sec. 2, 17 V.S.A. § 2801 (definitions), by adding a new subdivision to be subdivision (14) to read:

(14) "Separate segregated fund" means a bank account held separately from the general treasury of a corporation, labor union, political committee, or political party and which only contains contributions made by natural persons within the contribution limits of this chapter for those persons.

Second: By adding a new section to be Sec. 6a to read:

Sec. 6a. 17 V.S.A. § 2805c is added to read:

§ 2805c. LIMITATIONS ON CONTRIBUTIONS; CORPORATIONS AND LABOR UNIONS; POLITICAL COMMITTEES AND POLITICAL PARTIES

(a) Notwithstanding any provision of law to the contrary and except as provided in subsection (b) of this section, a corporation or labor union shall not make a contribution to a candidate.

(b) Notwithstanding the provisions of subsection (a) of this section, a corporation or labor union may:

(1) establish a separate segregated fund that may contribute to candidates.

(2) use money, property, labor, or any other thing of monetary value of that entity for the purposes of soliciting its stockholders, administrative officers, and members for contributions to the corporation's separate segregated fund and for financing the administration of that separate segregated fund. The corporation's employees to whom the foregoing authority does not extend may voluntarily contribute to the segregated separate fund but shall not be solicited for contributions; and

(3) provide its meeting facilities to a candidate, political committee, or political party on a nondiscriminatory and nonpreferential basis.

(c) Notwithstanding any provision of law to the contrary, a political committee or political party shall not contribute to a candidate except from the separate segregated fund of that political committee or political party.

(d) Notwithstanding any provision of law to the contrary, a candidate shall not accept a contribution from a corporation, labor union, political committee, or political party except from the separate segregated fund of that corporation, labor union, political committee, or political party.

S. 137.

An act relating to workers' compensation and unemployment compensation.

PENDING QUESTION: Shall the bill be amended as recommended by the Committee on Economic Development, Housing and General Affairs, as amended?

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR ASHE

Senator Ashe moves to amend the recommendation of amendment by the Committee on Economic Development, Housing and General Affairs by adding Sec. 26 to read as follows:

Sec. 26. FINDINGS

The general assembly finds:

(1) The right of employees to organize and form a labor organization to engage in collective bargaining is fundamental to both a free society and the generation and maintenance of a strong middle class.

(2) The state has long favored the right of employees to organize for the purpose of bargaining collectively with their employer.

(3) Vermont law recognizes that a labor organization democratically selected by bargaining unit employees is the exclusive representative of all the employees within the bargaining unit.

(4) A labor organization engages in both "chargeable" and "nonchargeable" activities on behalf of bargaining unit members. "Chargeable" activities are generally those related to negotiating and ensuring the enforcement of collective bargaining agreements on behalf of the bargaining unit as a whole and for every employee within it. "Nonchargeable" activities are generally those related to political activities and lobbying.

(5) With respect to "chargeable activities," a labor organization must represent all the employees within its bargaining unit. It may not discriminate between members of the labor organization who pay membership fees and those who exercise their rights not to become members. This is called "the

duty of fair representation." This duty does not extend to "nonchargeable" activities.

(6) The "chargeable" activities undertaken by labor organizations on behalf of all bargaining unit employees are in the interest of the public good.

(7) It is the policy of the state to require employees in bargaining units organized under state law who do not become members of the labor organization representing the unit to pay a "fair-share agency fee" for the chargeable activities undertaken on their behalf.

(8) Current labor law in Vermont leaves the question of a fair-share agency fee to the collective bargaining process itself.

(9) It is inconsistent with state policy to continue to permit employers, merely by not agreeing to fair-share fee provisions in collective bargaining agreements, to enable their bargaining unit employees who are not members of the labor organization to avoid paying their fair share of the organization's representation.

(10) The result of allowing employers to withhold consent to fair-share fees has resulted in a patchwork of collective bargaining agreements, some of which include fair-share provisions and some of which do not.

(11) By enacting a fair-share agency fee law, the state will allow employees not to join the labor organizations representing them, but will ensure equitable treatment across bargaining units organized under state law.

(12) The duty of fair representation should be balanced by the duty to pay a fair-share agency fee.

and by renumbering the remaining sections to be numerically correct.

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR SNELLING

Senator Snelling moves to amend the recommendation of the committee on Economic Development, Housing and General Affairs, as follows

First: By striking out Secs. 25, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, and 37 in their entirety and inserting in lieu thereof a new Sec. 25 to read as follows:

Sec. 25. 21 V.S.A. § 1624 is added to read:

§ 1624. CHILD-CARE PROVIDERS

Child-care providers have the right to form a union and once organized to negotiate the scope of bargaining rights with the state. The provisions of chapter 19 of this title related to elections and negotiation process shall apply to child care providers forming a union and negotiating with the state for purposes of a legally binding agreement.

Second: In Sec. 42, EFFECTIVE DATES, by striking out the designation (a) and subsections (b), (c), and (d) in their entirety

And by renumbering the remaining sections to be numerically correct

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR SEARS

Senator Sears moves to amend the bill in Sec. 27, 3 V.S.A. § 903, by adding at the end of subsection (c) a new sentence to read as follows:

This subsection shall not apply to employees who were not members of the employee organization and were not required to pay a collective bargaining service fee prior to July 1, 1998, and since that date have not joined the employee organization or paid a collective bargaining service fee.

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR MCCORMACK

Senator McCormack moves that the bill be amended by adding Secs. 43 and 44 to read:

Sec. 43. FINDINGS

The general assembly finds:

(1) Quality early childhood education and care is essential to the quality of life in Vermont and is a vital contributor to the healthy development of children. Numerous studies have demonstrated that high-quality early childhood education and care during the first five years of a child's life is crucial to brain development and increases the likelihood of a child's success in school and later in life.

(2) The early childhood education and care a child receives before school age has a profound effect on future mental, psychological, and academic success. High-quality early childhood education and care lay the vital groundwork for the success of Vermont children.

(3) The state is committed to ensuring that all Vermont children are ready to succeed in school; that Vermont families have access to high quality early childhood education and care and after school services; and that the early childhood and after school supports and services administered by the department for children and families are child-focused, family friendly, and fair to all child-care providers.

(4) Home-based child-care providers should have the opportunity to work collectively with the state to improve the standards in their profession, enhance educational training courses, increase child-care subsidy assistance, and ensure the constant improvement of early childhood education and care for the benefit of Vermont children.

Sec. 44. 33 V.S.A. chapter 36 is added to read:

CHAPTER 36. EXTENSION OF LIMITED COLLECTIVE BARGAINING RIGHTS TO CHILD-CARE PROVIDERS

§ 3601. DEFINITIONS

For purposes of this chapter:

(1) "Board" means the state labor relations board established in 3 V.S.A. § 921.

(2) "Child-care provider" shall have the same meaning as in subdivision 3511(2) of this title and includes people who provide child-care services as defined by subdivisions 3511(3) and 4902(2)–(3) of this title, except that it shall not include licensed child-care centers. For purposes of this chapter, "child-care provider" means the owner or operator of a licensed family-care home or a registered family day-care home, or a legally exempt child-care provider.

(3) "Collective bargaining" or "bargaining collectively" means the process by which the state and the exclusive representative of the child-care providers negotiate terms or conditions as defined in subsection 3603(b) of this title with the intent to arrive at an agreement which, when reached, shall be legally binding on all parties.

(4) "Exclusive representative" means a labor organization that has been elected or recognized and certified under this chapter and has the right to represent child-care providers in an appropriate bargaining unit for the purpose of collective bargaining.

(5) "Grievance" means a child-care provider's or the exclusive representative's formal written complaint regarding the improper application of one or more terms of the collective bargaining agreement, which has not been resolved to a satisfactory result through informal discussion with the state.

(6) "Legally exempt child-care provider" means a person who has obtained an Exempt Child Care Provider Certificate, has been approved by the department to provide legally exempt child care, and who is reimbursed for that care through the agency of human services.

(7) "Licensed family child-care home" means a home licensed by the department for children and families that provides child-care services for up to 12 children in the residence of the licensee, and the licensee is one of the primary caregivers.

(8) "Registered family day care home" means a home registered with the department for children and families that provides child-care services for

up to six children at any one time, and which in addition to the six children, may provide care for up to four school-age children for not more than four hours per day.

(9) "Subsidy payment" means any payment made by the state to assist in the provision of child-care services through the state's child-care financial assistance programs.

§ 3602. RIGHTS OF CHILD-CARE PROVIDERS

(a) Child-care providers shall have the right to:

(1) Organize, form, join, or assist a union or labor organization for the purposes of collective bargaining without interference, restraint, or coercion.

(2) Bargain collectively through their chosen representatives.

(3) Engage in concerted activities for the purpose of supporting or engaging in collective bargaining or exercising their rights under this chapter.

(4) Pursue grievances as provided in this chapter.

(5) Refrain from any or all such activities.

(b) Child-care providers shall not strike or curtail their services in recognition of a picket line of any employee or labor organization, unless otherwise permitted to do so under federal or state law, including the National Labor Relations Act (29 U.S.C. § 151 et seq.) or the Vermont state labor relations act (21 V.S.A. § 1501 et seq.).

§ 3603. ESTABLISHMENT OF LIMITED COLLECTIVE BARGAINING; SCOPE OF BARGAINING

(a) Child-care providers, through their exclusive representative, shall have the right to bargain collectively with the state, through the governor's designee, under this chapter.

(b) The scope of collective bargaining for child-care providers under this section is limited to the following:

(1) child-care subsidy payments, including rates and reimbursement practices and rate variations reflecting different provider classifications and quality incentives;

(2) professional development and training, including financial assistance for child-care providers and their staff;

(3) procedures for resolving grievances against the state; and

(4) a mechanism for the collection of dues and representation fees from the child-care providers, which shall be the financial responsibility of each individual provider and shall in no way result in a decrease in the amount of

subsidy funds available to eligible families.

(c) The state, acting through the governor's designee, shall meet with the exclusive representative for the purpose of entering into a written agreement that promotes access to high-quality early childhood education and care and after-school services and care for Vermont's children and families and ensures policies and practices that are child-focused, family friendly, and fair to all child-care providers. The negotiated agreement shall legally bind the state and the exclusive representative subject to subsection 3611(a) or subdivision 3612(a)(2) of this title.

§ 3604. PETITIONS FOR ELECTION; FILING; INVESTIGATIONS; HEARINGS; DETERMINATION

(a) A petition may be filed with the board in accordance with regulations prescribed by the board:

(1) By a child-care provider or a group of child-care providers or by any individual or labor union acting on their behalf alleging:

(A) that not less than 30 percent of the child-care providers in the petitioned bargaining unit wish to be represented for collective bargaining, and that the state has declined to recognize their exclusive representative; or

(B) that the labor organization which has been certified or is being recognized by the state as the exclusive representative no longer represents a majority of child-care providers.

(2) By the state alleging that one or more individuals or labor organizations have presented the state with a claim for recognition as the exclusive representative.

(b) The board shall investigate the petition and, if it has reasonable cause to believe that a question of unit determination or representation exists, conduct an appropriate hearing. Written notice of the hearing shall be mailed by certified mail to the parties named in the petition not less than seven days before the hearing. If the board finds upon the record of the hearing that a question of representation exists, it shall conduct an election by secret ballot and certify to the parties the election's results.

(c) In determining whether a question of representation exists, the board shall apply the same regulations and rules of decision regardless of the identity of the persons filing the petition or the kind of relief sought.

(d) Nothing in this chapter prohibits the waiving of hearings by stipulation for a consent election in conformity with the regulations and rules of the board.

(e) For the purposes of this chapter, the state may voluntarily recognize the exclusive representative of a unit of child-care providers, if the labor

organization demonstrates that it has the support of a majority of the child-care providers in the unit it seeks to represent, no rival employee organization seeks to represent the child-care providers, and the bargaining unit is appropriate under section 3606 of this chapter.

§ 3605. ELECTION; RUNOFF ELECTIONS

(a) In determining the representation of child-care providers in a collective bargaining unit, the board shall conduct a secret ballot of the providers and certify the results to the interested parties and to the state. The original ballot shall be prepared so as to permit a vote against representation by anyone named on the ballot. No exclusive representative shall be certified or remain certified with less than a majority of all votes cast. The labor organization receiving a majority of votes cast shall be certified by the board as the exclusive representative of the unit of child-care providers.

(b) A runoff election shall be conducted by the board when an election, in which the ballot provides for no less than three choices, results in no choice receiving a majority of valid votes cast. The ballot in the runoff election shall provide for a selection between the two choices receiving the largest and second largest number of valid votes cast in the original election.

§ 3606. BARGAINING UNITS

(a) The board shall decide the unit appropriate for the purpose of collective bargaining in each case and those child-care providers to be included in the units in order to promote the purposes of this statute. The board may consider as an appropriate bargaining unit or units, but is not restricted in its discretion, any of the following units:

(1) a unit composed of registered family day-care home providers;

(2) a unit composed of licensed family child-care home providers;

(3) a unit composed of legally exempt child-care providers;

(4) a unit composed of child-care providers in subdivisions (1)–(3) of this subsection;

(5) a unit composed of a combination of child-care providers in subdivisions (1)–(3) of this subsection.

(b) Child-care providers may elect an exclusive representative for the purpose of collective bargaining by using the election procedures set forth in section 3605 of this chapter.

(c) The exclusive representative of child-care providers is required to represent all of the child-care providers in the unit without regard to membership in the union.

§ 3607. POWERS OF REPRESENTATIVES

The exclusive representative certified by the board shall be the exclusive representative of all the child-care providers in the unit for the purposes of collective bargaining. However, any individual child-care provider or group of providers shall have the right at any time to present grievances to the board and have such grievances adjusted without the intervention of the exclusive representative, as long as the adjustment is not inconsistent with the terms of a collective bargaining agreement then in effect, and provided that the exclusive representative has been given an opportunity to be present at such an adjustment.

§ 3608. DUTY TO BARGAIN; PROHIBITED CONDUCT

(a) The state and all child-care providers and their representatives shall make every reasonable effort to make and maintain agreements concerning matters allowed under this chapter and to settle all disputes, whether arising out of the application of those agreements or disputes concerning the agreements. All such disputes between the state and child-care providers shall, upon request of either party, be considered within 15 days of the request or at such times as may be mutually agreed to and if possible settled with all expedition in conference between representatives designated and authorized to confer by the state or the interested child-care providers. This obligation does not compel either party to make any agreements or concessions.

(b) The state shall provide within seven days of a request by a labor organization the names, home addresses, telephone numbers, and workplace names of all registered family day-care homes, licensed family-care homes, and legally exempt child-care providers.

(c) The state shall not:

(1) Interfere with, restrain, or coerce child-care providers in the exercise of their rights under this chapter or by any law, rule, or regulation.

(2) Discriminate against a child-care provider because of the provider's affiliation with a labor organization or because a provider has filed charges or complaints or given testimony under this chapter.

(3) Take negative action against a child-care provider because the provider has taken actions demonstrating the provider's support for a labor organization, including signing a petition, grievance, or affidavit.

(4) Refuse to bargain collectively in good faith with the exclusive representative or fail to abide by any agreement reached.

(5) Discriminate against a child-care provider because of race, color, religion, ancestry, national origin, sex, sexual orientation, gender identity, place of birth, or age, or against a qualified disabled individual.

(6) Request or require a child-care provider to take an HIV-related blood test or discriminate against a child-care provider based on his or her HIV status.

(d) The exclusive representative or its agents shall not:

(1) Restrain or coerce child-care providers in the exercise of the rights guaranteed them by law, rule, or regulation. However, a labor organization may prescribe its own rules with respect to the acquisition or retention of membership, provided such rules are not discriminatory.

(2) Cause or attempt to cause the state to discriminate against a child-care provider in violation of this chapter or to discriminate against a child-care provider with respect to whom membership in the organization has been denied or terminated.

(3) Refuse to bargain collectively in good faith with the state.

(e) Complaints related to this section shall be made and resolved in accordance with the procedures set forth in 21 V.S.A. §§ 1622 and 1623.

§ 3609. MEDIATION; FACT-FINDING; LAST BEST OFFER

(a) If, after a reasonable period of negotiation, the representative of a collective bargaining unit and the state of Vermont reach an impasse, the board, upon petition of either party, may authorize the parties to submit their differences to mediation. Within five days after receipt of the petition, the board shall appoint a mediator who shall communicate with the parties and attempt to mediate an amicable settlement.

(b) If, after a minimum of 15 days after the appointment of a mediator, the impasse is not resolved, the mediator shall certify to the board that the impasse continues.

(c) Upon the request of either party, the board shall appoint a fact finder who has been mutually agreed upon by the parties. If the parties fail to agree on a fact finder within five days, the board shall appoint a fact finder. A member of the board or any individual who has actively participated in mediation proceedings for which fact-finding has been called shall not be eligible to serve as a fact finder under this section, unless agreed upon by the parties.

(d) The fact finder shall conduct hearings pursuant to rules of the board. Upon request of either party or of the fact finder, the board may issue subpoenas of persons and documents for the hearings, and the fact finder may require that testimony be given under oath and may administer oaths.

(e) Nothing in this section shall prohibit the fact finder from mediating the dispute at any time prior to issuing recommendations.

(f) The fact finder shall consider factors related to the scope of bargaining contained in this chapter in making a recommendation.

(g) Upon completion of the hearings as provided in subsection (d) of this section, the fact finder shall file written findings and recommendations with both parties.

(h) The costs of witnesses and other expenses incurred by either party in fact-finding proceedings shall be paid directly by the parties incurring them, and the costs and expenses of the fact finder shall be paid equally by the parties. The fact finder shall be paid a rate mutually agreed upon by the parties for each day or any part of a day while performing fact-finding duties and shall be reimbursed for all reasonable and necessary expenses incurred in the performance of his or her duties. A statement of fact-finding per diem and expenses shall be certified by the fact finder and submitted to the board for approval. The board shall provide a copy of approved fact-finding costs to each party with its order apportioning one-half of the total to each party for payment. Each party shall pay its half of the total within 15 days after receipt of the order. Approval by the board of fact-finding and the fact finder's costs and expenses and its order for payment shall be final as to the parties.

(i) If the dispute remains unresolved 15 days after transmittal of findings and recommendations, each party shall submit to the board its last best offer on all disputed issues as a single package. Each party's last best offer shall be certified to the board by the fact finder. The board may hold hearings and consider the recommendations of the fact finder. Within 30 days of the certifications, the board shall select between the last best offers of the parties, considered in their entirety without amendment, and shall determine its cost. The board shall not issue a recommendation under this subsection that is in conflict with any law or rule or that relates to an issue that is not subject to bargaining. The board shall recommend its choice to the general assembly as the agreement which shall become effective subject to appropriations by the general assembly pursuant to subsection 3611(a) of this title.

§ 3610. GRIEVANCE PROCEDURES; BINDING ARBITRATION

The state and the exclusive representative shall negotiate a procedure for resolving complaints and grievances. A collective bargaining agreement may provide for binding arbitration as the final step of a grievance procedure.

§ 3611. COST ITEMS TO BE SUBMITTED TO GENERAL ASSEMBLY; ANTITRUST EXEMPTION

(a) Agreements reached between the parties shall be submitted to the governor who shall request sufficient funds from the general assembly to implement the agreement. If the general assembly rejects any of the cost items submitted to it, all the cost items shall be returned to the parties to the

agreement for further bargaining. If the general assembly appropriates sufficient funds, the agreement shall become effective at the beginning of the next fiscal year. If the general assembly appropriates a different amount of funds, the terms of the agreement affected by that appropriation shall be renegotiated based on the amount of funds actually appropriated, and the new agreement shall become effective at the beginning of the next fiscal year.

(b) The activities of child-care providers and their exclusive representatives that are necessary for the exercise of their rights under this chapter shall be afforded state-action immunity under applicable state and federal antitrust laws. The state intends that the "State Action" exemption to federal antitrust laws be available only to the state, to child-care providers, and to their exclusive representative in connection with these necessary activities. Such exempt activities shall be actively supervised by the state.

§ 3612. RIGHTS UNALTERED

(a) This chapter does not alter or infringe upon the rights of:

(1) A parent or legal guardian to select, discontinue, or negotiate terms of child-care services.

(2) The general assembly and the judiciary to make modifications to the delivery of state services through child-care subsidy programs, including eligibility standards for families, legal guardians, and child-care providers participating in child-care subsidy programs and the nature of the services provided.

(b) Nothing in this chapter shall affect the rights and obligations of private sector employers and employees under the National Labor Relations Act (29 U.S.C. § 151 et seq.) or the Vermont state labor relations act (21 V.S.A. § 1501 et seq.).

(c) Child-care providers shall not be eligible for participation in the Vermont state employees' retirement system or in the health insurance plans available to executive branch employees.

(d) Child-care providers bargaining under this section do not become employees of the state by virtue of such bargaining.

§ 3613. SEVERABILITY

If any of the provisions of this act or its application is held invalid as it relates to state law, federal law, or federal funding requirements, the invalidity shall not affect other provisions of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are severable.

§ 3614. EXTENDING NEGOTIATING RIGHTS TO CENTER-BASED PROVIDERS; RULEMAKING; PILOT PROJECT

(a) It is the purpose of this section to establish a pilot project to allow child-care providers at child-care centers to negotiate with the state.

(b) The commissioner for children and families through rulemaking shall establish a program and related procedures by which the staff, including program directors, at licensed child-care facilities may voluntarily participate in a group that shall select a representative organization for the purposes of negotiating a binding written agreement with the department. The agreement shall be limited to the subjects in subdivisions 3603(b)(1)–(4) of this title and shall be applicable only to the group that was formed by participating. No program and related procedures established under this section shall be conducted prior to January 1, 2014.

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR SEARS

Senator Sears moves to amend the bill as follows

First: By adding Secs. 41b, 41c, and 41d to read:

Sec. 41b. 21 V.S.A. § 495i is added to read:

§ 495i. PRIVACY PROTECTION

(a) For purposes of this section:

(1) "Electronic communications device" means any device that uses electronic signals to create, transmit, and receive information, and includes computers, telephones, personal digital assistants, and other similar devices.

(2) "Retaliatory action" means discharge, threat, suspension, demotion, denial of promotion, discrimination, or other adverse employment action regarding the employee's compensation, terms, conditions, location, or privileges of employment.

(3) "Social networking service" means an online service, platform, or website that enables an individual to establish a profile within a bounded system created by the service for the purpose of sharing information with other users of the service.

(b) An employer shall not:

(1) Request or require that an employee or applicant disclose any user name, password, or other means for accessing a personal account or service through an electronic communications device.

(2) Request or require that an employee or applicant take an action that permits the employer to gain access to the employee's or applicant's account

or profile on a social networking service if that information is not available to the general public.

(3) Take retaliatory action against an employee for an employee's refusal to disclose any information specified in subdivision (1) or (2) of this subsection.

(4) Fail or refuse to hire any applicant as a result of the applicant's refusal to disclose any information specified in subdivision (1) or (2) of this subsection.

(c) An employer may require an employee to disclose any user name, password, or other means for accessing nonpersonal accounts or services that provide access to the employer's internal computer or information systems.

Sec. 41c. STATE OF VERMONT AS EMPLOYER

Upon passage of this act, the state of Vermont and its subdivisions shall immediately suspend any employment practices prohibited by Sec. 41b of this act.

Sec. 41d. VERMONT DEPARTMENT OF LABOR

The Vermont department of labor shall take appropriate steps to inform employers of Sec. 41b of this act.

Second: In Sec. 42, EFFECTIVE DATES by adding subsections (e) and (f) to read:

(e) Sec. 41b shall take effect on July 1, 2012.

(f) Secs. 41c and 41d shall take effect on passage.

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR ILLUZZI

Senator Illuzzi moves to amend the bill by inserting two new sections, to be numbered Secs. 15a and 15b, to read:

Sec. 15a. 30 V.S.A. § 248b is added to read:

§ 248b. PAYMENT OF PREVAILING WAGES

(a) This section applies to all wind generation facilities approved under section 248 of this title that benefit from the federal production tax credit for renewable energy (26 U.S.C. § 45), the federal business energy investment tax credit (26 U.S.C. § 48), or a grant in lieu of tax credit under section 1603 of the American Recovery and Reinvestment Act of 2009.

(b) The holder of a certificate issued for a facility identified in subsection (a) of this section shall require that all wages paid to laborers and mechanics contracted or subcontracted to develop the facility shall be paid no less than the locally prevailing wages and fringe benefits for corresponding

work on similar projects in the area, as established by the U.S. Department of Labor under the federal Davis-Bacon Act, 29 C.F.R. § 1 et seq., for projects in Vermont.

(c) The purpose of this section is to ensure that fair and adequate compensation is paid to laborers and mechanics engaged in the construction of wind generation facilities located in the state.

Sec. 15b. IMPLEMENTATION

The provisions of 30 V.S.A. § 248b (payment of prevailing wages) shall only apply to wages paid on and after passage of this act.

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR ILLUZZI ON BEHALF OF THE COMMITTEE ON ECONOMIC DEVELOPMENT, HOUSING AND GENERAL AFFAIRS

Senator Illuzzi, on behalf of the Committee on Economic Development, Housing and General Affairs moves to amend the bill by adding a new section within the Wage Claims portion of the bill to be numbered Sec. 3a to read as follows:

Sec. 3a. 33 V.S.A. § 2301 is amended to read:

§ 2301. BURIAL RESPONSIBILITY

* * *

(c) When a person other than one described in subsection (a) or (b) of this section dies in the town of domicile without sufficient known assets to pay for burial, the burial shall be arranged and paid for by the town. The department shall reimburse the town up to ~~$250.00~~ $1,100.00 for expenses incurred.

* * *

AMENDMENT TO S. 137 TO BE OFFERED BY SENATOR ILLUZZI

Senator Illuzzi moves that the bill be amended by inserting three new sections, to be numbered Secs. 15a, 15b, and 15c, to read:

Sec. 15a. 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~~ 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. Further, an appropriate economic method (e.g., an econometric model) shall be used to model the full costs and benefits of the purchase, investment, or construction and any multiplier effects. Costs and benefits to be modeled shall include those associated with the purchase of labor and durable goods for any proposed construction, the proximity of the sources of the labor and durable goods to the site of the proposed construction, and the transportation of labor and durable goods to such site;

* * *

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

§ 248b. PAYMENT OF PREVAILING WAGES

(a) This section applies to all wind generation facilities approved under section 248 of this title that benefit from the federal production tax credit for renewable energy (26 U.S.C. § 45), the federal business energy investment tax credit (26 U.S.C. § 48), or a grant in lieu of tax credit under section 1603 of the American Recovery and Reinvestment Act of 2009.

(b) The holder of a certificate issued for a facility identified in subsection (a) of this section shall require that all wages paid to laborers and mechanics contracted or subcontracted to develop the facility shall be paid no less than the locally prevailing wages and fringe benefits for corresponding work on similar projects in the area, as established under the federal Davis-Bacon Act by the U.S. Department of Labor, 29 C.F.R. § 1 et seq., for projects in Vermont.

(c) The purpose of this section is to ensure that fair and adequate compensation is paid to laborers and mechanics engaged in the construction of wind generation facilities located in the state.

Sec. 15c. IMPLEMENTATION

The provisions of 30 V.S.A. § 248b (payment of prevailing wages) shall apply to wages paid on and after passage of this act.

S. 204.

An act relating to creating an expert panel on the creation of a state bank.

PENDING QUESTION: Shall the bill be amended as recommended by the Committee on Finance?

S. 233.

An act relating to gradually increasing the mandatory age of school attendance.

Reported favorably with recommendation of amendment by Senator Lyons for the Committee on Education.

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

* * * Legal School Age * * *

Sec. 1. 16 V.S.A. § 1121 is amended to read:

§ 1121. ATTENDANCE BY CHILDREN OF SCHOOL AGE REQUIRED

~~A~~ (a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and 16 years, 183 days shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend; ~~or~~

(2) ~~has completed the tenth grade; or~~ has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

(b) A person having the control of a child who is enrolled in a home study program for the academic year in which the child is 15 years old shall not be subject to the provisions of subsection (a) of this section when the child is 16 years old or older.

Sec. 2. 16 V.S.A. § 1121(a) is amended to read:

(a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and ~~16~~ 17 years~~, 183 days~~ shall cause the child to attend a public school, an approved or recognized independent

school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend;

(2) has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

Sec. 3. 16 V.S.A. § 1121(a) is amended to read:

(a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and 17 years, 183 days shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend;

(2) has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

Sec. 4. 16 V.S.A. § 1121(a) is amended to read:

(a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and ~~17~~ 18 years~~, 183 days~~ shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend;

(2) has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

* * * Related Provisions * * *

Sec. 5. 16 V.S.A. § 1121a is added to read:

§ 1121a. PUPILS WHO ARE 16 YEARS OLD AND OLDER

(a) A child who is at least 16 years old but is younger than the legal school age established in section 1121 of this title and who is not subject to the exceptions set out in subdivisions (a)(1)–(4) or subsection (b) of that section may terminate his or her secondary education in a public school, an approved or recognized independent school, or an approved education program if the child and at least one of the child's parents or the child's legal guardian personally appear before the superintendent to sign a notice of withdrawal. The notice shall include a statement signed by the student, the parent or guardian, and the principal or headmaster of the school in which the child is enrolled that the child and the parent or guardian attended a final counseling session with the principal, headmaster, or school guidance counselor that included a discussion of alternative educational opportunities available to the child, including workforce development programs eligible to receive funding from the department of labor, and other services available to support the child, including Linking Learning to Life, Inc., Spectrum Youth and Family Services, Inc., Vermont Youth Build, and the Vermont Youth Conservation Corps, Inc.

(b) A school district shall contact each child who has voluntarily withdrawn from school pursuant to subsection (a) of this section within three months after the date of withdrawal to encourage the child to enroll in a public school, an approved or recognized independent school, a home study program, an approved education program, or a workforce development program or to pursue some other alternative educational or training opportunity.

(c) The departments of labor and of education shall publish and update at least annually a list of alternative education and workforce development programs under their respective jurisdictions that would be available to a student who has not completed secondary school.

Sec. 6. 16 V.S.A. § 1122 is amended to read:

§ 1122. PUPILS ~~OVER 16~~ WHO EXCEED THE LEGAL SCHOOL AGE

A person having the control of a child ~~over 16 years of~~ who exceeds the legal school age as established in section 1121 of this title who allows the child to become enrolled in a public school shall cause the child to attend the school continually for the full number of the school days of the term in which he or she is enrolled, unless the child is mentally or physically unable to continue, or

is excused in writing by the superintendent or a majority of the school directors. In case of ~~such~~ enrollment, the person, and the teacher, child, superintendent, and school directors shall be under the laws and subject to the penalties relating to the attendance of children ~~between the ages of six and 16 years~~ of legal school age.

Sec. 7. 16 V.S.A. § 1126 is amended to read:

§ 1126. FAILURE TO ATTEND; NOTICE BY TEACHER

When a pupil ~~between the ages of six and 16 years~~ of legal school age, as established in section 1121 of this title, who is not excused or exempted from school attendance~~,~~ fails to enter school at the beginning ~~thereof~~ of the academic year, or being enrolled, fails to continue to attend ~~the same~~, and when a pupil who ~~has become 16 years of~~ exceeds the legal school age becomes enrolled in a public school and fails to attend, the teacher or principal shall forthwith notify the superintendent or school directors, and the truant officer, unless the teacher or principal is satisfied upon information that the pupil is absent on account of sickness.

Sec. 8. 16 V.S.A. § 1128(a) is amended to read:

(a) A superintendent may and the truant officer shall stop a child ~~between the ages of six and 16 years or a child 16 years of age or over and~~ of legal school age or a child who exceeds the legal school age but is enrolled in public school, wherever found during school hours, and shall, unless ~~such~~ the child is excused or exempted from school attendance, take the child to the school which she or he should attend.

Sec. 9. 16 V.S.A. § 1123(c) is amended to read:

(c) ~~The superintendent with the consent of a majority of the school board of the town in which the pupil resides, may excuse, in writing, a pupil who has reached the age of fifteen years and has completed the work required in the first six years of the elementary school course from further school attendance if his services are needed for the support of those dependent upon him, or for any other sufficient reason.~~ [Repealed.]

* * * Human Services * * *

Sec. 10. 33 V.S.A. § 5102(3) is amended to read:

(3) "Child in need of care or supervision (CHINS)" means a child who:

* * *

(D) is under the age of 16 and is habitually and without justification truant from compulsory school attendance.

* * * Flexible Pathways to Graduation; Dual Enrollment * * *

Sec. 11. 16 V.S.A. chapter 23, subchapter 6 is amended to read:

Subchapter 6. Flexible Pathways to Secondary School Completion; Adult Education and Literacy

§ 1049. ~~PROGRAMS~~ FLEXIBLE PATHWAYS; POLICY; INITIATIVE; GUIDELINES; DEFINITIONS

~~(a) The commissioner of education may provide programs designed to fit the individual needs and circumstances of adult students. Programs authorized under this section shall give priority to those adult persons with the lowest levels of literacy skills.~~

~~(b)(1) Fees for general educational development shall be $3.00 for a transcript.~~

~~(2) The adult diploma program (ADP) means an assessment process administered by the Vermont department of education through which an adult can receive a local high school diploma granted by one of the program's participating high schools.~~

~~(3) General educational development (GED) means a testing program administered jointly by the Vermont department of education, the GED testing service, and approved local testing centers through which an adult can receive a secondary school equivalency certificate based on successful completion of the tests of general educational development.~~

~~(c) Fees collected under this section shall be credited to a special fund established and managed pursuant to chapter 7, subchapter 5 of Title 32, and shall be available to the department to offset the costs of providing those services.~~

(a) Policy. It is the policy of the state:

(1) to take all necessary measures to increase the Vermont secondary school completion rate to 100 percent;

(2) to promote opportunities for every Vermont student to have high-quality educational experiences; and

(3) to create opportunities for every Vermont student to achieve career and college readiness while respecting diverse student goals and personal learning styles and abilities.

(b) Flexible pathways initiative. There is created within the department a flexible pathways initiative:

(1) to promote opportunities for Vermont students to complete secondary school and achieve career and college readiness through

high-quality educational experiences that acknowledge individual goals, learning styles, and abilities; and

(2) to encourage and support the creativity of school districts as they develop or expand high-quality alternative educational experiences that advance the policies set forth in subsection (a) of this section.

(c) Flexible pathways guidance. The commissioner of education shall develop, publish, and regularly update guidance, in the form of technical assistance, sharing of best practices, legal interpretations, and other support, designed to encourage and assist school districts:

(1) to identify and support elementary and secondary students who require additional assistance to succeed in school, including individual students identified under subsection 2902(c) of this title, or who would otherwise benefit from flexible pathways to graduation;

(2) to encourage movement toward development of a personalized learning plan by every student, in consultation with a representative of the school and the student's parents or legal guardian;

(3) to implement strategies and flexible pathways components such as:

(A) the provision of targeted assistance, including individual tutoring, evidence-based literacy instruction, alternative and extended scheduling, and the provision of a variety of opportunities to earn credits or demonstrate proficiency necessary to earn a high school diploma;

(B) the assignment of one or more adults from within the school community to provide continuity to the student;

(C) the opportunity to acquire knowledge and skills through applied or work-based learning opportunities, including those that foster appropriate social interactions with adults and other students;

(D) the opportunity to participate in dual enrollment courses with tutorial support provided as needed;

(E) assessments that allow the student to demonstrate proficiency by applying his or her knowledge and skills to tasks that are of interest to that student; and

(4) to oversee implementation of publicly funded components of flexible pathways established in this subchapter, including:

(A) the high school completion program as set forth in section 1049a:

(B) the dual enrollment program as set forth in section 1049b;

(C) other innovative components as set forth in section 1049c; and

(D) the adult diploma and general educational development programs as set forth in section 1049d.

(d) Definitions. In this title:

(1) "Approved provider" means an entity approved by the commissioner to provide educational services that may be awarded credits or used to determine proficiency necessary for a high school diploma.

(2) "Career and college readiness" means the ability to enter the workforce or pursue postsecondary education or training without the need for remediation.

(3) "Contracting agency" means an entity that enters into a contract with the department to provide "flexible pathways to graduation" services itself or in conjunction with one or more approved providers in Vermont.

(4) "Dual enrollment" means enrollment by a secondary student in a course offered by an accredited postsecondary institution as defined in section 913 of this title and for which, upon successful completion of the course, the student will receive:

(A) credit toward graduation from the secondary school in which the student is enrolled; and

(B) postsecondary credit from the institution that offered the course if the course is a credit-bearing course at that institution.

(5) "Flexible pathways to graduation" means any combination of high-quality academic and experiential components leading to secondary school completion and career and college readiness.

(6) "Personalized learning plan" means a written document developed by a student, a representative of the school, and, if the student is a minor, the student's parents or legal guardian that describes a flexible pathway to graduation that is unique to the individual student. The plan shall define the scope and rigor of services necessary for the student to attain a high school diploma and may describe educational services to be provided by a public school, an approved independent school, an approved provider, a contracting agency, or a combination of these.

(e) Other initiatives. Nothing in this subchapter shall be construed as limiting the authority of any school district to develop or continue to provide alternative educational opportunities for its students that are otherwise permitted, including participation in dual enrollment programs with out-of-state postsecondary institutions or the provision of advanced placement courses.

(f) Scope. No individual entitlement or private right of action is created by this section.

§ 1049a. HIGH SCHOOL COMPLETION PROGRAM

(a) ~~In this section:~~

~~(1) "Graduation education plan" means a written plan leading to a high school diploma for a person who is 16 to 22 years of age and has not received a high school diploma, who may or may not be enrolled in a public or approved independent school. The plan shall define the scope and rigor of services necessary for the student to attain a high school diploma, and may describe educational services to be provided by a public high school, an approved independent high school, an approved provider, or a combination of these.~~

~~(2) "Approved provider" means an entity approved by the commissioner to provide educational services which may be counted for credit toward a high school diploma.~~

~~(3) "Contracting agency" means an agency that has entered into a contract with the department of education to provide adult education services in Vermont.~~ There is created a high school completion program to be a potential component of a flexible pathway for any student who is at least 16 years old, who has not received a high school diploma, and who may or may not be enrolled in a public or approved independent school.

(b) If a person who wishes to work on a ~~graduation education~~ personalized learning plan leading to graduation through the high school completion program is not enrolled in a public or approved independent school, then the commissioner shall assign the prospective student to a high school district, which shall be the district of residence whenever possible. The school district in which a student is enrolled or to which a non-enrolled student is assigned shall work with the contracting agency and the student to develop a ~~graduation education~~ personalized learning plan. The school district shall award a high school diploma upon successful completion of the plan.

(c) The commissioner shall reimburse, and net cash payments where possible, a school district that has agreed to a ~~graduation education~~ personalized learning plan under this section in an amount:

(1) established by the commissioner for development of the ~~graduation education~~ personalized learning plan and for other educational services typically provided by the assigned district or an approved independent school pursuant to the plan, such as counseling, health services, participation in cocurricular activities, and participation in academic or other courses, provided this amount shall not be available to a district that provides services under this section to an enrolled student; and

(2) negotiated by the commissioner and the contracting agency, with the approved provider, for services and outcomes purchased from the approved provider on behalf of the student pursuant to the ~~graduation education~~ personalized learning plan.

§ 1049b. DUAL ENROLLMENT PROGRAM

(a) Program created. There is created a statewide dual enrollment program to be a potential component of a student's flexible pathway and through which a Vermont secondary student who is enrolled in a Vermont public school or a Vermont approved independent school at public expense or who is assigned to a public school through the high school completion program may enroll in up to four postsecondary courses for which the program shall pay tuition.

(b) Courses. The dual enrollment program shall include college courses offered on the campus of an accredited postsecondary institution and college courses offered by an accredited postsecondary institution on the campus of a secondary school. The program may include online college courses or components. Provided, however, a personalized learning plan that includes a dual enrollment course offered by an accredited postsecondary institution that is not approved pursuant to section 176 or 176a of this title shall be submitted to the program manager for review prior to enrollment in the course. The program manager may approve enrollment if it determines that the institution meets quality standards established by the manager or state board rule, that the student does not have access to the same or a comparable course offered by an institution approved pursuant to section 176 or 176a of this title, and that enrollment is in the best interest of the student. A student may appeal a decision of the program manager to the commissioner, whose decision shall be final.

(c) Postsecondary institutions.

(1) Vermont's public postsecondary institutions shall work together to ensure that dual enrollment opportunities are available throughout the state. Other nonprofit accredited postsecondary institutions may participate in the dual enrollment program pursuant to criteria established by this section, the state board, and the program manager.

(2) Each participating postsecondary institution shall:

(A) define how it will determine whether a student is sufficiently prepared to succeed academically in a dual enrollment course;

(B) develop the curriculum and select instructors for dual enrollment courses;

(C) maintain the postsecondary academic record of each participating student and provide transcripts on request;

(D) agree to accept as full payment for a dual enrollment course the tuition set forth in subsection (f) of this section; and

(E) to the extent permitted under the Family Educational Rights and Privacy Act, collect and send data related to student participation and success to the student's secondary school and the commissioner.

(d) Secondary schools. A public secondary school, regional technical center as defined in section 1522 of this title, and approved independent secondary school that receives publicly funded tuition dollars shall:

(1) provide access for eligible students to participate in dual enrollment courses offered on the campus of the secondary school;

(2) accept postsecondary credit awarded for dual enrollment courses as meeting secondary school graduation requirements;

(3) collect enrollment data as prescribed by the department for longitudinal review and evaluation;

(4) identify and provide necessary support for participating students and continue to provide services for students with disabilities; and

(5) provide support for a seamless transition to postsecondary enrollment upon graduation.

(e) Students.

(1) A Vermont resident in any flexible pathway who has completed grade 10 but has not received a high school diploma is eligible to participate in the dual enrollment program if:

(A) the student is enrolled in a Vermont public school or a Vermont approved independent school at public expense or is assigned to a public school through the high school completion program;

(B) dual enrollment is an element included within the student's personalized learning plan; and

(C) the secondary school and the postsecondary institution have determined that the student is sufficiently prepared to succeed in a dual enrollment course, which can be determined in part by the assessment tool or tools identified by the participating postsecondary institution.

(2) An eligible student may enroll in up to four dual enrollment courses prior to completion of secondary school for which the dual enrollment program will pay tuition. A student may enroll in courses offered while secondary school is in session and during the summer.

(3) A student's personalized learning plan shall include provisions for support services, including transitional support for students with disabilities and including academic, emotional, and other support services as appropriate.

(f) Tuition.

(1) For any course for which the postsecondary institution pays the instructor, the commissioner shall reimburse a secondary school district the full amount of tuition paid to the postsecondary institution, which shall not exceed the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(2) For any course that is taught by an instructor who is paid as part of employment by a secondary school, the commissioner shall reimburse a secondary school district the full amount of tuition paid to the postsecondary institution, which shall not exceed 50 percent of the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(g) Program management**.** The department shall manage or may contract for the management of the dual enrollment program in Vermont by:

(1) coordinating secondary and postsecondary partners to ensure success of the programs, including assisting partners to develop memoranda of understanding;

(2) marketing of the dual enrollment program to students and their families throughout the state;

(3) evaluating all aspects of the dual enrollment program;

(4) coordinating with secondary and postsecondary partners to understand and define student academic readiness;

(5) assessing what is needed to support student success;

(6) reviewing program costs;

(7) managing distribution of tuition funds;

(8) coordinating the use of technology to ensure access and coordination of the program;

(9) ensuring overall quality and accountability;

(10) convening regular meetings of interested parties to explore and develop improved student support services; and

(11) performing other necessary or related duties.

(h) Annually in January, the commissioner and program manager shall report to the house and senate committees on education regarding the dual

enrollment program, including data relating to student demographics, levels of participation, and program success.

§ 1049c. INNOVATIVE COMPONENTS OF FLEXIBLE PATHWAYS

(a) The commissioner may use sums appropriated for the high school completion program to support other innovative components of a flexible pathway that are available to a student instead of or in addition to the high school completion program by reimbursing or awarding grants to Vermont public schools, Vermont career and technical education centers, Vermont supervisory unions, approved providers, and contracting agencies for activities that create opportunities for Vermont students to have high-quality educational experiences and achieve career and college readiness while respecting diverse student goals and personal learning styles and abilities, including:

(1) implementation of innovative, comprehensive programs offered by and within a school; and

(2) implementation of innovative, comprehensive programs offered through the school by entities other than the school or offered at a location other than the school campus, including work-based learning, virtual or blended learning, career and technical education, dual enrollment, and programs operated by the Vermont Youth Conservation Corps, Inc.

(b) Money awarded by the commissioner under this section shall be pursuant to criteria established in rule by the state board.

§ 1049d. ADULT DIPLOMA PROGRAM; GENERAL EDUCATIONAL DEVELOPMENT PROGRAM

(a) The department shall maintain an adult diploma program ("ADP"), which shall be an assessment process administered by the department through which an individual who is at least 20 years old can receive a local high school diploma granted by one of the program's participating high schools.

(b) The department shall maintain a general educational development ("GED") program, which it shall administer jointly with the GED testing service and approved local testing centers and through which an individual who is at least 16 years old and who is not enrolled in secondary school can receive a secondary school equivalency certificate based on successful completion of the GED tests.

(c) The commissioner of education may provide additional programs designed to address the individual needs and circumstances of adult students, particularly students with the lowest levels of literacy skills.

Sec. 12. APPROPRIATION

The sum of $1,200,000.00 is appropriated from the education fund in fiscal year 2013 to be used for the purposes of paying tuition under Sec. 11, 16 V.S.A. §§ 1049b (dual enrollment) of this act.

Sec. 13. EFFECTIVE DATES

(a) Sec. 1 of this act shall take effect on July 1, 2013, but shall not apply to a child who lawfully stopped attending school prior to that date.

(b) Sec. 2 of this act shall take effect on July 1, 2014, but shall not apply to a child who lawfully stopped attending school prior to that date.

(c) Sec. 3 of this act shall take effect on July 1, 2015, but shall not apply to a child who lawfully stopped attending school prior to that date.

(d) Sec. 4 of this act shall take effect on July 1, 2016, but shall not apply to a child who lawfully stopped attending school prior to that date.

(e) This section and Secs. 5 through 12 of this act shall take effect on July 1, 2012.

(f) The commissioner of education shall ensure that both new and updated guidance documents required by this act are published no later than July 1, 2012.

and that after passage the title of the bill be amended to read: "An act relating to the mandatory age of school attendance and creating flexible pathways to high school completion"

(Committee vote: 5-0-0)

Reported favorably with recommendation of amendment by Senator Kitchel for the Committee on Appropriations.

The Committee recommends that the bill be amended as follows:

First: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (a) in its entirety and inserting in lieu thereof a new subsection (a) to read:

(a) Program created. There is created a statewide dual enrollment program to be a potential component of a student's flexible pathway and through which a Vermont secondary student who is enrolled in a Vermont public school or a Vermont-approved independent school at public expense or who is assigned to a public school through the high school completion program may enroll in postsecondary courses for which neither the student nor the student's parent or guardian shall be required to pay tuition.

Second: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, § 1049b, in subsection (e), by striking out subdivision (2) in its entirety and inserting in lieu thereof a new subdivision (2) to read:

(2) Subject to available funding, an eligible student may enroll in up to four dual enrollment courses prior to completion of secondary school for which neither the student nor the student's parent or guardian shall be required to pay tuition. A student may enroll in courses offered while secondary school is in session and during the summer.

Third: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (f) in its entirety and inserting in lieu thereof a new subsection (f) to read:

(f) Tuition.

(1) For any course for which the postsecondary institution pays the instructor, tuition shall not exceed the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(2) For any course that is taught by an instructor who is paid as part of employment by a secondary school, tuition shall not exceed 50 percent of the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

Fourth: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, by striking out § 1049c (innovative components of flexible pathways) in its entirety, redesignating § 1049d as § 1049c, and inserting a new § 1049d to read:

§ 1049d. REPORT

Notwithstanding provisions of 2 V.S.A. § 20(d) to the contrary, the prekindergarten–16 council created in section 2905 of this title shall report annually in January to the senate and house committees on appropriations and on education, the senate committee on finance, and the house committee on ways and means regarding the flexible pathways initiative and its potential components as set forth in this subchapter 6, including detailed data regarding and analysis of:

(1) the annual expenditures from the education fund for dual enrollment courses and other alternative programs under this subchapter, including a breakdown of the amount spent for each program statewide and by each participating secondary school;

(2) the annual number of students accessing dual enrollment and alternative programs, including a breakdown by secondary school of:

(A) the total number of students eligible to participate;

(B) the number of students accessing each program;

(C) the per-student tuition and other costs paid for each program;

(3) the geographic areas of the state that are underserved or unable to access dual enrollment programs and each other type of alternative program; and

(4) whether participation in dual enrollment and other alternative programs has improved high school completion rates, student aspiration, college and career readiness, and completion of college or other postsecondary education or training.

Fifth: By striking out Sec. 12 (appropriation) in its entirety and inserting in lieu thereof a new Sec. 12 to read:

Sec. 12. 16 V.S.A. § 2885(c) and (g) are amended to read:

(c) In August of each fiscal year~~, beginning in the year 2000~~, the state treasurer shall withdraw and divide an amount equal to five percent of the assets equally among the University of Vermont, the Vermont ~~state colleges~~ State Colleges, and the Vermont ~~student assistance corporation~~ Student Assistance Corporation. In this subsection, "assets" means the average of the fund's market values at the end of each quarter for the most recent 12 quarters, or all quarters of operation, whichever is less. Therefore, up to five percent of the fund assets are hereby annually allocated pursuant to this section, provided that the amount allocated shall not exceed an amount which would bring the fund balance below the initial funding made in fiscal year 2000 plus any additional contributions to the principal. The University of Vermont and the Vermont ~~state colleges~~ State Colleges shall use the funds to provide nonloan financial aid to Vermont students attending their institutions; the Vermont ~~student assistance corporation~~ Student Assistance Corporation shall use the funds to provide nonloan financial aid to Vermont students attending a Vermont postsecondary institution. For purposes of this section, "nonloan financial aid" includes tuition paid for financially needy Vermont students and Vermont students whose parents have not pursued higher education for:

(1) early college and dual enrollment programs; and

(2) Science, Technology, Engineering, and Mathematics ("STEM") programs.

(g) The University of Vermont, the Vermont State Colleges, and the Vermont Student Assistance Corporation shall review expenditures made from the fund, evaluate the impact of the expenditures on higher education in Vermont, and report this information to the state treasurer each year in January. In addition, in November of each year, the three entities shall report to the joint fiscal committee regarding expenditures made in connection with early college, dual enrollment, and STEM programs.

(Committee vote: 6-0-1)

SUBSTITUTE RECOMMENDATION OF AMENDMENT TO S. 233 BY SENATOR KITCHEL ON BEHALF OF THE COMMITTEE ON APPROPRIATIONS

Senator Kitchel, on behalf of the Committee on Appropriations, moves to substitute the following recommendation of amendment of the Committee on Appropriations, to wit:

That the bill be amended as recommended by the Committee on Education with the following amendments thereto:

First: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (a) in its entirety and inserting in lieu thereof a new subsection (a) to read:

(a) Program created. There is created a statewide dual enrollment program to be a potential component of a student's flexible pathway and through which a Vermont secondary student who is enrolled in a Vermont public school or a Vermont-approved independent school at public expense or who is assigned to a public school through the high school completion program may enroll in postsecondary courses for which neither the student nor the student's parent or guardian shall be required to pay tuition.

Second: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, § 1049b, in subsection (e), by striking out subdivision (2) in its entirety and inserting in lieu thereof a new subdivision (2) to read:

(2) Subject to available funding, an eligible student may enroll in up to four dual enrollment courses under this section prior to completion of secondary school for which neither the student nor the student's parent or guardian shall be required to pay tuition. A student may enroll in courses offered while secondary school is in session and during the summer.

Third: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (f) in its entirety and inserting in lieu thereof a new subsection (f) to read:

(f) Tuition.

(1) For any course for which the postsecondary institution pays the instructor, tuition shall not exceed the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(2) For any course that is taught by an instructor who is paid as part of employment by a secondary school, tuition shall not exceed 50 percent of the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

Fourth: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, by inserting a new § 1049f to read:

§ 1049f. REPORT

Notwithstanding provisions of 2 V.S.A. § 20(d) to the contrary, the prekindergarten–16 council created in section 2905 of this title, in cooperation with the department of education, shall report annually in January to the senate and house committees on appropriations and on education, the senate committee on finance, and the house committee on ways and means regarding the flexible pathways initiative and its potential components as set forth in this subchapter 6, including detailed data regarding and analysis of:

(1) the annual expenditures from the education fund for dual enrollment courses and other alternative programs under this subchapter, including a breakdown of the amount spent for each program statewide and by each participating secondary school;

(2) the annual number of students accessing dual enrollment and alternative programs including, to the extent permitted by the Federal Educational Rights and Privacy Act, a breakdown by secondary school of:

(A) the total number of students eligible to participate;

(B) the number of students accessing each program;

(C) the per-student tuition and other costs paid for each program;

(D) the number of students in the school who are eligible for free and reduced-price lunch and, of those, the number of students accessing each program;

(E) the number of students in the school whose parents have not completed a postsecondary degree and, of those, the number of students accessing each program;

(3) the geographic areas of the state that are underserved or unable to access dual enrollment programs and each other type of alternative program; and

(4) whether participation in dual enrollment and other alternative programs has improved high school completion rates, student aspiration, college and career readiness, and completion of college or other postsecondary education or training.

Fifth: By striking out Sec. 12 (appropriation) in its entirety and inserting in lieu thereof a new Sec. 12 to read:

Sec. 12. 16 V.S.A. § 2885(c) and (g) are amended to read:

(c) In August of each fiscal year~~, beginning in the year 2000~~, the state treasurer shall withdraw and divide an amount equal to five percent of the assets equally among the University of Vermont, the Vermont ~~state colleges~~

State Colleges, and the Vermont ~~student assistance corporation~~ Student Assistance Corporation. In this subsection, "assets" means the average of the fund's market values at the end of each quarter for the most recent 12 quarters, or all quarters of operation, whichever is less. Therefore, up to five percent of the fund assets are hereby annually allocated pursuant to this section, provided that the amount allocated shall not exceed an amount which would bring the fund balance below the initial funding made in fiscal year 2000 plus any additional contributions to the principal. The University of Vermont and the Vermont ~~state colleges~~ State Colleges shall use the funds to provide nonloan financial aid to Vermont students attending their institutions; the Vermont ~~student assistance corporation~~ Student Assistance Corporation shall use the funds to provide nonloan financial aid to Vermont students attending a Vermont postsecondary institution. For purposes of this section, "nonloan financial aid" includes tuition paid for financially needy Vermont students to access early college and dual enrollment programs.

(g) The University of Vermont, the Vermont State Colleges, and the Vermont Student Assistance Corporation shall review expenditures made from the fund, evaluate the impact of the expenditures on higher education in Vermont, and report this information to the state treasurer each year in January. In addition, in November of each year, the three entities shall report to the joint fiscal committee regarding expenditures made in connection with early college and dual enrollment programs.

Favorable with Proposal of Amendment

H. 37.

An act relating to telemedicine.

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

The Committee recommends that the Senate propose to the House to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. chapter 107, subchapter 14 is added to read:

Subchapter 14. Telemedicine

§ 4100k. COVERAGE FOR TELEMEDICINE SERVICES

(a) All health insurance plans in this state shall provide coverage for telemedicine services delivered to a patient in a health care facility to the same extent that the services would be covered if they were provided through in-person consultation.

(b) A health insurance plan may charge a deductible, co-payment, or coinsurance for a health care service provided through telemedicine so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(c) A health insurance plan may limit coverage to health care providers in the plan's network and may require originating site health care providers to document the reason the services are being provided by telemedicine rather than in person.

(d) Nothing in this section shall be construed to prohibit a health insurance plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(e) A health insurance plan may reimburse for teleophthalmology or teledermatology provided by store and forward means and may require the distant site health care provider to document the reason the services are being provided by store and forward means.

(f) Nothing in this section shall be construed to require a health insurance plan to reimburse the distant site health care provider if the distant site health care provider has insufficient information to render an opinion.

(g) As used in this subchapter:

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid, the Vermont health access plan, and any other public health care assistance program offered or administered by the state or by any subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(2) "Health care facility" shall have the same meaning as in 18 V.S.A. § 9402.

(3) "Store and forward" means an asynchronous transmission of medical information to be reviewed at a later date by a health care provider at a distant site who is trained in the relevant specialty and by which the health care provider at the distant site reviews the medical information without the patient present in real time.

(4) "Telemedicine" means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.

Sec. 2. 18 V.S.A. chapter 219 is redesignated to read:

CHAPTER 219. HEALTH INFORMATION TECHNOLOGY AND TELEMEDICINE

Sec. 3. STATUTORY REVISION

18 V.S.A. §§ 9351–9352 shall be recodified as subchapter 1 (Health Information Technology) of chapter 219.

Sec. 4. 18 V.S.A. chapter 219, subchapter 2 is added to read:

Subchapter 2. Telemedicine

§ 9361. HEALTH CARE PROVIDERS PROVIDING TELEMEDICINE OR STORE AND FORWARD SERVICES

(a) Subject to the limitations of the license under which the individual is practicing, a health care provider licensed in this state may prescribe, dispense, or administer drugs or medical supplies, or otherwise provide treatment recommendations to a patient after having performed an appropriate examination of the patient either in person or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically. Treatment recommendations made via electronic means, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional provider–patient settings. For purposes of this subchapter, "telemedicine" shall have the same meaning as in 8 V.S.A. § 4100k.

(b) Receiving teledermatology or teleophthalmology by store and forward means shall not preclude a patient from receiving real time telemedicine or face-to-face services with the distant site health care provider at a future date. Originating site health care providers involved in the store and forward process shall ensure informed consent from the patient. For purposes of this subchapter, "store and forward" shall have the same meaning as in 8 V.S.A. § 4100k.

Sec. 5. RULEMAKING

(a) The commissioner of Vermont health access may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this act.

(b) The commissioner of banking, insurance, securities, and health care administration may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this act.

Sec. 6. HEALTH CARE FACILITY; STUDY

(a) The commissioner of financial regulation or designee shall convene a workgroup comprising health care providers, health insurers, and other interested stakeholders to consider whether and to what extent Vermont should

require health insurance coverage of services delivered to a patient by telemedicine outside a health care facility.

(b) No later than January 15, 2013, the commissioner of financial regulation or designee shall report the workgroup's recommendations to the house committee on health care and the senate committees on health and welfare and on finance.

Sec. 7. EFFECTIVE DATE

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

(b) The remaining sections of this act shall take effect on passage.

(Committee vote: 4-0-0)

(For House amendments, see House Journal for March 14, 2012, page 574.)

H. 78.

An act relating to wages for laid-off employees.

PENDING QUESTION: Shall the Senate propose to the House to amend the bill as recommended by the Committee on Economic Development, Housing and General Affairs?

H. 254.

An act relating to consumer protection.

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

The Committee recommends that the Senate propose to the House 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 63, subchapter 1C is added to read:

Subchapter 1C. Discount Membership Programs

§ 2470aa. DEFINITIONS

In this subchapter:

(1) "Billing information" means any data that enables a seller of a discount membership program to access a consumer's credit or debit card, bank, or other account, but does not include the consumer's name, e-mail address, telephone number, or mailing address. For credit card and debit card accounts, billing information includes the full account number, card type, and

expiration date, and, if necessary, the security code. For accounts at a financial institution, "billing information" includes the full account number and routing number, and, if necessary, the name of the financial institution holding the account.

(2) A "discount membership program" is a program that entitles consumers to receive discounts, rebates, rewards, or similar incentives on the purchase of goods or services or both, in whole or in part, from any third party.

§ 2470bb. APPLICABILITY

A discount membership program is a good or service within the meaning of subsection 2451a(b) of this chapter. This subchapter applies only to persons who are regularly and primarily engaged in trade or commerce in this state in connection with offering or selling discount membership programs. This subchapter shall not apply to an electronic payment system, as defined in 9 V.S.A. § 2480o, or to a financial institution, as defined in 8 V.S.A. § 11101(32).

§ 2470cc. REQUIRED DISCLOSURES; CONSENT

(a) No person shall charge or attempt to charge a consumer for a discount membership program, or to renew a discount membership program beyond the term expressly agreed to by the consumer or the term permitted under section 2470ff of this title, whichever is shorter, unless:

(1) Before obtaining the consumer's billing information, the person has clearly and conspicuously disclosed to the consumer all material terms of the transaction, including:

(A) A description of the types of goods and services on which a discount is available;

(B) The name of the discount membership program and the name and address of the seller of the program;

(C) The amount, or a good faith estimate, of the typical discount on each category of goods and services;

(D) The cost of the program, including the amount of any periodic charges, how often such charges are imposed, and the method of payment;

(E) The right to cancel and to terminate the program, which shall be no more restrictive than as required by section 2470ee of this subchapter, and a toll-free telephone number and e-mail address that can be used to cancel the membership;

(F) The maximum length of membership, as described in section 2470ff of this subchapter;

(G) In the event that the program is offered on the Internet through a link or referral from another business's website, the fact that the seller is not affiliated with that business;

(H) The fact that periodic notices of the program billings will be e-mailed or mailed to the consumer, as the case may be, consistent with section 2470dd of this title; and

(2) The person has received express informed consent for the charge from the consumer whose credit or debit card, bank, or other account will be charged, by:

(A) Obtaining from the consumer:

(i) the consumer's billing information; and

(ii) the consumer's name and address and a means to contact the consumer; and

(B) Requiring the consumer to perform an additional affirmative action, such as clicking on an online confirmation button, checking an online box that indicates the consumer's consent to be charged the amount disclosed, or expressly giving consent over the telephone.

(b) A person who sells discount membership programs shall retain evidence of a consumer's express informed consent for at least three years after the consent is given.

§ 2470dd. PERIODIC NOTICES

(a) A person who periodically charges a consumer for a discount membership program shall send the consumer a notice of the charge no less frequently than every three months from the date of initial enrollment that clearly and conspicuously discloses:

(1) A description of the program;

(2) The name of the discount membership program and the name and address of the seller of the program;

(3) The cost of the program, including the amount of any periodic charges, how often such charges are imposed, and the method of payment;

(4) The right to cancel and to terminate the program, which shall be no more restrictive than as required by section 2470ee of this subchapter, and a toll-free number and e-mail address that can be used to cancel the membership; and

(5) The maximum length of membership, as described in section 2470ff of this subchapter.

(b) The notice specified in subsection (a) of this section:

(1) Shall be sent:

(A) To the consumer's last known e-mail address, if the consumer enrolled in the discount membership program online or by e-mail, with the subject line, "IMPORTANT INFORMATION ABOUT YOUR DISCOUNT PROGRAM BILLING," or substantially similar words, provided that the sender takes reasonable steps to verify that the e-mail has been opened; or

(B) Otherwise by first-class mail to the consumer's last known mailing address, with the heading on the enclosure and outside envelope, "IMPORTANT INFORMATION ABOUT YOUR DISCOUNT PROGRAM BILLING," or substantially similar words; and

(2) Shall not include any solicitation or advertising.

§ 2470ee. CANCELLATION AND TERMINATION

(a) In addition to any other right to revoke an offer, a consumer may cancel the purchase of a discount membership program until midnight on the 30th day after the date the consumer has given express informed consent to be charged for the program. If the consumer cancels within the 30-day period, the seller of the discount membership program shall, within ten days of receiving the notice of cancellation, provide a full refund to the consumer.

(b) Notice of cancellation shall be deemed given when deposited in a mailbox properly addressed and postage prepaid or when e-mailed to the e-mail address of the seller of the discount membership program.

(c) In addition to the right to cancel described in this subchapter, a consumer may terminate a discount membership program at any time by providing notice to the seller by one of the methods described in this section. In that case, the consumer shall not be obligated to make any further payments under the program and shall not be entitled to any discounts under the program for any period of time after the last month for which payment has been made.

(d) If the seller of a discount membership program cancels the program for any reason other than nonpayment by the consumer, the seller shall make pro rata reimbursement to the consumer of all periodic charges paid by the consumer for periods of time after cancellation. Prior to such cancellation, the seller shall first provide reasonable notice and an explanation of the cancellation in writing to the consumer.

§ 2470ff. MAXIMUM LENGTH OF PLAN

No person shall sell, or offer for sale, a discount membership program lasting longer than 18 months.

§ 2470gg. BILLING INFORMATION

No person who offers or sells discount membership programs shall obtain billing information relating to a consumer except directly from the consumer.

§ 2470hh. VIOLATIONS

(a) A violation of this subchapter is deemed to be a violation of section 2453 of this title.

(b) The attorney general has the same authority to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as is provided under subchapter 1 of this chapter.

Sec. 2. 9 V.S.A. chapter 63 is amended to read:

CHAPTER 63. CONSUMER ~~FRAUD~~ PROTECTION

* * *

§ 2453. PRACTICES PROHIBITED; ANTITRUST AND CONSUMER ~~FRAUD~~ PROTECTION

* * *

§ 2461e. REQUIREMENTS FOR GUARANTEED PRICE PLANS AND PREPAID CONTRACTS

* * *

(d) Private right of action under consumer ~~fraud~~ protection act. In addition to the remedies set forth in sections 2458 and 2461 of this title, a home heating oil, kerosene, or liquefied petroleum gas dealer may bring an action against its heating oil, kerosene, or liquefied petroleum gas suppliers for failing to honor its contract with the home heating oil, kerosene, or liquefied petroleum gas dealer. The home heating oil, kerosene, or liquefied petroleum gas dealer bringing the action may recover all remedies available to consumers under subsection 2461(b) of this title.

* * *

§ 2480q. PENALTIES

(a) The following penalties shall apply to violations of this subchapter:

* * *

(3) A violation of section 2480p of this subchapter shall be deemed a violation of ~~chapter 63~~ section 2453 of this title~~, the Consumer Fraud Act~~. The attorney general has the same authority to conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as provided under subchapter 1 ~~of chapter 63~~ of this ~~title~~ chapter.

* * *

Sec. 3. REDESIGNATION OF TERM "CONSUMER FRAUD" TO READ "CONSUMER PROTECTION"

(a) The legislative council, under its statutory revision authority pursuant to 2 V.S.A. § 424, is directed to delete the term "consumer fraud" and to insert in lieu thereof the term "consumer protection" wherever it appears in each of the following sections: 7 V.S.A. § 1010; 8 V.S.A. §§ 2706, 2709, and 2764; 9 V.S.A. § 2471; 18 V.S.A. §§ 1511, 1512, 4086, 4631, 4633, 4634, and 9473; 20 V.S.A. § 2757; and 33 V.S.A. §§ 1923 and 2010; and in any other sections as appropriate.

(b) Notwithstanding the provisions of 3 V.S.A. chapter 25, the attorney general shall have the authority to delete the term "consumer fraud" and to insert in lieu thereof the term "consumer protection" wherever it appears in the attorney general's rules, regulations, and procedures and shall exercise such authority upon passage of this act as he or she deems to be necessary, appropriate, and consistent with the purposes of this section.

Sec. 4. 9 V.S.A. chapter 62 is amended to read:

CHAPTER 62: PROTECTION OF PERSONAL INFORMATION

§ 2430. DEFINITIONS

The following definitions shall apply throughout this chapter unless otherwise required:

* * *

(5)(A) "~~Personal~~ Personally identifiable information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either the name or the data elements are not encrypted or redacted or protected by another method that renders them unreadable or unusable by unauthorized persons:

(i) Social Security number;

(ii) Motor vehicle operator's license number or nondriver identification card number;

(iii) Financial account number or credit or debit card number, if circumstances exist in which the number could be used without additional identifying information, access codes, or passwords;

(iv) Account passwords or personal identification numbers or other access codes for a financial account.

(B) "~~Personal~~ Personally identifiable information" does not mean publicly available information that is lawfully made available to the general public from federal, state, or local government records.

* * *

(8)(A) "Security breach" means unauthorized acquisition ~~or access~~ of ~~computerized~~ electronic data or a reasonable belief of an unauthorized acquisition of electronic data that compromises the security, confidentiality, or integrity of ~~personal~~ a consumer's personally identifiable information maintained by the data collector.

(B) "Security breach" does not include good faith but unauthorized acquisition ~~or access~~ of ~~personal~~ personally identifiable information by an employee or agent of the data collector for a legitimate purpose of the data collector, provided that the ~~personal~~ personally identifiable information is not used for a purpose unrelated to the data collector's business or subject to further unauthorized disclosure.

(C) In determining whether personally identifiable information has been acquired or is reasonably believed to have been acquired by a person without valid authorization, a data collector may consider the following factors, among others:

(i) indications that the information is in the physical possession and control of a person without valid authorization, such as a lost or stolen computer or other device containing information;

(ii) indications that the information has been downloaded or copied;

(iii) indications that the information was used by an unauthorized person, such as fraudulent accounts opened or instances of identity theft reported; or

(iv) that the information has been made public.

§ 2435. NOTICE OF SECURITY BREACHES

(a) This section shall be known as the Security Breach Notice Act.

(b) Notice of breach.

(1) Except as set forth in subsection (d) of this section, any data collector that owns or licenses computerized ~~personal~~ personally identifiable information that includes personal information concerning a consumer shall notify the consumer that there has been a security breach following discovery or notification to the data collector of the breach. Notice of the security breach shall be made in the most expedient time possible and without unreasonable delay, but not later than 45 days after the discovery or notification, consistent with the legitimate needs of the law enforcement agency, as provided in ~~subdivision~~ subdivisions (3) and (4) of this subsection, or with any measures

necessary to determine the scope of the security breach and restore the reasonable integrity, security, and confidentiality of the data system.

(2) Any data collector that maintains or possesses computerized data containing ~~personal~~ personally identifiable information of a consumer that the ~~business~~ data collector does not own or license or any data collector that acts or conducts business in Vermont that maintains or possesses records or data containing ~~personal~~ personally identifiable information that the data collector does not own or license shall notify the owner or licensee of the information of any security breach immediately following discovery of the breach, consistent with the legitimate needs of law enforcement as provided in ~~subdivision~~ subdivisions (3) and (4) of this subsection.

(3) A data collector or other entity subject to this subchapter, other than a person or entity licensed or registered with the department of financial regulation under Title 8 or this title, shall provide notice of a breach to the attorney general's office as follows:

(A)(i) The data collector shall notify the attorney general of the date of the security breach and the date of discovery of the breach and shall provide a preliminary description of the breach within 14 business days, consistent with the legitimate needs of the law enforcement agency as provided in subdivisions (3) and (4) of this subsection, of the data collector's discovery of the security breach or when the data collector provides notice to consumers pursuant to this section, whichever is sooner.

(ii) Notwithstanding subdivision (A)(i) of this subdivision (b)(3), a data collector who, prior to the date of the breach, on a form and in a manner prescribed by the office of the attorney general, had sworn in writing to the attorney general that it maintains written policies and procedures to maintain the security of personally identifiable information and respond to a breach in a manner consistent with Vermont law shall notify the attorney general of the date of the security breach and the date of discovery of the breach and shall provide a description of the breach prior to providing notice of the breach to consumers pursuant to subdivision (1) of this subsection.

(iii) If the date of the breach is unknown at the time notice is sent to the attorney general, the data collector shall send the attorney general the date of the breach as soon as it is known.

(iv) Unless otherwise ordered by a court of this state for good cause shown, a notice provided under this subdivision (3)(A) shall not be disclosed to any person other than the authorized agent or representative of the attorney general, a state's attorney, or another law enforcement officer engaged in legitimate law enforcement activities without the consent of the data collector.

(B)(i) When the data collector provides notice of the breach pursuant to subdivision (1) of this subsection (b), the data collector shall notify the attorney general of the number of Vermont consumers affected, if known to the data collector, and shall provide a copy of the notice provided to consumers under subdivision (1) of this subsection (b).

(ii) The data collector may send to the attorney general a second copy of the consumer notice, from which is redacted the type of personally identifiable information that was subject to the breach, and which the attorney general shall use for any public disclosure of the breach.

(4) The notice to a consumer required by this subsection shall be delayed upon request of a law enforcement agency. A law enforcement agency may request the delay if it believes that notification may impede a law enforcement investigation, or a national or homeland security investigation or jeopardize public safety or national or homeland security interests. In the event law enforcement makes the request in a manner other than in writing, the data collector shall document such request contemporaneously in writing, including the name of the law enforcement officer making the request and the officer's law enforcement agency engaged in the investigation. A law enforcement agency shall promptly notify the data collector when the law enforcement agency no longer believes that notification may impede a law enforcement investigation, or a national or homeland security investigation or jeopardize public safety or national or homeland security interests. The data collector shall provide notice required by this section without unreasonable delay upon receipt of a written communication, which includes facsimile or electronic communication, from the law enforcement agency withdrawing its request for delay.

~~(4)~~(5) The notice to a consumer shall be clear and conspicuous. The notice shall include a description of each of the following, if known to the data collector:

(A) The incident in general terms.

(B) The type of ~~personal~~ personally identifiable information that was subject to the ~~unauthorized access or acquisition~~ security breach.

(C) The general acts of the ~~business~~ data collector to protect the ~~personal~~ personally identifiable information from further ~~unauthorized access or acquisition~~ security breach.

(D) A ~~toll-free~~ telephone number, toll-free if available, that the consumer may call for further information and assistance.

(E) Advice that directs the consumer to remain vigilant by reviewing account statements and monitoring free credit reports.

(F) The approximate date of the security breach.

~~(5)~~(6) For purposes of this subsection, notice to consumers may be provided by one of the following methods:

* * *

(h) Vermont law enforcement agencies, including the department of public safety, shall not be considered a data collector. Except as provided in subdivisions (b)(2) and (b)(3) of this section, Vermont law enforcement agencies, including the department of public safety, shall be exempt from this subchapter.

Sec. 5. 3 V.S.A. § 2222 is amended to read:

§ 2222. POWERS AND DUTIES; BUDGET AND REPORT

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

* * *

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

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

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

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

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

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

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

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

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

* * *

Sec. 6. 22 V.S.A. § 901 is amended to read:

§ 901. DEPARTMENT OF INFORMATION AND INNOVATION

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

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

(2) to manage GOVnet;

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

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

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

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

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

(8) to inventory technology assets within state government;

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

* * *

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

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

Sec. 7. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: 5-0-1)

(No House amendments.)

H. 412.

An act relating to harassment and bullying in educational settings.

PENDING QUESTION: Shall the Senate propose to the House to amend the bill as recommended by the Committee on Education

PROPOSAL OF AMENDMENT TO H. 412 TO BE OFFERED BY SENATOR BARUTH

Senator Baruth moves that the Senate propose to the House to amend the bill in Sec. 1, 16 V.S.A. § 14, subsection (c) by striking out subdivision (2) and inserting in lieu thereof a new subdivision (2) to read as follows:

(2) The conduct was either:

(A) for multiple instances of conduct, so pervasive that when viewed from an objective standard of a similarly situated reasonable person, it substantially and adversely affected the targeted student's equal access to educational opportunities or benefits provided by the educational institution; or

(B) for a single instance of conduct, so severe that when viewed from an objective standard of a similarly situated reasonable person, it substantially

and adversely affected the targeted student's equal access to educational opportunities or benefits provided by the educational institution.

H. 467.

An act relating to limited liability for a landowner who permits a person to enter the owner's land for recreational use.

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

The Committee recommends that the Senate propose to the House to amend the bill in Sec. 1, 12 V.S.A. § 5792(4), after "skiing" by adding the word , snowboarding

(Committee vote: 4-0-1)

(No House amendments.)

H. 485.

An act relating to establishing universal recycling of solid waste.

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

The Committee recommends that the Senate propose to the House to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Universal Recycling of Solid Waste * * *

Sec. 1. 10 V.S.A. § 6602 is amended to read:

§ 6602. DEFINITIONS

For the purposes of this chapter:

(1) "Secretary" means the secretary of the agency of natural resources, or his or her duly authorized representative.

(2) "Solid waste" means any discarded garbage, refuse, septage, sludge from a waste treatment plant, water supply plant, or pollution control facility and other discarded material, including solid, liquid, semi-solid, or contained gaseous materials resulting from industrial, commercial, mining, or agricultural operations and from community activities but does not include animal manure and absorbent bedding used for soil enrichment; high carbon bulking agents used in composting; or solid or dissolved materials in industrial discharges which are point sources subject to permits under the Water Pollution Control Act, chapter 47 of this title.

* * *

(12) "Disposal" means the discharge, deposit, injection, dumping, spilling, leaking, or placing of any solid waste or hazardous waste into or on any land or water so that such solid waste or hazardous waste or any constituent thereof may enter the environment or be emitted into the air or discharged into any ground or surface waters.

(13) "Waste" means a material that is discarded or is being accumulated, stored, or physically, chemically, or biologically treated prior to being discarded or has served its original intended use and is normally discarded or is a manufacturing or mining by-product and is normally discarded.

* * *

(19) "Implementation plan" means that plan which is adopted to be consistent with the state solid waste management plan. This plan must include all the elements required for consistency with the state plan and an applicable regional plan and shall be approved by the secretary. This implementation plan is the basis for state certification of facilities under subsection 6605(c) of this title.

* * *

(27) "Closed-loop recycling" means a system in which a product made from one type of material is reclaimed and reused in the production process or the manufacturing of a new or separate product.

(28) "Commercial hauler" means any person that transports:

(A) regulated quantities of hazardous waste; or

(B) solid waste for compensation in a motor vehicle having a rated capacity of more than one ton.

(29) "Mandated recyclable" means the following source separated materials: aluminum and steel cans; aluminum foil and aluminum pie plates; glass bottles and jars from foods and beverages; polyethylene terephthalate (PET) plastic bottles or jugs; high density polyethylene (HDPE) plastic bottles and jugs; corrugated cardboard; white and colored paper; newspaper; magazines; catalogues; paper mail and envelopes; boxboard; and paper bags.

(30) "Leaf and yard residual" means source separated, compostable untreated vegetative matter, including grass clippings, leaves, kraft paper bags, and brush, which is free from noncompostable materials. It does not include such materials as pre- and postconsumer food residuals, food processing residuals, or soiled paper.

(31) "Food residual" means source separated and uncontaminated material that is derived from processing or discarding of food and that is

recyclable, in a manner consistent with section 6605k of this title. Food residual may include preconsumer and postconsumer food scraps. "Food residual" does not mean meat and meat-related products when the food residuals are composted by a resident on site.

(32) "Source separated" or "source separation" means the separation of compostable and recyclable materials from noncompostable, nonrecyclable materials at the point of generation.

(33) "Wood waste" means trees, untreated wood, and other natural woody debris, including tree stumps, brush and limbs, root mats, and logs.

Sec. 2. 10 V.S.A. § 6604 is amended to read:

§ 6604. SOLID WASTE MANAGEMENT ~~PLANS~~ PLAN

(a) No later than ~~April 30, 1988~~ November 1, 2013, the secretary shall ~~publish and~~ adopt, after notice and public hearing pursuant to 3 V.S.A. chapter 25 ~~of Title 3~~, a solid waste management plan which sets forth a comprehensive statewide strategy for the management of waste~~, including whey. No later than July 1, 1991, the secretary shall publish and adopt, after notice and public hearing pursuant to chapter 25 of Title 3, a hazardous waste management plan, which sets forth a comprehensive statewide strategy for the management of hazardous waste~~.

(1)~~(A)~~ The ~~plans~~ plan shall ~~be based upon~~ promote the following priorities~~, in descending order~~, as found appropriate for certain waste streams, based on data obtained by the secretary as part of the analysis and assessment required under subdivision (2) of this subsection:

~~(i)~~(A) the greatest feasible reduction in the amount of waste generated;

~~(ii)~~(B) materials management, which furthers the development of products that will generate less waste and which promotes responsibility by manufacturers for waste generated from goods produced by a manufacturer;

(C) the reuse and closed-loop recycling of waste to reduce to the greatest extent feasible the volume remaining for processing and disposal;

(D) the reduction of the state's reliance on waste disposal to the greatest extent feasible;

(E) the creation of an integrated waste management system that promotes energy conservation, reduces greenhouse gases, and limits adverse environmental impacts;

~~(iii)~~(F) waste processing to reduce the volume or toxicity of the waste stream necessary for disposal~~;~~

~~(iv) land disposal of the residuals.~~

~~(B) Processing and disposal alternatives shall be preferred which do not foreclose the future ability of the state to reduce, reuse, and recycle waste. In determining feasibility, the secretary shall evaluate alternatives in terms of their expected life-cycle costs~~.

(2) The ~~plans~~ plan shall be revised at least once every five years and shall include:

(A) an analysis of the volume and nature of wastes generated in the state, the source of the waste, and the current fate or disposition of the waste. Such an analysis shall include a waste composition study conducted in accordance with generally accepted practices for such a study;

(B) an assessment of the feasibility and cost of diverting each waste category from disposal, including, to the extent the information is available to the agency, the cost to stakeholders, such as municipalities, manufacturers, and customers. As used in this subdivision (a)(2), "waste category" means:

(i) marketable recyclables;

(ii) leaf and yard residuals;

(iii) food residuals;

(iv) construction and demolition residuals;

(v) household hazardous waste; and

(vi) additional categories or subcategories of waste that the secretary identifies that may be diverted to meet the priorities set forth under subdivision (a)(1) of this section;

(C) a survey of existing and potential markets for each waste category that can be diverted from disposal;

(D) measurable goals and targets for waste diversion for each waste category;

(E) methods to reduce and remove material from the waste stream, including commercially generated and other organic wastes, used clothing, and construction and demolition debris, and to separate, collect, and recycle, treat or dispose of specific waste materials that create environmental, health, safety, or management problems, including~~, but not limited to,~~ tires, batteries, obsolete electronic equipment, and unregulated hazardous wastes. These portions of the plans shall include strategies to assure recycling in the state, and to prevent the incineration or other disposal of marketable recyclables~~. They shall consider both the current solid waste stream and its projected changes, and shall be based on:~~

~~(i) an analysis of the volume and nature of wastes generated in the state, the sources of those wastes, and the current fate or disposition of those wastes;~~

~~(ii) an assessment of the feasibility and cost of recycling each type of waste, including an assessment of the feasibility of providing the option of single source recycling;~~

~~(iii) a survey of existing and potential markets for each type of waste that can be recycled~~;

(F) a coordinated education and outreach component that advances the objectives of the plan, including the source separation requirements, generator requirements to remove food residuals, and the landfill disposal bans contained within this chapter;

(G) performance and accountability measures to ensure that implementation plans are effective in meeting the requirements of this section;

~~(B)~~(H) ~~a proposal for the development~~ an assessment of facilities and programs necessary at the state, regional or local level to achieve the priorities identified in subdivision (a)(1) of this section and the goals established in the plan. ~~Consideration shall be given to the need for additional regional or local composting facilities, the need to expand the collection of commercially generated organic wastes, and the cost-effectiveness of developing single stream waste management infrastructure adequate to serve the entire population, which may include material recovery centers.~~ These portions of the plan shall be based, in part, on an assessment of the status, capacity, and life expectancy of existing ~~treatment and disposal~~ solid waste facilities, and they shall include siting criteria for waste management facilities, and shall establish requirements for full public involvement.

(b) ~~The secretary may manage the hazardous wastes generated, transported, treated, stored or disposed in the state by administering a regulatory and management program which, at a minimum, meets the requirements of subtitle C of the Resource Conservation and Recovery Act of 1976, and amendments thereto, codified as 42 U.S.C. chapter 82, subchapter 3, and the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended.~~

~~(1) Removal of hazardous waste from the waste stream. The secretary is authorized to carry out studies, evaluations and pilot projects to remove significant quantities of unregulated hazardous wastes from the waste stream, when in the secretary's opinion the public health and safety will not be adversely affected. One or more of these projects shall investigate the feasibility and effectiveness of separating from the rest of the waste stream~~

~~those nonhazardous materials which require disposal in landfills, but which may not require the use of liners and leachate collection systems.~~

~~(2) Report on disposal of hazardous wastes. The secretary shall consult with interested persons on the disposal of hazardous waste, including persons with relevant expertise and representatives from state and local government, industry, the agricultural sector, the University of Vermont, and the general public. The secretary shall conduct public hearings, take relevant testimony, perform appropriate analysis and report to the general assembly and the governor by January 1, 1990, on the following:~~

~~(A) the nature, origin and amount of hazardous waste generated in the state;~~

~~(B) the cost and environmental impact of current disposal practices;~~

~~(C) options for the treatment and disposal of leachate collected from sanitary landfills;~~

~~(D) steps that can be taken to reduce waste flows, or recycle wastes;~~

~~(E) the need for recycling, treatment and disposal facilities to be located within the state; and~~

~~(F) a proposed process and proposed criteria for use in siting and constructing needed facilities within the state, and for obtaining the maximum amount of public input in any such process.~~

~~(c)~~ The secretary shall hold public hearings, ~~perform studies as required, conduct ongoing analyses,~~ conduct analyses, and make recommendations to the ~~general assembly with respect to the reduction~~ house and senate committees on natural resources and energy regarding the volume, amount, and toxicity of the waste stream. In this process, the secretary shall consult with manufacturers of commercial products and of packaging used with commercial products, retail sales enterprises, health and environmental advocates, waste management specialists, the general public, and state agencies. The goal of the process is to ensure that packaging used and products sold in the state are not an undue burden to the state's ability to manage its waste. The secretary shall seek voluntary changes on the part of the industrial and commercial sector in both their practices and the products they sell, so as to serve the purposes of this section. In this process, the secretary may obtain voluntary compliance schedules from the appropriate industry or commercial enterprise, and shall entertain recommendations for alternative approaches. The secretary shall report at the beginning of each biennium to the ~~general assembly~~ house and senate committees on natural resources and energy, with any recommendations or options for legislative consideration. At

least 45 days prior to submitting its report, the secretary shall post any recommendations within the report to its website for notice and comment.

(1) In carrying out the provisions of this subsection, the secretary first shall consider ways to keep hazardous material; toxic substances, as that term is defined in subdivision 6624(7) of this title; and nonrecyclable, nonbiodegradable material out of the waste stream, as soon as possible. In this process, immediate consideration shall be given to the following:

(A) evaluation of products and packaging that contain large concentrations of chlorides, such as packaging made with polyvinyl chloride (PVC);

(B) evaluation of polystyrene packaging, particularly that used to package fast food on the premises where the food is sold;

(C) evaluation of products and packaging that bring heavy metals into the waste stream, such as disposable batteries, paint and paint products and containers, and newspaper supplements and similar paper products;

(D) identification of unnecessary packaging, which is nonrecyclable and nonbiodegradable.

(2) With respect to the above, the secretary shall consider the following:

(A) product and packaging bans, products or packaging which ought to be exempt from such bans, the existence of less burdensome alternatives, and alternative ways that a ban may be imposed;

(B) tax incentives, including the following options:

(i) product taxes, based on a sliding scale, according to the degree of undue harm caused by the product, the existence of less harmful alternatives, and other relevant factors;

(ii) taxes on all nonrecyclable, nonbiodegradable products or packaging;

(C) deposit and return legislation and extended producer responsibility legislation for certain products.

~~(d)~~(c) A portion of the state's solid waste management plan shall set forth a comprehensive statewide program for the collection, treatment, beneficial use, and disposal of septage and sludge. The secretary shall work cooperatively with the department of health and the agency of agriculture, food and markets in developing this portion of the plan and the rules to carry it out, both of which shall be consistent with or more stringent than that prescribed by section 405 of the Clean Water Act (33 U.S.C. § 1251, et seq.). In addition, the secretary shall consult with local governmental units and the interested public in the development of the plans. The sludge management plan and the septage

management plan shall be developed and adopted by January 15, 1987. In the development of these portions of the plan, consideration shall be given to, but shall not be limited to, the following:

(1) the varying characteristics of septage and sludge;

(2) its value as a soil amendment;

(3) the need for licensing or other regulation of septage and sludge handlers;

(4) the need for seasonal storage capability;

(5) the most appropriate burdens to be borne by individuals, municipalities, and industrial and commercial enterprises;

(6) disposal site permitting procedures;

(7) appropriate monitoring and reporting requirements;

(8) actions which can be taken through existing state programs to facilitate beneficial use of septage and sludge;

(9) the need for regional septage facilities;

(10) an appropriate public information program; and

(11) the need for and proposed nature and cost of appropriate pilot projects.

~~(e)~~(d) Although the ~~plans~~ plan adopted under this section and any amendments to ~~these plans~~ the plan shall be adopted by means of a public process that is similar to the process involved in the adoption of administrative rules, the ~~plans~~ plan, as initially adopted or as amended, shall not be a rule.

Sec. 3. 10 V.S.A. § 6603 is amended to read:

§ 6603. SECRETARY; POWERS

In addition to any other powers conferred on him or her by law, the secretary shall have the power to:

(1) Adopt, amend, and repeal rules pursuant to 3 V.S.A. chapter 25 ~~of Title 3~~ implementing the provisions of this chapter;

(2) Issue compliance orders as may be necessary to effectuate the purposes of this chapter and enforce the same by all appropriate administrative and judicial proceedings;

(3) Encourage local units of government to manage solid waste problems within their respective jurisdictions, or by contract on a cooperative regional or interstate basis;

(4) Provide technical assistance to municipalities;

(5) Contract in the name of the state for the service of independent contractors under bond, or with an agency or department of the state, or a municipality, to perform services or to provide facilities necessary for the implementation of the state plan, including but not limited to the transportation and disposition of solid waste;

(6) Accept, receive and administer grants or other funds or gifts from public and private agencies, including the federal government, for the purpose of carrying out any of the functions of this chapter. This would include the ability to convey such grants or other funds to municipalities, or other instruments of state or local government.

(7) Prepare a report which proposes methods and programs for the collection and disposal of household quantities of hazardous waste. The report shall compare the advantages and disadvantages of alternate programs and their costs. The secretary shall undertake a voluntary pilot project to determine the feasibility and effectiveness of such a program when in the secretary's opinion such can be undertaken without undue risk to the public health and welfare. Such pilot program may address one or more forms of hazardous waste.

(8) Provide financial assistance to municipalities.

(9) Manage the hazardous wastes generated, transported, treated, stored, or disposed in the state by administering a regulatory and management program which, at a minimum, meets the requirements of subtitle C of the Resource Conservation and Recovery Act of 1976, and amendments thereto, codified as 42 U.S.C. Chapter 82, subchapter 3, and the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, as amended.

(10) Require a facility permitted under section 6605 of this title or a transporter permitted under section 6607 of this title to explain its rate structure for different categories of waste to ensure that the rate structure is transparent to residential consumers.

Sec. 4. 10 V.S.A. § 6605 is amended to read:

§ 6605. SOLID WASTE MANAGEMENT FACILITY CERTIFICATION

(a)(1) No person shall construct, substantially alter, or operate any solid waste management facility without first obtaining certification from the secretary for such facility, site, or activity, except for sludge or septage treatment or storage facilities located within the fenced area of a domestic wastewater treatment plant permitted under chapter 47 of this title. This exemption for sludge or septage treatment or storage facilities shall exist only if:

(A) the treatment facility does not utilize a process to further reduce pathogens in order to qualify for marketing and distribution; and

(B) the facility is not a drying bed, lagoon, or nonconcrete bunker; and

(C) the owner of the facility has submitted a sludge and septage management plan to the secretary and the secretary has approved the plan. Noncompliance with an approved sludge and septage management plan shall constitute a violation of the terms of this chapter, as well as a violation under chapters 201 and 211 of this title.

(2) Certification shall be valid for a period not to exceed ten years~~, except that a certification issued to a sanitary landfill or a household hazardous waste facility under this section shall be for a period not to exceed five years~~.

(b) Certification for a solid waste management facility, where appropriate, shall:

(1) Specify the location of the facility, including limits on its development;

(2) Require proper operation and development of the facility in accordance with the engineering plans approved under the certificate;

(3) Specify the projected amount and types of waste material to be disposed of at the facility, which, in case of landfills and incinerators, shall include the following:

(A) if the waste is being delivered from a municipality that has an approved implementation plan, hazardous materials and recyclables shall be removed from the waste according to the terms of that implementation plan;

(B) if the waste is being delivered from a municipality that does not have an approved implementation plan, ~~yard waste~~ leaf and yard residuals shall be removed from the waste stream, ~~as shall a minimum of approximately 75~~ and 100 percent of each of the following shall be removed from the waste stream: ~~marketable~~ mandated recyclables, hazardous waste from households, and hazardous waste from small quantity generators;

(4) Specify the type and numbers of suitable pieces of equipment that will operate the facility properly;

(5) Contain provisions for air, groundwater, and surface water monitoring throughout the life of the facility and provisions for erosion control, capping, landscaping, drainage systems, and monitoring systems for leachate and gas control;

(6) Contain such additional conditions, requirements, and restrictions as the secretary may deem necessary to preserve and protect the public health and

the air, groundwater and surface water quality. This may include~~, but is not limited to,~~ requirements concerning reporting, recording, and inspections of the operation of the site.

(c) The secretary shall not issue a certification for a new facility or renewal for an existing facility, except for a sludge or septage land application project, unless it is included in an implementation plan adopted pursuant to 24 V.S.A. § 2202a, for the area in which the facility is located. ~~The implementation plan must be consistent with the state plan and in conformance with any municipal or regional plan adopted in accordance with 24 V.S.A. chapter 117. After July 1, 1990, the secretary shall not recertify a facility except for a sludge or septage land application project unless it is included in an implementation plan adopted pursuant to 24 V.S.A. § 2202a, for the area in which the facility is located. The implementation plan must be consistent with the state plan, unless the secretary determines that recertification promotes the public interest, considering the policies and priorities established in this chapter. After July 1, 1990, the secretary shall not recertify a facility, unless it is in conformance with any municipal or regional plan adopted in accordance with 24 V.S.A. chapter 117.~~

* * *

(j) A facility certified under this section that offers the collection of municipal solid waste shall:

(1) Beginning July 1, 2014, collect mandated recyclables separate from other solid waste and deliver mandated recyclables to a facility maintained and operated for the management and recycling of mandated recyclables. A facility shall not be required to accept mandated recyclables from a commercial hauler.

(2) Beginning July 1, 2015, collect leaf and yard residuals separate from other solid waste and deliver leaf and yard residuals to a location that manages leaf and yard residuals in a manner consistent with the priority uses established under subdivisions 6605k(a)(3)–(5) of this title.

(3) Beginning July 1, 2016, collect food residuals separate from other solid waste and deliver food residuals to a location that manages food residuals in a manner consistent with the priority uses established under subdivisions 6605k(a)(2)–(5) of this title.

(k) The secretary may, by rule, adopt exemptions to the requirements of subsection (j) of this section, provided that the exemption is consistent with the purposes of this chapter and the objective of the state plan.

(l) A facility certified under this section that offers the collection of municipal solid waste shall not charge a separate fee for the collection of

mandated recyclables. A facility certified under this section may incorporate the cost of the collection of mandated recyclables into the cost of the collection of municipal solid waste and may adjust the charge for the collection of municipal solid waste. A facility certified under this section may charge a separate fee for the collection of leaf and yard residuals or food residuals. If a facility collects mandated recyclables from a commercial hauler, the facility may charge a fee for the collection of those mandated recyclables.

Sec. 5. 10 V.S.A. § 6605c is amended to read:

§ 6605c. SOLID WASTE CATEGORICAL CERTIFICATIONS

* * *

(b) The secretary may, by rule, list certain solid waste categories as eligible for certification pursuant to this section:

(1) Solid waste categories to be deposited in a disposal facility shall not be a source of leachate harmful to human health or the environment.

(2) Solid waste categories to be managed in a composting facility shall not present an undue threat to human health or the environment.

(3) ~~Solid waste managed~~ Recyclable materials either recycled or prepared for recycling at a recycling facility ~~shall be restricted to facilities that manage 400 tons per year or less of recyclable solid waste~~.

* * *

Sec. 6. 10 V.S.A. § 6605k is added to read:

§ 6605k. FOOD RESIDUALS; MANAGEMENT HIERARCHY

(a) It is the policy of the state that food residuals collected under the requirements of this chapter shall be managed according to the following order of priority uses:

(1) Reduction of the amount generated at the source;

(2) Diversion for food consumption by humans;

(3) Diversion for agricultural use, including consumption by animals;

(4) Composting, land application, and digestion; and

(5) Energy recovery.

(b) A person who produces more than an amount identified under subsection (c) of this section in food residuals and is located within 20 miles of a certified organics management facility that has available capacity and that is willing to accept the materials shall:

(1) Separate food residuals from other solid waste, provided that a de minimis amount of food residuals may be disposed of in municipal solid waste when a person has established a program to separate food residuals and the program includes a component for the education of program users regarding the need to separate food residuals; and

(2) Arrange for the transfer of food residuals to a location that manages food residuals in a manner consistent with the priority uses established under subdivisions (a)(2)–(5) of this section or shall manage food residuals on site.

(c) The following persons shall be subject to the requirements of subsection (b) of this section:

(1) Beginning July 1, 2014, a person whose acts or processes produce more than 104 tons per year of food residuals;

(2) Beginning July 1, 2015, a person whose acts or processes produce more than 52 tons per year of food residuals;

(3) Beginning July 1, 2016, a person whose acts or processes produce more than 26 tons per year of food residuals;

(4) Beginning July 1, 2017, a person whose acts or processes produce more than 18 tons per year of food residuals; and

(5) Beginning July 1, 2018, any person who generates any amount of food residuals.

Sec. 7. 10 V.S.A. § 6605l is added to read:

§ 6605l. PUBLIC COLLECTION CONTAINERS FOR SOLID WASTE

(a) As used in this section:

(1) "Public building" means a state, county, or municipal building, airport terminal, bus station, railroad station, school building, or school.

(2) "Public land" means all land that is owned or controlled by a municipal or state governmental body. "Public land" shall not mean land leased by the state to a person for private use.

(b) Beginning July 1, 2015, when a container or containers in a public building or on public land are provided to the public for use for solid waste destined for disposal, an equal number of containers shall be provided for the collection of mandated recyclables. The containers shall be labeled to clearly show the containers are for recyclables and shall be placed as close to each other as possible in order to provide equally convenient access to users. Bathrooms in public buildings and on public land shall be exempt from the requirement of this section to provide an equal number of containers for the collection of mandated recyclables.

Sec. 8. 10 V.S.A. § 6607a is amended to read:

§ 6607a. WASTE TRANSPORTATION

(a) A commercial hauler desiring to transport waste within the state shall apply to the secretary for a permit to do so, by submitting an application on a form prepared for this purpose by the secretary and by submitting the disclosure statement described in section 6605f of this title. These permits shall have a duration of five years~~. The secretary shall establish a system whereby one-fifth of the permits issued under this section, or that were issued prior to July 1, 1996,~~ and shall be renewed annually. ~~The secretary may extend the expiration date of permits issued under this section as of July 1, 1996, for up to four years.~~ The application shall indicate the nature of the waste to be hauled ~~and the area to be served by the hauler~~. The secretary may specify conditions that the secretary deems necessary to assure compliance with state law. ~~If an area to be served is subject to a duly adopted flow control ordinance, the entity that adopted the flow control ordinance may notify the secretary of that fact on forms provided by the secretary, and shall specify the facility or facilities which must be the recipient of the waste from that area. The secretary shall issue to the applicant a permit which specifies those facilities to which the applicant must deliver waste collected from an area that is subject to a duly adopted flow control ordinance, and which otherwise contains the solid waste management conditions established by the secretary, sufficient to assure compliance with state law.~~

* * *

(g)(1) Except as set forth in subdivisions (2) and (3) of this subsection, a transporter certified under this section that offers the collection of municipal solid waste shall:

(A) Beginning July 1, 2014, offer to collect mandated recyclables separated from other solid waste and deliver mandated recyclables to a facility maintained and operated for the management and recycling of mandated recyclables.

(B) Beginning July 1, 2015, offer to collect leaf and yard residuals separate from other solid waste and deliver leaf and yard residuals to a location that manages leaf and yard residuals in a manner consistent with the priority uses established under subdivisions 6605k(a)(3)–(5) of this title.

(C) Beginning July 1, 2016, offer collection of food residuals separate from other solid waste and deliver to a location that manages food residuals in a manner consistent with the priority uses established under subdivisions 6605k(a)(2)–(5) of this title.

(2) In a municipality that has adopted a solid waste management ordinance addressing the collection of mandated recyclables, leaf and yard residuals, or food residuals, a transporter in that municipality is not required to comply with the requirements of subdivision (1) of this subsection and subsection (h) of this section for the material addressed by the ordinance if the ordinance:

(A) is applicable to all residents of the municipality;

(B) prohibits a resident from opting out of municipally provided solid waste services; and

(C) does not apply a variable rate for the collection for the material addressed by the ordinance.

(3) A transporter is not required to comply with the requirements of subdivision (1)(B) or (C) of this subsection in a specified area within a municipality if:

(A) the secretary has approved a solid waste implementation plan for the municipality;

(B) the approved plan delineates an area where solid waste management services required by subdivision (1)(B) or (C) of this subsection are not required; and

(C) in the delineated area, alternatives to the services, including on site management, required under subdivision (1)(B) or (C) are offered, the alternative services have capacity to serve the needs of all residents in the delineated area, and the alternative services are convenient to residents of the delineated area.

(h) A transporter certified under this section that offers the collection of municipal solid waste shall not charge a separate fee for the collection of mandated recyclables from a residential customer. A transporter certified under this section may incorporate the cost of the collection of mandated recyclables into the cost of the collection of municipal solid waste and may adjust the charge for the collection of municipal solid waste. A transporter certified under this section that offers the collection of municipal solid waste may charge a separate fee for the collection of leaf and yard residuals or organic waste from a residential customer.

Sec. 9. 10 V.S.A. § 6613 is amended to read:

§ 6613. VARIANCES

(a) A person who owns or is in control of any plant, building, structure, process, or equipment may apply to the secretary for a variance from the rules

adopted under this chapter. The secretary may grant a variance if he or she finds that:

(1) The variance proposed does not endanger or tend to endanger human health or safety.

(2) Compliance with the rules from which variance is sought would produce serious hardship without equal or greater benefits to the public.

(3) The variance granted does not enable the applicant to generate, transport, treat, store, or dispose of hazardous waste in a manner which is less stringent than that required by the provisions of Subtitle C of the Resource Conservation and Recovery Act of 1976, and amendments thereto, codified in 42 U.S.C. Chapter 82, subchapter 3, and regulations promulgated under such subtitle.

(b) A person who owns or is in control of any facility may apply to the secretary for a variance from the requirements of subdivision 6605(j)(2) or (3) of this title if the applicant demonstrates alternative services, including on-site management, are available in the area served by the facility, the alternative services have capacity to serve the needs of all persons served by the facility requesting the variance, and the alternative services are convenient to persons served by the facility requesting the variance.

(c) No variance shall be granted pursuant to this section except after public notice and an opportunity for a public meeting and until the secretary has considered the relative interests of the applicant, other owners of property likely to be affected, and the general public.

~~(c)~~(d) Any variance or renewal thereof shall be granted within the requirements of subsection (a) of this section and for time periods and under conditions consistent with the reasons therefor, and within the following limitations:

(1) If the variance is granted on the ground that there is no practicable means known or available for the adequate prevention, abatement, or control of the air and water pollution involved, it shall be only until the necessary practicable means for prevention, abatement, or control become known and available, and subject to the taking of any substitute or alternate measures that the secretary may prescribe.

(2) If the variance is granted on the ground that compliance with the particular requirement or requirements from which variance is sought will necessitate the taking of measures which, because of their extent or cost, must be spread over a considerable period of time, it shall be for a period not to exceed such reasonable time as, in the view of the secretary, is requisite for the taking of the necessary measures. A variance granted on the ground specified

herein shall contain a time schedule for the taking of action in an expeditious manner and shall be conditioned on adherence to the time schedule.

(3) If the variance is granted on the ground that it is justified to relieve or prevent hardship of a kind other than that provided for in subdivisions (1) and (2) of this subsection, it shall be for not more than one year, except that in the case of a variance from the siting requirements for a solid waste management facility, the variance may be for as long as the secretary determines necessary, including a permanent variance.

~~(d)~~(e) Any variance granted pursuant to this section may be renewed on terms and conditions and for periods, which would be appropriate on initial granting of a variance. If a complaint is made to the secretary on account of the variance, no renewal thereof shall be granted, unless following public notice and an opportunity for a public meeting on the complaint, the secretary finds that renewal is justified. No renewal shall be granted except on application therefore. The application shall be made at least 60 days prior to the expiration of the variance. Immediately upon receipt of an application for renewal, the secretary shall give public notice of the application.

~~(e)~~(f) A variance or renewal shall not be a right of the applicant or holder thereof but shall be in the discretion of the secretary.

~~(f)~~(g) This section does not limit the authority of the secretary under section 6610 of this title concerning imminent hazards from solid waste, nor under section 6610a of this title concerning hazards from hazardous waste and violations of statutes, rules, or orders relating to hazardous waste.

Sec. 10. 10 V.S.A. § 6621a is amended to read:

§ 6621a. LANDFILL DISPOSAL REQUIREMENTS

(a) In accordance with the following schedule, no person shall knowingly dispose of the following materials in municipal solid waste or in landfills:

(1) Lead-acid batteries, after July 1, 1990.

(2) Waste oil, after July 1, 1990.

(3) White goods, after January 1, 1991. "White goods" include discarded refrigerators, washing machines, clothes ~~driers~~ dryers, ranges, water heaters, dishwashers, and freezers. Other similar domestic and commercial large appliances may be added, as identified by rule of the secretary.

(4) Tires, after January 1, 1992.

(5) Paint (whether water based or oil based), paint thinner, paint remover, stains, and varnishes. This prohibition shall not apply to solidified water based paint in quantities of less than one gallon, nor shall this prohibition apply to solidified water based paint in quantities greater than one gallon if

those larger quantities are from a waste stream that has been subject to an effective paint reuse program, as determined by the secretary.

(6) Nickel-cadmium batteries, small sealed lead acid batteries, ~~and~~ nonconsumer mercuric oxide batteries, ~~after July 1, 1992, in any district or municipality in which there is an ongoing program to accept these wastes for treatment~~ and any other battery added by the secretary by rule.

(7)(A) Labeled mercury-added products on or before July 1, 2007.

(B) Mercury-added products, as defined in chapter 164 of this title, after July 1, 2007, except as other effective dates are established in that chapter.

(8) Banned electronic devices. After January 1, 2011, computers; peripherals; computer monitors; cathode ray tubes; televisions; printers; personal electronics such as personal digital assistants and personal music players; electronic game consoles; printers; fax machines; wireless telephones; telephones; answering machines; videocassette recorders; digital versatile disc players; digital converter boxes; stereo equipment; and power supply cords (as used to charge electronic devices).

(9) Mandated recyclable materials after July 1, 2014.

(10) Leaf and yard residuals and wood waste after July 1, 2015.

(11) Food residuals after July 1, 2018.

(b) This section shall not prohibit the designation and use of separate areas at landfills for the storage or processing, or both, of material specified in this section.

(c) Insofar as it applies to the operator of a solid waste management facility, the secretary may suspend the application of this section to material specified in subdivisions (a)(2), (3), (4), (5), or (6) of this section, or any combination of these, upon finding that insufficient markets exist and adequate uses are not reasonably available to serve as an alternative to disposal.

Sec. 11. 24 V.S.A. § 2202a is amended to read:

§ 2202a. MUNICIPALITIES—RESPONSIBILITIES FOR SOLID WASTE

(a) Municipalities are responsible for the management and regulation of the storage, collection, processing, and disposal of solid wastes within their jurisdiction in conformance with the state solid waste management plan authorized under 10 V.S.A. chapter 159 ~~of Title 10~~. Municipalities may issue exclusive local franchises and may make, amend, or repeal rules necessary to manage the storage, collection, processing, and disposal of solid waste materials within their limits and impose penalties for violations thereof, provided that the rules are consistent with the state plan and rules ~~promulgated~~

adopted by the secretary of the agency of natural resources under 10 V.S.A. chapter 159. A fine may not exceed $1,000.00 for each violation. This section shall not be construed to permit the existence of a nuisance.

(b) Municipalities may satisfy the requirements of the state solid waste management plan and the rules of the secretary of the agency of natural resources through agreement between any other unit of government or any operator having a permit from the secretary, as the case may be.

(c)(1) No later than July 1, 1988 each municipality, as defined in subdivision 4303(12) of this title, shall join or participate in a solid waste management district organized pursuant to chapter 121 of this title no later than January 1, 1988 or participate in a regional planning commission's planning effort for purposes of solid waste implementation planning, as implementation planning is defined in 10 V.S.A. § 6602.

(2) No later than July 1, 1990 each regional planning commission shall work on a cooperative basis with municipalities within the region to prepare a solid waste implementation plan for adoption by all of the municipalities within the region which are not members of a solid waste district, that conforms to the state waste management plan and describes in detail how the region will achieve the priorities established by 10 V.S.A. § 6604(a)(1). A solid waste implementation plan adopted by a municipality that is not a member of a district shall not in any way require the approval of a district. No later than July 1, 1990 each solid waste district shall adopt a solid waste implementation plan that conforms to the state waste management plan, describes in detail how the district will achieve the priorities established by 10 V.S.A. § 6604(a)~~(1)~~, and is in conformance with any regional plan adopted pursuant to chapter 117 of this title. Municipalities or solid waste management districts that have contracts in existence as of January 1, 1987, which contracts are inconsistent with the state solid waste plan and the priorities established in 10 V.S.A. § 6604(a)~~(1)~~, shall not be required to breach those contracts, provided they make good faith efforts to renegotiate those contracts in order to comply. The secretary may extend the deadline for completion of a plan upon finding that despite good faith efforts to comply, a regional planning commission or solid waste management district has been unable to comply, due to the unavailability of planning assistance funds under 10 V.S.A. § 6603b(a) or delays in completion of a landfill evaluation under 10 V.S.A. § 6605a.

(3) A municipality that does not join or participate as provided in this subsection shall not be eligible for state funds to plan and construct solid waste facilities, nor can it use facilities certified for use by the region or by the solid waste management district.

(4) ~~By no later than July 1, 1992, a~~ A regional plan or a solid waste implementation plan shall include a component for the management of nonregulated hazardous wastes.

(A) At the outset of the planning process for the management of nonregulated hazardous wastes and throughout the process, solid waste management districts or regional planning commissions, with respect to areas not served by solid waste management districts, shall solicit the participation of owners of solid waste management facilities that receive mixed solid wastes, local citizens, businesses, and organizations by holding informal working sessions that suit the needs of local people. At a minimum, an advisory committee composed of citizens and business persons shall be established to provide guidance on both the development and implementation of the nonregulated hazardous waste management plan component.

(B) The regional planning commission or solid waste management district shall hold at least two public hearings within the region or district after public notice on the proposed plan component or amendment.

(C) The plan component shall be based upon the following priorities, in descending order:

(i) The elimination or reduction, whenever feasible, in the use of hazardous, particularly toxic, substances.

(ii) Reduction in the generation of hazardous waste.

(iii) Proper management of household and exempt small quantity generator hazardous waste.

(iv) Reduction in the toxicity of the solid waste stream, to the maximum extent feasible in accordance with the priorities of 10 V.S.A. § 6604(a)(1).

(D) At a minimum, this plan component shall include the following:

(i) An analysis of preferred management strategies that identifies advantages and disadvantages of each option.

(ii) An ongoing educational program for schools and households, promoting the priorities of this subsection.

(iii) An educational and technical assistance program for exempt small quantity generators that provides information on the following: use and waste reduction; preferred management strategies for specific waste streams; and collection, management and disposal options currently or potentially available.

(iv) A management program for household hazardous waste.

(v) A priority management program for unregulated hazardous waste streams that present the greatest risks.

(vi) A waste diversion program element, that is coordinated with any owners of solid waste management facilities and is designed to remove unregulated hazardous waste from the waste stream entering solid waste facilities and otherwise to properly manage unregulated hazardous waste.

(vii) A waste management system established for all the waste streams banned from landfills under 10 V.S.A. § 6621a.

(E) For the purposes of this subsection, nonregulated hazardous wastes include hazardous wastes generated by households and exempt small quantity generators as defined in the hazardous waste management regulations adopted under 10 V.S.A. chapter 159.

(d) By no later than July 1, 2015, a municipality shall implement a variable rate pricing system that charges for the collection of municipal solid waste from a residential customer for disposal based on the volume or weight of the waste collected.

(e) The education and outreach requirements of this section need not be met through direct mailings, but may be met through other methods such as television and radio advertising; use of the Internet, social media, or electronic mail; or the publication of informational pamphlets or materials.

Sec. 12. ANR REPORT ON SOLID WASTE

(a) On or before November 1, 2013, the secretary of natural resources shall submit to the house and senate committees on natural resources and energy a report addressing solid waste management in the state. At a minimum, the report shall include:

(1) Waste analysis. An analysis of the volume and nature of wastes generated in the state, the sources of those wastes, and the current fate or disposition of those wastes. This analysis shall include:

(A) the results of a waste composition study; and

(B) an analysis of the quantities and types of materials received at recycling facilities, the contamination levels of materials received at recycling facilities, and the final disposition of materials received by recycling facilities.

(2) Cost analysis.

(A) An estimate of the cost of implementation of the existing solid waste management system for the state, including the cost to consumers, avoided costs, and foreseeable future costs;

(B) An estimate of the cost of managing individual categories of solid waste as that term is defined in 10 V.S.A. § 6604(a)(2)(B);

(C) An estimate of the costs, cost savings, increased efficiencies, and economic opportunities attendant to the diversion of solid waste categories, including:

(i) the costs of recycling individual categories of materials, such as glass, aluminum, and polyethylene terephthalate (PET) plastic;

(ii) market opportunities for the sale of recyclable materials; and

(iii) the effect of fluctuating commodity prices on the diversion of solid waste and recycling and how to maintain existing recycling rates during commodity fluctuations;

(D) An estimate of the cost to and potential savings to all stakeholders, including municipalities, manufacturers, and customers, from beverage container deposit and return legislation and extended producer responsibility legislation.

(3) Local governance analysis. An analysis of the services provided by municipalities responsible for the management and regulation of the storage, collection, processing, and disposal of solid waste under 24 V.S.A. § 2202a. The analysis shall summarize:

(A) The organizational structure municipalities use to provide solid waste services, including the number of solid waste districts in the state and the number of towns participating in a solid waste district;

(B) The type of solid waste services provided by municipalities, including the categories of solid waste collected and the disposition of collected solid waste;

(C) The effectiveness of beverage container deposit and return legislation or other types of extended producer responsibility legislation for certain products in achieving the priorities and goals established by the state solid waste management plan;

(D) The effectiveness of those facilities and programs in achieving the priorities and goals established by the state solid waste plan; and

(E) The cost-effectiveness of solid waste services provided by municipalities.

(4) Infrastructure analysis.

(A) An assessment of facilities and programs necessary at the state, regional, or local level to achieve the priorities and the goals established in the state solid waste plan.

(B) An estimate of the landfill capacity available in Vermont and an estimated time at which there will be no landfill capacity remaining in the state.

(C) An assessment of the status, capacity, and life expectancy of existing solid waste management facilities.

(D) An estimate of the cost of infrastructure necessary for the mandatory recycling of categories of solid waste.

(5) Natural resources and environmental analysis.

(A) A general, narrative summary or assessment of the natural resources and environmental impacts of current solid waste management practices on air quality, greenhouse gas emissions, and water quality.

(B) A general, narrative summary of how litter or improper disposal or management of solid waste impacts scenic or aesthetic resources.

(6) Legislative recommendation. Recommendations for amending solid waste management practices in the state, including recommended legislative or regulatory changes to promote the reduction in solid waste generation and to increase recycling and diversion of solid waste. Recommendations submitted under this subdivision shall include a summary of the rationale for the recommendation and a general, narrative summary of the costs and benefits of the recommended action.

(b) In preparing the report required by subsection (a) of this section, the secretary shall consult with interested persons, including manufacturers, recyclers, collectors, retailers, solid waste districts, and environmental groups.

Sec. 13. REPEAL

10 V.S.A. § 7113 (advisory committee on mercury pollution) is repealed.

Sec. 14. AGENCY OF NATURAL RESOURCES REPORT OF WASTE TIRE MANAGEMENT AND DISPOSAL

On or before January 15, 2013, the secretary of natural resources shall submit to the house and senate committees on natural resources and energy a report regarding the management of waste tires within the state. The report shall include:

(1) An inventory of sites in the state where the secretary determines, in his or her discretion, that the disposal, management, or disposition of waste tires is a problem.

(2) An estimate of the number of waste tires disposed of or stored at the problem sites identified under subdivision (1) of this section.

(3) An estimate of how much it would cost to properly dispose of or arrange for the final disposition of the number of waste tires estimated under subdivision (2) of this section.

(4) An estimate of the amount of time required for the proper disposal or final disposition of the number of waste tires estimated under subdivision (2) of this section.

Sec. 15. 10 V.S.A. § 6618(b) is amended to read:

(b) The secretary may authorize disbursements from the solid waste management assistance account for the purpose of enhancing solid waste management in the state in accordance with the adopted waste management plan. This includes:

* * *

(10) the costs of the proper disposal of waste tires. Prior to disbursing funds under this subsection, the secretary shall provide a person with notice and opportunity to dispose of waste tires properly. The secretary may condition a disbursement under this subsection on the repayment of the disbursement. If a person fails to provide repayment subject to the terms of a disbursement, the secretary may initiate an action against the person for repayment to the fund or may record against the property of the person a lien for the costs of cleaning up waste tires at a property.

* * * Collection and Recycling of Electronic Devices * * *

Sec. 16. 10 V.S.A. § 7551 is amended to read:

§ 7551. DEFINITIONS

For the purposes of this chapter:

* * *

(4) "Collector" means a public or private entity that receives ~~covered electronic devices~~ electronic waste from covered entities~~,~~ or from another collector and that performs any of the following:

(A) arranges for the delivery of the ~~devices~~ electronic waste to a recycler.

(B) sorts electronic waste.

(C) consolidates electronic waste.

(D) provides data security services in a manner approved by the secretary.

(5) "Computer" means ~~an~~ a laptop computer, desktop computer, tablet computer, or central processing unit that conveys electronic, magnetic, optical,

electrochemical, or other high-speed data processing device performing logical, arithmetic, or storage functions~~, including a laptop computer, desktop computer, and central processing unit~~. "Computer" does not include an automated typewriter or typesetter or other similar device.

* * *

(8) "Covered electronic device" means a: computer; computer monitor; device containing a cathode ray tube; printer; or television ~~sold to~~ from a covered entity. "Covered electronic device" does not include: any motor vehicle or any part thereof; a camera or video camera; a portable or stationary radio; a wireless telephone; a household appliance, such as a clothes washer, clothes dryer, water heater, refrigerator, freezer, microwave oven, oven, range, or dishwasher; equipment that is functionally or physically part of a larger piece of equipment intended for use in an industrial, research and development, or commercial setting; security or anti-terrorism equipment; monitoring and control instruments or systems; thermostats; hand-held transceivers; a telephone of any type; a portable digital assistant or similar device; a calculator; a global positioning system receiver or similar navigation device; commercial medical equipment that contains a cathode ray tube, a cathode ray tube device, a flat panel display, or similar video display that is not separate from the larger piece of equipment; or other medical devices, as the term "device" is defined under 21 U.S.C. § 321(h) of the Federal Food, Drug, and Cosmetic Act, as that section is amended from time to time.

(9) "Covered entity" means any household, charity, or school district in the state; or a business in the state that employs ten or fewer individuals. If seven or fewer covered electronic devices are delivered to a collector at any given time, those devices shall be presumed to be from a covered entity.

(10) "Electronic waste" means a: computer; computer monitor; computer peripheral; device containing a cathode ray tube; printer; or television ~~sold to~~ from a covered entity. "Electronic waste" does not include: any motor vehicle or any part thereof; a camera or video camera; a portable or stationary radio; a wireless telephone; a household appliance, such as a clothes washer, clothes dryer, water heater, refrigerator, freezer, microwave oven, oven, range, or dishwasher; equipment that is functionally or physically part of a larger piece of equipment intended for use in an industrial, library, research and development, or commercial setting; security or antiterrorism equipment; monitoring and control instruments or systems; thermostats; handheld transceivers; a telephone of any type; a portable digital assistant or similar device; a calculator; a global positioning system receiver or similar navigation device; commercial medical equipment that contains a cathode ray tube, a cathode ray tube device, a flat panel display, or similar video display that is not separate from the larger piece of equipment; or other medical devices, as the

term "device" is defined under 21 U.S.C. § 321(h) of the Federal Food, Drug, and Cosmetic Act, as that section is amended from time to time.

* * *

(12) "Market share" means a "manufacturer's market share" which shall be the manufacturer's percentage share of the total weight of covered electronic devices sold in the state as determined by ~~the best available information, which may include~~ an estimate of the aggregate total weight of the manufacturer's covered electronic devices sold in the state during the previous program year based on national sales data unless the secretary approves a manufacturer to use actual sales data.

* * *

(14) "Program year" means the period ~~from July 1 through June 30~~ established by the secretary as the program year in the plan required by section 7552 of this title.

* * *

(20) "Transporter" means a person that moves electronic waste from a collector to either another collector or to a recycler.

* * * Beverage Container Redemption System * * *

Sec. 17. 10 V.S.A. § 1521 is amended to read:

§ 1521. DEFINITIONS

For the purpose of this chapter:

(1) "Beverage" means ~~beer or other malt beverages and mineral waters, mixed wine drink, soda water and carbonated soft drinks in liquid form and intended for human consumption. As of January 1, 1990 "beverage" also shall mean liquor~~:

(A) beer, mixed wine drinks, and other malt beverages in liquid form and intended for human consumption; and

(B) mineral water, soda water, carbonated soft drinks, and all nonalcoholic carbonated or noncarbonated drinks in liquid form and intended for human consumption, except for rice milk, soy milk, milk, and dairy.

(2) "Biodegradable material" means material which is capable of being broken down by bacteria into basic elements.

(3) "Container" means the individual, separate, bottle, can, jar, or carton composed of glass, metal, paper, plastic, or any combination of those materials ~~containing~~ that, at the time of sale, contains three liters or less of a consumer

product. This definition shall not include containers made of biodegradable material.

(4) "Distributor" means every person who engages in the sale of consumer products in containers to a dealer in this state including any manufacturer who engages in such sales. Any dealer or retailer who sells, at the retail level, beverages in containers without having purchased them from a person otherwise classified as a distributor, shall be a distributor.

(5) "Manufacturer" means every person bottling, canning, packing, or otherwise filling containers for sale to distributors or dealers.

(6) "Recycling" means the process of sorting, cleansing, treating, and reconstituting waste and other discarded materials for the purpose of reusing the materials in the same or altered form.

(7) "Redemption center" means a store or other location where any person may, during normal business hours, redeem the amount of the deposit for any empty beverage container labeled or certified pursuant to section 1524 of this title.

(8) "Secretary" means the secretary of the agency of natural resources.

(9) "Mixed wine drink" means a beverage containing wine and more than 15 percent added plain, carbonated, or sparkling water; and which contains added natural or artificial blended material, such as fruit juices, flavors, flavoring, adjuncts, coloring, or preservatives; which contains not more than 16 percent alcohol by volume; or other similar product marketed as a wine cooler.

~~(10) "Liquor" means spirits as defined in 7 V.S.A. § 2.~~

Sec. 18. 10 V.S.A. § 1522 is amended to read:

§ 1522. BEVERAGE CONTAINERS; DEPOSIT

(a) ~~Except with respect to beverage containers which contain liquor, a~~ A deposit of not less than ~~five cents~~ $0.05 shall be paid by the consumer on each beverage container sold at the retail level and refunded to the consumer upon return of the empty beverage container. ~~With respect to beverage containers of volume greater than 50 ml. which contain liquor, a deposit of 15 cents shall be paid by the consumer on each beverage container sold at the retail level and refunded to the consumer upon return of the empty beverage container. The difference between liquor bottle deposits collected and refunds made is hereby retained by the liquor control fund for administration of this subsection.~~

(b) A retailer or a person operating a redemption center who redeems beverage containers shall be reimbursed by the manufacturer or distributor of such beverage containers in an amount which is ~~three and one-half cents~~

$0.035 per container for containers of beverage brands that are part of a commingling program and ~~four cents~~ $0.04 per container for containers of beverage brands that are not part of a commingling program.

(c) [Deleted.]

(d) Containers shall be redeemed during no fewer than 40 hours per week during the regular operating hours of the establishment.

Sec. 19. 10 V.S.A. § 1524 is amended to read:

§ 1524. LABELING

(a) Every beverage container sold or offered for sale at retail in this state shall clearly indicate by embossing or imprinting on the normal product label, or in the case of a metal beverage container on the top of the container, the word "Vermont" or the letters "VT" and the refund value of the container in not less than one-eighth inch type size or such other alternate indications as may be approved by the secretary. This subsection does not prohibit including names or abbreviations of other states with deposit legislation comparable to this chapter.

~~(b) The commissioner of the department of liquor control may allow, in the case of liquor bottles, a conspicuous, adhesive sticker to be attached to indicate the deposit information required in subsection (a) of this section, provided that the size, placement, and adhesive qualities of the sticker are as approved by the commissioner. The stickers shall be affixed to the bottles by the manufacturer, except that liquor which is sold in the state in quantities less than 100 cases per year may have stickers affixed by personnel employed by the department.~~

(c) This section shall not apply to permanently labeled beverage containers.

(d) [Repealed.]

Sec. 20. 10 V.S.A. § 1528 is amended to read:

§ 1528. BEVERAGE REGISTRATION

No distributor or manufacturer shall sell a beverage container in the state of Vermont without the manufacturer registering the beverage container with the agency of natural resources prior to sale~~, unless distributed by the department of liquor control~~. This registration shall take place on a form provided by the secretary and include the following:

(1) The name and principal business address of the manufacturer;

(2) The name of the beverage and the container size;

(3) Whether the beverage is a part of an approved commingling agreement; and

(4) The name of the person picking up the empty beverage container, if that person is different from the manufacturer.

* * * Retail Use of Plastic Carryout Bags * * *

Sec. 21. 10 V.S.A. chapter 167 is added to read:

CHAPTER 167. RETAIL USE OF PLASTIC CARRYOUT BAGS

§ 7601. DEFINITIONS

As used in this chapter:

(1) "Compostable plastic bag" means a plastic bag that meets the current American Society for Testing Materials (ASTM) D6400 standard for compostable plastic, as that standard may be amended from time to time.

(2) "Plastic carryout bag" means a bag composed primarily of thermoplastic synthetic polymeric material that is provided by a retail establishment to a consumer at the time of sale.

(3) "Recyclable paper bag" means a bag that:

(A) is composed of 100 percent recyclable material;

(B) contains 40 percent postconsumer recycled content; and

(C) displays the words "reusable" and "recyclable."

(4) "Retail establishment" means a place where goods, food, or other products are offered to the public for sale, including supermarkets, grocery stores, convenience stores, retail merchandise stores, and restaurants.

(5) "Reusable bag" means a bag designed and manufactured for multiple reuse composed of:

(A) cloth or machine-washable fabric; or

(B) durable plastic that is at least 2.25 mils thick.

§ 7602. PROHIBITION ON USE OF PLASTIC CARRYOUT BAGS

Beginning January 1, 2014:

(1) A retail establishment shall not provide customers with plastic carryout bags; and

(2) A retail establishment shall provide only compostable plastic bags, recyclable paper bags, or reusable bags for the purpose of carrying goods, food, or other products from the retail establishment.

§ 7603. PENALTY

A person who violates a provision of this chapter shall be fined not more than $500.00 for each violation.

* * * Appeals, Enforcement, and Effective Dates * * *

Sec. 22. 10 V.S.A. § 8003(a) is amended to read:

(a) The secretary may take action under this chapter to enforce the following statutes and rules, permits, assurances, or orders implementing the following statutes:

* * *

(21) 10 V.S.A. chapter 166, relating to collection and recycling of electronic waste; ~~and~~

(22) 10 V.S.A. chapter 164A, collection and disposal of mercury-containing lamps;

(23) 24 V.S.A. § 2202a, relating to a municipality's adoption and implementation of a municipal solid waste implementation plan that is consistent with the state solid waste plan; and

(24) 10 V.S.A. chapter 167, relating to the use of plastic carryout bags.

Sec. 23. 10 V.S.A. § 8503 is amended to read:

§ 8503. APPLICABILITY

(a) This chapter shall govern all appeals of an act or decision of the secretary, excluding enforcement actions under chapters 201 and 211 of this title and rulemaking, under the following authorities and under the rules adopted under those authorities:

(1) The following provisions of this title:

* * *

(R) chapter 167 (use of plastic carryout bags).

* * *

(g) This chapter shall govern all appeals of an act or decision of the secretary of natural resources that a municipal solid waste implementation plan proposed under 24 V.S.A. § 2202a conforms with the state solid waste implementation plan adopted pursuant to section 6604 of this title.

Sec. 24. EFFECTIVE DATE

This act shall take effect on July 1, 2012, except that Secs. 17 (definitions; beverage redemption), 18 (beverage container deposit), 19 (beverage container labeling), and 20 (beverage registration) of this act shall take effect July 1, 2014.

(Committee vote: 4-1-0)

(For House amendments, see House Journal for March 1, 2012, page 522; March 2, 2012, page 528.)

PROPOSAL OF AMENDMENT TO H. 485 TO BE OFFERED BY SENATOR ILLUZZI

Senator Illuzzi moves to amend the proposal of amendment of the Committee on Natural Resources as follows

First: By striking out Secs. 17 through 20 in their entirety and inserting in lieu thereof the following:

Sec. 17. ANR REPORT ON THE COSTS AND BENEFITS OF EXPANSION OF THE BEVERAGE CONTAINER REDEMPTION SYSTEM

(a) Findings. The general assembly finds and declares that:

(1) the beverage container redemption system, commonly referred to as the bottle bill, originally was developed as a method of litter control and not as a comprehensive recycling system;

(2) since enactment of the beverage container redemption system, communities and solid waste haulers have developed the management, markets, and infrastructure necessary to implement zero-sort, single-stream recycling programs that allow a broad range of recyclable material to be collected and recycled without source-separation and with minimal labor;

(3) in municipalities where zero-sort, single-stream recycling has been implemented, local recycling collection rates have increased 20 to 30 percent while program operating costs have been reduced by more than 10 percent;

(4) expanding the beverage container redemption system will divert higher-value recyclable material from zero-sort, single-stream recycling programs, which will reduce the dollar value municipalities receive from the commodities market for recyclable material, thereby increasing the costs of municipal solid waste programs; and

(5) in order to determine whether the bottle bill should be expanded, the secretary of natural resources should analyze the costs and benefits of the bottle bill under the existing recycling system and infrastructure in the state in order to determine if expansion of the bottle bill provides Vermont with the optimal, cost-efficient, and effective means of collecting and recycling solid waste in the state.

(b) Report on costs on bottle bill. On or before November 15, 2013, the secretary of natural resources shall submit to the senate and house committees on natural resources and energy, the senate committee on economic development, housing and general affairs, and the house committee on

commerce a report regarding the costs and benefits of expanding the beverage container redemption system to include containers for all noncarbonated drinks. The report shall include:

(1) An estimate of the cost of implementing the existing beverage container redemption system;

(2) An estimate of the cost of implementing expansion of the beverage container redemption system to include containers for all noncarbonated drinks, including an estimate of the commodity value lost by municipalities due to diversion of recyclable material from single-stream recycling programs.

(3) An estimate of the cost of implementing a zero-sort, single-stream recycling program.

(4) A summary of the total recycling benefits of a single-stream recycling program in contrast to the beverage container redemption system.

(5) A recommendation from the secretary whether the beverage container redemption system should be expanded, remain unchanged, or be repealed.

Second: By striking Sec. 24 in its entirety and inserting in lieu thereof the following:

Sec. 24. EFFECTIVE DATE

This act shall take effect on July 1, 2012.

H. 496.

An act relating to preserving Vermont's working landscape.

Reported favorably with recommendation of proposal of amendment by Senator Starr for the Committee on Agriculture.

The Committee recommends that the Senate propose to the House to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 6 V.S.A. § 2966 (Vermont agricultural development board) is repealed in its entirety and new §§ 2966 is added to read:

§ 2966. ESTABLISHMENT OF THE VERMONT WORKING LANDS ENTERPRISE BOARD

(a) Board Established. The Vermont working lands enterprise board is hereby established as the successor in interest to the Vermont agricultural development board.

(b) Goals. The Vermont working lands enterprise board shall perform its duties pursuant to sections 2967 and 2968 of this title:

(1) to promote job creation and the economic viability, growth, and sustainability of the working landscape;

(2) to attract a new generation of entrepreneurs to agriculture and forestry, food and forest systems, and value-added production as a foundation for rural job creation and working lands conservation;

(3) to increase the value and sales of the products of the working landscape by means which reward sound farm and forest management, including appropriate increases in the proportion of value-added farm and forest products relative to raw material exports; and

(4) to build Vermont's reputation as the national leader in food systems development, environmental quality, land stewardship, access to outdoor recreation, and working lands entrepreneurism.

(c) Board Composition. The board shall be composed of the following 24 members:

(1) six members appointed by the governor:

(A) a person with expertise in rural economic development issues;

(B) an employee of a Vermont postsecondary institution experienced in researching issues related to agriculture or forestry;

(C) a person familiar with the agricultural or forest tourism industry;

(D) a member of the Northeast Organic Farming Association of Vermont;

(E) a member of the Vermont Forest Products Association; and

(F) a member of the Vermont Wood Manufacturers Association;

(2) six members appointed by the speaker of the house of representatives:

(A) a person who produces an agricultural commodity other than dairy products;

(B) a person who creates a value-added product using ingredients substantially produced on Vermont farms or from Vermont forests;

(C) a person with expertise in sales and marketing;

(D) a person representing the feed, seed, fertilizer, or equipment enterprises;

(E) a member of the Vermont Woodlands Association; and

(F) a member of the Vermont Forest Stewardship Committee;

(3) six members appointed by the committee on committees of the senate:

(A) a representative of Vermont's dairy industry who is also a dairy farmer;

(B) a person with expertise in land planning and conservation efforts that support Vermont's working landscape;

(C) a representative from a Vermont agricultural or forestry advocacy organization;

(D) a person with experience in providing youth with educational opportunities enhancing understanding of agriculture or forestry;

(E) a member of the Green Mountain Division, Society of American Foresters; and

(F) a member of the Forest Guild who is a resident of Vermont.

(4) the following three members from the executive branch:

(A) the secretary of agriculture, food and markets;

(B) the secretary of commerce and community development; and

(C) the commissioner of forest, parks and recreation; and

(5) the following three members who shall serve as ex officio, non-voting members:

(A) the manager of the Vermont economic development authority;

(B) the executive director of the Vermont sustainable jobs fund; and

(C) the executive director of the Vermont housing conservation board.

(d) Governance.

(1) Eleven voting members of the board shall constitute a quorum, and an action of the board shall be taken by a majority of those members present and voting at a meeting of the members at which a quorum is present.

(2)(A) The chair of the board shall be elected by the board from its membership at the first meeting. The chair shall serve for the duration of his or her member term, until his or her earlier resignation, or until his or her unanimous removal by the governor, the speaker of the house, and the president pro tempore of the senate. A chair may be reappointed, provided that no individual may serve more than two consecutive three-year terms as chair.

(3) Each member of the board shall serve a term of three years, or until his or her earlier resignation. A member shall not serve more than two

consecutive three-year terms. Any vacancy occurring among the members shall be filled by the respective appointing authority, and shall be filled for the balance of the unexpired term.

(e) Compensation. Members who are not state employees or whose membership is not supported by their employer or association may receive reimbursement for actual and necessary expenses incurred in the performance of their duties pursuant to 32 V.S.A. § 1010.

Sec. 2. 6 V.S.A. § 2967 is added to read:

§ 2967. POWERS AND DUTIES OF THE VERMONT WORKING LANDS ENTERPRISE BOARD

(a) The Vermont working lands enterprise board shall have the authority to promote job creation and the economic viability, growth, and sustainability of the working landscape through three mechanisms:

(1) Direct grants and investments in agricultural and forestry enterprises;

(2) Services and assistance to agricultural and forestry enterprises, both through direct coordination with public and private partners, and through performance contracts with one or more persons, including:

(A) technical assistance and product research services;

(B) marketing assistance, market development, and business and financial planning;

(C) local, statewide, regional, national, or international marketing of the Vermont working landscape, its entrepreneurs and sectors, and the public and private programs and partners supporting the working landscape;

(D) organizational, regulatory, and development assistance; and

(E) feasibility studies of facilities or capital investments to optimize construction and other cost efficiencies.

(3) Direct grants and investments in food and forest systems infrastructure.

(b) The board shall have the additional authority:

(1) to pursue, receive, and accept any type of funding from public or private funding sources for the performance of its work;

(2) to use the services and staff of the agency of agriculture, food and markets to assist in the performance of the board's duties, with the concurrence of the secretary of agriculture, food and markets;

(3) to contract for support, technical, or other professional services necessary to complete its work; and

(4) to advise and make recommendations to the secretary of agriculture, food and markets and to the commissioner of forests, parks and recreation on the adoption and amendment of laws, regulations, and governmental policies that affect agriculture and forestry.

Sec. 3. 6 V.S.A. § 2968 is added to read:

§ 2968. VERMONT WORKING LANDS ENTERPRISE FUND

There is created a special fund in the state treasury to be known as the "Vermont working lands enterprise fund." Notwithstanding any contrary provisions of 32 V.S.A. Chapter 7, subchapter 5:

(1) the fund shall be administered, and the monies of the funds shall be expended, by the Vermont working lands enterprise board created in section 2966 of this title;

(2) the fund shall be composed of moneys from time to time appropriated to the fund by the general assembly or received from any other source, private or public, approved by the board, and unexpended balances and any earnings shall remain in the fund from year to year; and

(3) the board shall make expenditures from the fund consistent with the duties and authority of the board to promote job creation and the economic viability, growth, and sustainability of the working landscape consistent with section 2967 of this title.

Sec. 4. TRANSITION

Notwithstanding any provision of Sec. 1. of this act to the contrary, upon the effective date of this act, each member of the Vermont agricultural development board shall become a member of the Vermont working lands enterprise board and shall serve the remainder of his or her current term, upon the expiration of which a member may be reappointed or replaced as provided in 6 V.S.A. § 2966, as amended by this act.

Sec. 5. 10 V.S.A. chapter 15 is amended to read:

CHAPTER 15. VERMONT HOUSING AND CONSERVATION TRUST FUND

* * *

§ 302. POLICY, FINDINGS, AND PURPOSE

(a) The dual goals of creating affordable housing for Vermonters, and conserving and protecting Vermont's agricultural ~~land~~ and forest land, historic properties, important natural areas, and recreational lands are of primary importance to the economic vitality and quality of life of the state.

(b) In the best interests of all of its citizens and in order to improve the quality of life for Vermonters and to maintain for the benefit of future generations the essential characteristics of the Vermont countryside, Vermont should encourage and assist in creating affordable housing and in preserving the state's agricultural ~~land~~ and forest land, historic properties, important natural areas, and recreational lands.

(c) It is the purpose of this chapter to create the Vermont housing and conservation trust fund to be administered by the Vermont housing and conservation board to further the policies established by subsections (a) and (b) of this section.

§ 303. DEFINITIONS

As used in this chapter:

(1) "Board" means the Vermont housing and conservation board established by this chapter.

(2) "Fund" means the Vermont housing and conservation trust fund established by this chapter.

(3) "Eligible activity" means any activity which will carry out either or both of the dual purposes of creating affordable housing and conserving and protecting important Vermont lands, including activities which will encourage or assist:

(A) the preservation, rehabilitation or development of residential dwelling units which are affordable to lower income Vermonters;

(B) the retention of agricultural land for agricultural use, and of forest land for forestry use;

(C) the protection of important wildlife habitat and important natural areas;

(D) the preservation of historic properties or resources;

(E) the protection of areas suited for outdoor public recreational activity;

(F) the development of capacity on the part of an eligible applicant to engage in an eligible activity.

* * *

§ 311. CREATION OF THE VERMONT HOUSING AND CONSERVATION BOARD

(a) There is created and established a body politic and corporate to be known as the "Vermont housing and conservation board" to carry out the

provisions of this chapter. The board is constituted a public instrumentality exercising public and essential governmental functions, and the exercise by the board of the powers conferred by this chapter shall be deemed and held to be the performance of an essential governmental function of the state. The board is exempt from licensure under 8 V.S.A. chapter 73 ~~of Title 8~~.

(b) The board shall consist of the following 11 members:

(1) The secretary of agriculture, food and markets or his or her designee.

(2) The secretary of human services or his or her designee.

(3) The secretary of natural resources or his or her designee.

(4) The executive director of the Vermont housing finance agency or his or her designee.

(5) Three public members appointed by the governor with the advice and consent of the senate, who shall be residents of the state and who shall be experienced in creating affordable housing or conserving and protecting Vermont's agricultural ~~land~~ and forest land, historic properties, important natural areas, or recreational lands, one of whom shall be a representative of lower income Vermonters and one of whom shall be a farmer as defined in 32 V.S.A. § 3752(7).

(6) One public member appointed by the speaker of the house, who shall not be a member of the general assembly at the time of appointment.

(7) One public member appointed by the senate committee on committees, who shall not be a member of the general assembly at the time of appointment.

(8) Two public members appointed jointly by the speaker of the house and the president pro tempore of the senate as follows:

(A) One member from the nonprofit affordable housing organizations that qualify as eligible applicants under subdivision 303(4) of this title who shall not be an employee or board member of any of those organizations at the time of appointment.

(B) One member from the nonprofit conservation organizations whose activities are eligible under subdivision 303(3) of this title who shall not be an employee or member of the board of any of those organizations at the time of appointment.

* * *

§ 321. GENERAL POWERS AND DUTIES

* * *

(d) On behalf of the state of Vermont, the board shall seek and administer federal farmland protection and forestland conservation funds to facilitate the acquisition of interests in land to protect and preserve in perpetuity important farmland for future agricultural use and forestland for future forestry use. Such funds shall be used to implement and effectuate the policies and purposes of this chapter. In seeking federal farmland protection and forestland conservation funds under this subsection, the board shall seek to maximize state participation in the federal wetlands reserve program ~~in order~~ and such other programs as is appropriate to allow for increased or additional implementation of conservation practices on farmland and forestland protected or preserved under this chapter.

* * *

§ 324. STEWARDSHIP

If an activity funded by the board involves acquisition by the state of an interest in real property for the purpose of conserving and protecting agricultural ~~land~~ or forest land, important natural areas, or recreation lands, the board, in its discretion, may make a one-time grant to the appropriate state agency or municipality. The grant shall not exceed ten percent of the current appraised value of that property interest and shall be used to support its proper management or maintenance or both.

* * *

Sec. 6. APPROPRIATIONS

(a) The amount of $1,500,000.00 is appropriated from the general fund to the Vermont working lands enterprise fund in the amounts and for the purposes as follows:

(1) $500,000.00 for direct grants and investments in agricultural or forestry enterprises pursuant to 6 V.S.A. § 2966(a)(1).

(2) $375,000.00 to provide services and assistance to agricultural and forestry enterprises pursuant to 6 V.S.A. § 2966(a)(2).

(3) $500,000.00 for direct grants and investments in food and forest systems infrastructure pursuant to 6 V.S.A. § 2966(a)(3).

(b) The amount of $125,000.00 is appropriated from the general fund to the agency of agriculture, food and markets to provide funding for one full-time position of "Vermont working landscape development director," support staff, and for fiscal management and operations costs.

Sec. 6. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: 5-0-0)

Reported favorably with recommendation of proposal of amendment by Senator Starr for the Committee on Appropriations.

The Committee recommends that the Senate propose to the House to amend the bill as recommended by the Committee on Agriculture with the following amendment thereto:

By striking out Sec. 6 (appropriations) in its entirety and by inserting in lieu thereof a new Sec. 6 to read as follows:

Sec. 6. PRIORITIES FOR WORKING LANDS INVESTMENTS

In the event that sources of funding for investments are available in the agency of agriculture, food and markets, the working lands enterprise board, and the working lands enterprise fund, it is the intent of the general assembly to invest in the following priorities:

(1) funding for direct grants and investments in food and forest systems infrastructure pursuant to 6 V.S.A. § 2966(a)(3).

(2) funding for direct grants and investments in agricultural or forestry enterprises pursuant to 6 V.S.A. § 2966(a)(1).

(3) funding to provide services and assistance to agricultural and forestry enterprises pursuant to 6 V.S.A. § 2966(a)(2).

(4) funding to the agency of agriculture, food and markets for one full-time position of "Vermont working landscape development director," for support staff, and for fiscal management and operations costs.

and by renumbering the remaining sections to be numerically correct

H. 627.

An act relating to an opioid addiction treatment system.

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

The Committee recommends that the Senate propose to the House to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 18 V.S.A. chapter 93 is added to read:

CHAPTER 93. TREATMENT OF OPIOID ADDICTION

§ 4751. PURPOSE

It is the purpose of this chapter to authorize the department of health to establish a regional system of opioid addiction treatment.

§ 4752. OPIOID ADDICTION TREATMENT SYSTEM

(a) The department of health shall establish by rule a regional system of opioid addiction treatment.

(b) The rules shall include the following requirements:

(1) Patients shall receive appropriate, comprehensive assessment and therapy from a physician or advanced practice registered nurse and from a licensed clinical professional with clinical experience in addiction treatment, including a psychiatrist, master's- or doctorate-level psychologist, mental health counselor, clinical social worker, or drug and alcohol abuse counselor.

(2) A medical assessment shall be conducted to determine whether pharmacological treatment, which may include methadone, buprenorphine, and other federally approved medications to treat opioid addiction, is medically appropriate.

(3) A routine medical assessment of the appropriateness for the patient of continued pharmacological treatment based on protocols designed to encourage cessation of pharmacological treatment as medically appropriate for the individual treatment needs of the patient.

(4) Controlled substances for use in federally approved pharmacological treatments for opioid addiction shall be dispensed only by:

(A) a treatment program authorized by the department of health; or

(B) a physician or advanced practice registered nurse who is not affiliated with an authorized treatment program but who meets federal requirements for use of controlled substances in the pharmacological treatment of opioid addiction.

(5) Comprehensive education and training requirements shall apply for health care providers, pharmacists, and the licensed clinical professionals listed in subdivision (1) of this subsection, including relevant aspects of therapy and pharmacological treatment.

(6) Patients shall abide by rules of conduct, violation of which may result in discharge from the treatment program, including:

(A) provisions requiring urinalysis at such times as the program may direct;

(B) restrictions on medication dispensing designed to prevent diversion of medications and to diminish the potential for patient relapse; and

(C) such other rules of conduct as a provider authorized to provide treatment under subdivision (4) of this subsection may require.

(c) No later than January 15 of each year from 2013 through 2016, inclusive, the commissioner shall report to the house committees on human services and on health care and the senate committee on health and welfare regarding the regional system of opioid addiction treatment, including the system's effectiveness.

Sec. 2. REPEAL

Sec. 132 of No. 66 of the Acts of 2003 (Opiate addiction treatment) is repealed on passage of this act.

Sec. 3. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: 4-0-1)

(For House amendments, see House Journal for March 20, 2012, page 731.)

H. 699.

An act relating to scrap metal processors.

Reported favorably with recommendation of proposal of amendment by Senator Carris for the Committee on Economic Development, Housing and General Affairs.

The Committee recommends that the Senate propose to the House 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 82 is amended to read:

CHAPTER 82. SCRAP METAL PROCESSORS

§ 3021. DEFINITIONS

As used in this chapter:

(1) ~~"Authorized scrap seller" means a licensed plumber, electrician, HVAC contractor, building or construction contractor, demolition contractor, construction and demolition debris contractor, public utility, transportation company, licensed peddler or broker, an industrial and manufacturing company; marine, automobile, or aircraft salvage and wrecking company, or a government entity.~~ [Repealed.]

* * *

(7) "Scrap metal processor" means:

(A) a salvage yard, as defined in 24 V.S.A. § 2241(7); or

(B) a person ~~authorized to conduct a business that processes and manufactures scrap metal into prepared grades for sale as raw material to mills,~~

~~foundries, and other manufacturing facilities~~ engaged in the business of purchasing ferrous scrap, nonferrous scrap, metal articles, or proprietary articles, whether for resale or for processing into raw material products consisting of prepared grades.

(C) "Scrap metal processor" does not include:

(i) a salvage yard described in 24 V.S.A. § 2248(e); or

(ii) a salvage yard or salvage dealer that only accepts or dismantles motor vehicles and flattens or crushes the motor vehicles for transportation to a scrap metal processor.

§ 3022. PURCHASE OF NONFERROUS SCRAP, METAL ARTICLES, AND PROPRIETARY ARTICLES

(a) ~~A scrap metal processor may purchase nonferrous scrap, metal articles, and proprietary articles directly from an authorized scrap metal seller or the seller's authorized agent or employee~~. [Repealed.]

(b) A scrap metal processor may purchase nonferrous scrap, metal articles, and proprietary articles ~~from a person who is not an authorized scrap metal seller or the seller's authorized agent or employee, provided~~ only if the scrap metal processor complies with all the following procedures:

(1) At the time of sale, the processor:

(A) ~~requires~~ Requires the seller to provide a current government-issued photographic identification that indicates the seller's full name, current address, and date of birth, and records in a permanent ledger the identification information of the seller, the time and date of the transaction, the license number of the seller's vehicle, and a description of the items received from the seller. ~~This information shall be retained for at least five years at the processor's normal place of business or other readily accessible and secure location. On request, this information shall be made available to any law enforcement official or authorized security agent of a governmental entity who provides official credentials at the scrap metal processor's business location during regular business hours.~~

~~(2)~~(B) Requests and, if available, collects documentation from the seller of the items offered for sale, such as a bill of sale, receipt, letter of authorization, or similar evidence that establishes that the seller lawfully owns the items to be sold.

~~(3)~~(2) After purchasing an item from a person who fails to provide documentation pursuant to subdivision ~~(2)~~(1)(B) of this subsection ~~(b) of this section~~, the processor:

(A) ~~submits~~ Submits to the ~~local law enforcement agency~~ department of public safety no later than the close of the following business day a report that describes the item and the seller's identifying information required in subdivision (1)(A) of this subsection~~, and~~.

(B) ~~holds~~ Holds the proprietary article for at least ~~15~~ 30 days following purchase.

(c) The information collected by a scrap metal processor pursuant to this section shall be retained for at least five years at the processor's normal place of business or other readily accessible and secure location. On request, this information shall be made available to any law enforcement official or authorized security agent of a governmental entity who provides official credentials at the scrap metal processor's business location during regular business hours.

§ 3023. PENALTIES

(a) A scrap metal processor who violates any provision of this chapter for the first time may be assessed a civil penalty not to exceed $1,000.00 for each transaction.

(b) A scrap metal processor who violates any provision of this chapter for a second or subsequent time shall be fined not more than $25,000.00 for each transaction.

Sec. 2. REPORTING SCRAP METAL SALES

The department of public safety, in collaboration with the department of environmental conservation, shall develop:

(1) a uniform form for the report required for purchases pursuant to 9 V.S.A. § 3022(b)(2)(A);

(2) an electronic form and reporting system through which scrap metal processors may submit to the department of public safety the report required for purchases pursuant to 9 V.S.A. § 3022(b)(2)(A); and

(3) an implementation and public outreach process to inform scrap metal processors that the electronic form and reporting system are available for use.

Sec. 3. 13 V.S.A. § 2561 is amended to read:

§ 2561. PENALTY FOR RECEIVING STOLEN PROPERTY; VENUE

~~(a)~~ A person who ~~is a dealer in property who~~ knowingly or recklessly buys, receives, sells, possesses ~~unless with the intent to restore to the owner~~, or aids in the concealment of stolen property~~, knowing or believing the property to be stolen~~ without the intent to restore the property to the rightful owner shall be punished the same as for the stealing of ~~such~~ the property. A prosecution

under this section may be brought where the stolen item is recovered or in the location from where it was stolen.

~~(b) A person who buys, receives, sells, possesses unless with the intent to restore to the owner, or aids in the concealment of stolen property, knowing the same to be stolen, shall be punished the same as for the stealing of such property.~~

~~(c) A buyer, receiver, seller, possessor, or concealer under subsection (a) or (b) of this section may be prosecuted and punished in the criminal division of the superior court in the unit where the person stealing the property might be prosecuted, although such property is bought, received, or concealed in another county or unit.~~

Sec. 4. 9 V.S.A. § 3865 is amended to read:

§ 3865. ~~PAWNBROKER'S RECORD BOOK~~ RECORDS OF A PAWNBROKER OR SECONDHAND DEALER

(a) A pawnbroker or a secondhand dealer shall keep ~~a book in which shall be fairly written in the English language, at the time of making a loan, an account and description of the goods, articles or things pawned or pledged, the amount of money loaned thereon, the time of pledging the same, the rate of interest to be paid on such loan, and the name and residence of the person pawning or pledging such property~~ the following records together for each transaction:

(1) a legible statement written at the time of making the loan describing the items pawned, pledged, or sold, and the amount of money lent or paid thereon, the time of the transaction, and the rate of interest to be paid on the loan, as applicable;

(2) a legible statement of the name, current address, telephone number, and vehicle license number of the person pawning, pledging, or selling the items;

(3) a photograph of the items pawned, pledged, or sold; and

(4) a photocopy of a government-issued identification card issued to the person pawning, pledging, or selling the items. If the seller does not have a government-issued identification card, the purchaser shall take and retain a photograph of the seller's face.

(b) At all reasonable times, ~~such book~~ the records required under subsection (a) of this section shall be open to the inspection of ~~the town or city authorities, all courts, the chief of police, or of any person who is duly authorized in writing for that purpose by such authority, court, or chief of police and who exhibits such written authority to such pawnbroker~~ law enforcement.

(c) In this section:

(1) "Precious metal" means gold, silver, platinum, or palladium.

(2) "Secondhand dealer" means a person in the business of purchasing used or estate precious metal, coins, or jewelry for the purpose of sale to consumers or for scrap.

Sec. 5. 9 V.S.A. § 3872 is added to read:

§ 3872. SECONDHAND DEALERS; RETENTION OF GOODS

A pawnbroker or secondhand dealer, as defined in section 3865 of this title, shall retain property pawned, pledged, or purchased for no fewer than 30 days before offering it for sale or for scrap.

and that after passage the title of the bill be amended to read: "An act relating to scrap metal processors, pawnbrokers, and secondhand dealers"

(Committee vote: 3-0-2)

(For House amendments, see House Journal for March 21, 2012, page 779.)

AMENDMENTS TO PROPOSAL OF AMENDMENT OF THE COMMITTEE ON ECONOMIC DEVELOPMENT, HOUSING AND GENERAL AFFAIRS TO H. 699 TO BE OFFERED BY SENATOR SEARS

Senator Sears moves to amend the proposal of amendment of the Committee on Economic Development, Housing and General Affairs by striking out Sec. 3 in its entirety and inserting in lieu thereof a new Sec. 3 to read as follows:

Sec. 3. POSSESSION OF STOLEN PROPERTY; STUDY; NONVIOLENT MISDEMEANOR SENTENCE REVIEW COMMITTEE

The nonviolent misdemeanor sentence review committee created by Sec. 4 of No. 41 of the Acts of 2011 shall study the feasibility and advisability of broadening the scope of Vermont's possession and receipt of stolen property statute, 13 V.S.A. § 2561. The study shall consider the practical and policy implications of amending 13 V.S.A. § 2561 to apply to reckless conduct or of otherwise amending state stolen property law to limit the likelihood that stolen property will be purchased and resold by pawnbrokers and other persons engaged in the business of reselling property.

H. 730.

An act relating to miscellaneous consumer protection laws.

Reported favorably with recommendation of proposal of amendment by Senator Illuzzi for the Committee on Economic Development, Housing and General Affairs.

The Committee recommends that the Senate propose to the House to amend the bill as follows:

First: By adding Secs. 1a and 1b to read:

Sec. 1a. 9 V.S.A. chapter 63 is amended to read:

CHAPTER 63. CONSUMER ~~FRAUD~~ PROTECTION

* * *

§ 2453. PRACTICES PROHIBITED; ANTITRUST AND CONSUMER. ~~FRAUD~~ PROTECTION

* * *

§ 2461e. REQUIREMENTS FOR GUARANTEED PRICE PLANS AND PREPAID CONTRACTS

* * *

(d) Private right of action under consumer ~~fraud~~ protection act. In addition to the remedies set forth in sections 2458 and 2461 of this title, a home heating oil, kerosene, or liquefied petroleum gas dealer may bring an action against its heating oil, kerosene, or liquefied petroleum gas suppliers for failing to honor its contract with the home heating oil, kerosene, or liquefied petroleum gas dealer. The home heating oil, kerosene, or liquefied petroleum gas dealer bringing the action may recover all remedies available to consumers under subsection 2461(b) of this title.

* * *

§ 2480q. PENALTIES

(a) The following penalties shall apply to violations of this subchapter:

* * *

(3) A violation of section 2480p of this subchapter shall be deemed a violation of ~~chapter 63~~ section 2453 of this title~~, the Consumer Fraud Act~~. The attorney general has the same authority to conduct civil investigations, enter into assurances of discontinuance, and bring civil actions as provided under subchapter 1 ~~of chapter 63~~ of this ~~title~~ chapter.

* * *

Sec. 1b. REDESIGNATION OF TERM "CONSUMER FRAUD" TO READ "CONSUMER PROTECTION"

(a) The legislative council, under its statutory revision authority pursuant to 2 V.S.A. § 424, is directed to delete the term "consumer fraud" and to insert in lieu thereof the term "consumer protection" wherever it appears in each of the following sections: 7 V.S.A. § 1010; 8 V.S.A. §§ 2706, 2709, and 2764; 9 V.S.A. § 2471; 18 V.S.A. §§ 1511, 1512, 4086, 4631, 4633, 4634, and 9473; 20 V.S.A. § 2757; and 33 V.S.A. §§ 1923 and 2010; and in any other sections as appropriate.

(b) Notwithstanding the provisions of 3 V.S.A. chapter 25, the attorney general shall have the authority to delete the term "consumer fraud" and to insert in lieu thereof the term "consumer protection" wherever it appears in the attorney general's rules, regulations, and procedures and shall exercise such authority upon passage of this act as he or she deems to be necessary, appropriate, and consistent with the purposes of this section.

Second: In Sec. 3, in 9 V.S.A. § 2463, in the first sentence, by striking out the following: "in the United States or Canada"

Third: In Sec. 4, by striking out subdivision (7) in its entirety

Fourth: In Sec. 6, in the section catchline following "SERVICES" by adding the following: "; OBLIGATION OF BUSINESS RECIPIENT TO NOTIFY SELLER" and in 9 V.S.A. § 4401(b)(1), in the second sentence before the period by adding the following: and shall have no further obligation to accommodate the seller's schedule for pick-up or return shipment or otherwise to facilitate the recovery of the item beyond the requirements of this section

Fifth: In Sec. 9, in 8 V.S.A. § 4260(a), by striking out the sixth sentence and inserting in lieu thereof a new sentence to read as follows: A customer is deemed to consent to receive notice and correspondence by electronic means if the insurer or vendor first discloses to the customer that by providing an electronic mail address the customer consents to receive electronic notice and correspondence at the address, and, the customer provides an electronic mail address.

Sixth: By striking out Sec. 13 in its entirety and inserting in lieu thereof a new Sec. 13 to read:

Sec. 13. 33 V.S.A. § 2607 is amended to read:

§ 2607. PAYMENTS TO FUEL SUPPLIERS

* * *

(g) The public service board shall require natural gas suppliers to provide a discount to fuel assistance customers that is substantially similar to the discount required in public service board docket 7535 for Central Vermont Public Service Corporation and Green Mountain Power.

Seventh: By adding a Sec. 13a to read:

Sec. 13a. STUDY; RESIDENTIAL SPRINKLER SYSTEMS

The department of public safety, in consultation with the department of financial regulation, home builders, and insurance carriers, as well as other interested parties, shall study the costs of requiring sprinklers in new residential construction, including whether fire insurance carriers should be required to absorb all of the costs of sprinkler installation by offsetting premiums until the cost is paid in full and the reduction in premiums is not otherwise recovered in premiums charged to other insureds. The department shall report its findings and any recommendations regarding the cost of installing and paying for residential sprinkler systems to the senate committee on economic development, housing and general affairs and the house committee on general, housing and military affairs on or before January 15, 2013.

(Committee vote: 3-0-2)

(No House amendments.)

NEW BUSINESS

Third Reading

H. 789.

An act relating to reapportioning the final representative districts of the House of Representatives.

Second Reading

Favorable with Recommendation of Amendment

S. 172.

An act relating to creating a private activity bond advisory committee.

Reported favorably with recommendation of amendment by Senator Illuzzi for the Committee on Economic Development, Housing and General Affairs.

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. STUDY OF STATE OWNERSHIP INTEREST IN VERMONT'S TRANSMISSION ASSETS

(a) The joint fiscal office shall retain the services of a financial advisor to study the costs, benefits, and risks associated with the state's acquisition of up to a 51-percent ownership interest in Vermont's high-voltage bulk electric (115 kV and above) transmission assets, which are currently owned and financed by Vermont Transco, LLC (Transco) and managed by the Vermont Electric Power Co., Inc. (VELCO). The financial advisor shall report his or her findings and recommendations to the senate committees on economic development, housing, and general affairs and on finance and the house committees on commerce and economic development and on ways and means not later than April 2, 2012. The advisor may rely on public financial filings with the U.S. Federal Energy Regulatory Commission, the Vermont public service board, ISO-New England, any bond prospectus prepared and issued by the corporation, as well as any other available, relevant information.

(b) The joint fiscal office shall retain the services of a consultant, who may or may not be the same advisor retained under subsection (a) of this section, to study whether the state's acquisition of transmission assets would position the state to influence public benefits such as:

(1) providing low income or underserved individuals or communities with beneficial products or services;

(2) promoting economic opportunity for individuals or communities with beneficial products or services;

(3) preserving or improving the environment; and

(4) accomplishing any other identifiable benefit for society or the environment.

The consultant shall report his or her findings and recommendations to the senate committees on economic development, housing, and general affairs and on finance and the house committees on commerce and economic development and on ways and means not later than April 2, 2012.

(c) Based on the reports authorized under subsections (a) and (b) of this section, the secretary of administration shall make a recommendation as to whether the acquisition of up to 51-percent of Vermont's transmission assets would benefit the people of Vermont and shall provide the reasons for his or her recommendation. The secretary shall submit his or her recommendation to the senate committees on economic development, housing, and general affairs and on finance and the house committees on commerce and economic development and on ways and means not later than April 9, 2012.

(d) Costs incurred in preparing the reports authorized by this section may be reimbursed from the general fund to the joint fiscal office up to $250,000.00.

Sec. 2. EFFECTIVE DATE

This act shall be effective on passage.

and that after passage the title of the bill be amended to read: "An act relating to the study of state ownership interest in Vermont's transmission assets".

(Committee vote: 5-0-0)

Reported adversely by Senator Cummings for the Committee on Finance.

(Committee vote: 4-1-2)

Reported adversely by Senator Kitchel for the Committee on Appropriations.

(Committee vote: 5-2-0)

AMENDMENT TO S. 172 TO BE OFFERED BY SENATOR MCCORMACK

Senator McCormack moves to amend the recommendation of amendment of the Committee on Economic Development, Housing and General Affairs in Sec. 1(c) by striking out the words "up to" and inserting in lieu thereof the words no less than

AMENDMENT TO S. 172 TO BE OFFERED BY SENATOR ILLUZZI

Senator Illuzzi moves to amend the bill by adding a new section to be numbered Sec. 1a to read as follows:

Sec. 1a. STUDY OF STATE OWNERSHIP INTEREST IN VERMONT'S TRANSMISSION ASSETS

(a) In Docket No. 7770 (regarding the acquisition of Central Vermont Public Service Corporation [CVPS] by Gaz Métro and the merger of CVPS with Green Mountain Power Corporation), the public service board shall not issue a final order until after it has received the study and recommendation required under subsection (b) of this section and, if the study recommends the state acquire an ownership interest in Vermont's high-voltage bulk electric transmission assets, which are currently owned and financed by Vermont Transco, LLC (Transco), then the board shall include in its final order a condition giving the state of Vermont the option to acquire by legislative enactment an ownership interest in those assets at fair market or book value, whichever is less. Notice of intent to exercise the option shall be provided by the General Assembly to Transco or its successor in interest not later than the end of the 72nd biennial session or June 1, 2014, whichever is sooner.

(b) The joint fiscal office shall study whether the state's financial interests would be enhanced by acquiring an ownership interest in Transco, financed in whole or in part with private activity or general obligation bonds or by

acquiring or assuming an equal amount of debt and, if so, make a recommendation on a specific level of ownership. The joint fiscal office may retain the services of a financial advisor to conduct the study and make the recommendation required by this subsection, the reasonable costs of which shall be reimbursed by the petitioners in Docket No. 7770 per order of the public service board. The joint fiscal office shall submit the study and recommendation to the public service board, the department of public service, and the senate committees on economic development, housing, and general affairs, on finance, and on natural resources and energy, and the house committees on commerce and economic development and on natural resources and energy not later than September 1, 2013.

Favorable with Proposal of Amendment

H. 600.

An act relating to mandatory mediation in foreclosure proceedings.

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 as follows:

First: In Sec. 2, 12 V.S.A. § 4631, in subsection (c), by striking out the words "a randomized" and inserting in lieu thereof the words an objective and neutral

Second: In Sec. 6, in subsection (a) and (c), by striking out the following: "December 3, 2013" where it twice appears and inserting in lieu thereof the following: December 31, 2013

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

Sec. 7. EFFECTIVE DATES

(a) This section and Secs. 1, 5, and 6 of this act shall take effect on passage.

(b) Secs. 2, 3, and 4 of this act shall take effect on July 1, 2012.

(Committee vote: 4-0-1)

(For House amendments, see House Journal for March 15, 2012, page 645.)

NOTICE CALENDAR

Favorable

H. 272.

An act relating to maintenance of private roads.

Reported favorably by Senator Cummings for the Committee on Judiciary.

(Committee vote: 5-0-0)

(For House amendments, see House Journal of March 15, 2012, page 649)

Favorable with Proposal of Amendment

H. 535.

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

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

The Committee recommends that the Senate propose to the House to amend the bill by striking out 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.

(Committee vote: 4-0-1)

(For House amendments, see House Journal for March 27, 2012, page 818.)

H. 556.

An act relating to creating a private activity bond advisory committee.

Reported favorably with recommendation of proposal of amendment by Senator Doyle for the Committee on Economic Development, Housing and General Affairs.

The Committee recommends that the Senate propose to the House to amend the bill in Sec. 3, in 10 V.S.A. § 219(d), wherever it appears, by striking out the following: "or the governor-elect"

(Committee vote: 3-0-2)

(For House amendments, see House Journal for April 19, 2012, page 11.)

Reported favorably by Senator Kitchel for the Committee on Appropriations.

(Committee vote: 7-0-0)

H. 559.

An act relating to health care reform implementation.

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

The Committee recommends that the Senate propose to the House to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

* * *

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

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

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

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

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

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

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

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

* * *

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

§ 1804. QUALIFIED EMPLOYERS

~~[Reserved.]~~

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

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

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

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

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

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

(b) A qualified health benefit plan shall provide the following benefits:

(1)(A) The essential benefits package required by Section 1302(a) of the Affordable Care Act and any additional benefits required by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

(B) Notwithstanding subdivision (1)(A) of this subsection, a health insurer or a stand-alone dental insurer, including a nonprofit dental service corporation, may offer a plan that provides only limited dental benefits, either separately or in conjunction with a qualified health benefit plan, if it meets the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code and provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act. Said plans may include child-only policies or family policies. If permitted under federal law, a qualified health benefit plan offered in conjunction with a stand-alone dental plan providing pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act shall be deemed to meet the requirements of this subsection.

(2) At least the ~~silver~~ bronze level of coverage as defined by Section 1302 of the Affordable Care Act and the cost-sharing limitations for individuals provided in Section 1302 of the Affordable Care Act, as well as any more restrictive cost-sharing requirements specified by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

* * *

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

(b) Navigators shall have the following duties:

* * *

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

Sec. 2c. EXCHANGE OPTIONS

In approving benefit packages for the Vermont health benefit exchange pursuant to 18 V.S.A. § 9375(b)(7), the Green Mountain Care board shall approve a full range of cost-sharing structures for each level of actuarial value. To the extent permitted under federal law, the board shall also allow health insurers to establish rewards, premium discounts, split benefit designs, rebates, or 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 that allow licensed insurance agents and brokers to:

(A) enroll qualified individuals and qualified employers in any qualified health plan offered through the exchange for which the individual or employer is eligible and to be appropriately compensated for doing so; and

(B) assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health benefit plans purchased through the exchange.

Sec. 2e. 33 V.S.A. § 1806(e)(1) is amended to read:

(e)(1) A health insurer offering a qualified health benefit plan shall comply with the following insurance and consumer information requirements:

* * *

(D) Provide accurate and timely disclosure of information to the public and to the Vermont health benefit exchange relating to claims denials, enrollment data, rating practices, out-of-network coverage, enrollee and

participant rights provided by Title I of the Affordable Care Act, the compensation paid to licensed insurance brokers and agents for enrollments made through the exchange, and other information as required by the commissioner of Vermont health access or by the commissioner of banking, insurance, securities, and health care administration. The commissioner of banking, insurance, securities, and health care administration shall define, by rule, the acceptable time frame for provision of information in accordance with this subdivision.

* * *

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

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

(a) As used in this section:

(1) "Health benefit plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered through the Vermont health benefit exchange and issued to an individual or to an employee of a small employer. The term does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage in which benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

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

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

employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

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

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

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

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

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

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

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

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

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

(B) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, split benefit designs, rebates, or 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 banking, insurance, securities, and health care administration and the Green Mountain Care board shall report to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance regarding the allocation of expenses among hospitals and health insurers to finance the department's and the board's regulatory activities pursuant to 18 V.S.A. §§ 9374(h) and 9415. The report shall address the basis for the formula and how it is applied and shall contain the department's and the board's recommendations for alternate expense allocation formulas or models.

* * * Unified Health Care Budget * * *

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

§ 9373. DEFINITIONS

* * *

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

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

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

§ 9402. DEFINITIONS

* * *

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

* * *

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

§ 9403. DIVISION OF HEALTH CARE ADMINISTRATION; PURPOSES

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

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

(b) On or before July 1, 2005, the commissioner, in consultation with the secretary of human services, shall submit to the governor a four-year health resource allocation plan. The plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

(1) The plan shall include:

* * *

(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the commissioner shall consider at least the following factors: the values and goals reflected in the state health plan; the needs of the population on a statewide basis; the needs of particular geographic areas of the state, as identified in the state health plan; the needs of uninsured and underinsured populations; the use of Vermont facilities by out-of-state residents; the use of out-of-state facilities by Vermont residents; the needs of populations with special health care needs; the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; the cost impact of these resource requirements on health care expenditures; the services appropriate for the four categories of hospitals described in

subdivision 9402(12) of this title; the overall quality and use of health care services as reported by the Vermont program for quality in health care and the Vermont ethics network; the overall quality and cost of services as reported in the annual hospital community reports; individual hospital four-year capital budget projections; ~~the unified health care budget;~~ and the four-year projection of health care expenditures prepared by the division.

* * *

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

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

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

~~(1) The budget shall:~~

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

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

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

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

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

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

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

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

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

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

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

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

§ 9375a. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET

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

(1) The budget shall:

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

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

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

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

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

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

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

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

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

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

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

* * * Claims Edit Standards * * *

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

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

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a

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

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

(1) The CPT, HCPCS, and NCCI;

(2) National specialty society edit standards; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The payment percentages for modifiers; and

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

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

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

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

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

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

(b) The departments of health and of mental health shall develop clinical and performance quality measures to evaluate and ensure that health care professionals and health care facilities in Vermont provide high quality mental health and substance abuse treatment services to their patients.

§ 9462. QUALITY IMPROVEMENT PROJECTS

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

Sec. 11c. 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. 11d. PARITY FOR PRIMARY MENTAL HEALTH CARE SERVICES; RULEMAKING

To carry out the purposes of Sec. 11c of this act, the commissioner of banking, insurance, securities, and health care administration shall adopt rules pursuant to 3 V.S.A. chapter 25, 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.

Sec. 11e. 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.

(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.

* * * Prior Authorization * * *

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

§ 9418b. PRIOR AUTHORIZATION

* * *

(g)(1) Notwithstanding any provision of law to the contrary, on and after March 1, 2014, a health plan shall accept only the uniform prior authorization forms developed pursuant to subdivision (3) of this subsection when requiring prior authorization of prescription drugs, medical procedures, and medical tests. If a health plan fails to utilize or accept a uniform prior authorization form, or fails to respond within two business days of receipt of a completed prior authorization request from a prescribing health care provider, the prior authorization request shall be deemed to have been granted.

(2) No later than September 1, 2013, the department of banking, insurance, securities, and health care administration shall develop two uniform prior authorization forms. One form shall be used for prior authorization requests for prescription drugs, and one form shall be used for prior authorization requests for medical procedures and medical tests. Notwithstanding any provision of law to the contrary, beginning March 1, 2014, each prescribing health care provider licensed to practice in Vermont shall use the applicable uniform prior authorization forms to request prior authorization for coverage of prescription drugs, medical procedures, and medical tests, and each health plan licensed to do business in Vermont shall accept the uniform prior authorization forms as sufficient to request prior authorization for the applicable benefits.

(3) To the extent consistent with federal law, each uniform prior authorization form developed pursuant to subdivision (2) of this subsection shall meet the following criteria:

(A) The form shall not exceed two pages.

(B) The form shall be made available electronically by the department and by the health plan.

(C) The completed form may be submitted electronically from the prescribing health care provider to the health plan.

(D) The department shall develop the form with input from interested parties from at least one public meeting.

(E) In developing the uniform prior authorization form, 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, if available.

* * * Certificate of Need * * *

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

(b) The board shall have the following duties:

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

* * *

(6) ~~Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business~~ Approve or disapprove requests for health insurance 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 banking, insurance, securities, and health care administration, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board~~, on:~~

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

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

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

~~(7)~~(9) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A.

chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

~~(8)~~(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

* * *

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

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

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

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

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

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

* * *

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

* * *

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

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

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

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

§ 9412. ENFORCEMENT

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

* * *

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

(b) In order to carry out the policy goals of this subchapter, the ~~department~~ board shall adopt by rule by ~~October 1, 2005~~ January 1, 2013, certificate of need procedural guidelines to assist in its decision-making. The guidelines shall be consistent with the state health plan and the health resource allocation plan.

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

§ 9433. ADMINISTRATION

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

(a) For purposes of this section:

(1) "Commissioner" means the commissioner of banking, insurance, securities, and health care administration.

(2) "Department" means the department of banking, insurance, securities, and health care administration.

(b) The Sorry Works! pilot program is established under the oversight of the commissioner. Any hospital that voluntarily chooses to participate shall be eligible for the program beginning on February 1, 2013. Hospitals may participate only with the approval of the hospital administration and the hospital's medical staff.

(c)(1) Under the program, participating hospitals and physicians shall promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements. If a settlement is accepted, further litigation with respect to the mistake shall be prohibited.

(2) Participating hospitals shall provide to the patient written notification of the patient's right to legal counsel. The notification shall include an affirmative declaration that no action was taken to dissuade a patient from using counsel for the negotiations.

(3) A communication between parties engaged in negotiation pursuant to this program is privileged and is not subject to discovery or admissible in evidence in any civil or administrative proceeding. Evidence or information that is otherwise admissible or subject to discovery does not become inadmissible or protected from discovery solely by reason of its disclosure or use in negotiations pursuant to this program.

(4) Participation in Sorry Works! shall toll the applicable statute of limitations in cases where such negotiations are unsuccessful. The commissioner shall establish guidelines for determining when negotiations under the Sorry Works! program begin and end for purposes of tolling the statute of limitations.

(d) Participating hospitals shall report to the department their total costs for medical malpractice verdicts, settlements, and defense litigation for the preceding five years to enable the department to determine average costs for that hospital during that period. The department shall develop standards and protocols to compare costs for cases handled by traditional means and cases handled under the Sorry Works! program for purposes of reporting to the general assembly as to the financial impact of the program.

(e) The commissioner shall establish criteria for the program, including the criteria under which hospitals shall be selected to participate. A program participant may withdraw from the program by notifying the commissioner. Any mistakes in patient care that result in harm that occurred prior to the program participant notifying the commissioner shall continue to be subject to this section and the terms of the program.

(f) In consultation with hospitals, providers, and other interested parties, the department shall adopt rules to implement the pilot program no later than October 1, 2012.

(g) The department shall initiate a dialogue with insurers and encourage them to participate in the Sorry Works! pilot program with any hospital that is willing to commit to the program.

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 in accordance with 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), 24b (Sorry Works! pilot program), 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, 24b, 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, 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 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.

Sec. 24g. LEGISLATIVE INTENT; FEASIBILITY ANALYSIS

(a) The general assembly recognizes the need to balance the rights of consumers to due process of law and to access the court system with the importance of reducing costs to the health care system created by the practice of defensive medicine.

(b) No later than January 15, 2013, the secretary of administration or designee shall report to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary with an analysis of the feasibility of implementing a pretrial screening process for medical malpractice claims without jeopardizing patients' due process rights or their ability to access the courts. In addition to the feasibility analysis, the report shall also include recommendations designed to reduce the practice of defensive medicine without jeopardizing patient care.

* * * Insurance Rate Reviews * * *

Sec. 25. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, health maintenance organization, or a managed care organization and not exempted by subdivision

3368(a)(4) of this title shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until:

(A) a copy of the form, premium rates, and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; ~~nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, or in the case of a request for a rate increase, until~~ and

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

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

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

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

~~(2)~~(3) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this state. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. The board may, in its discretion,

conduct a hearing on the premium rate jointly with any such hearing before the commissioner.

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

(b) At any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section, the commissioner may, after a hearing of which at least 20 days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

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

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

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

with the public comments for their consideration in approving any ~~rate increases~~ rates.

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

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

(B) the review standards in subdivision ~~(a)(2)~~ (a)(3) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and

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

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

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

Sec. 26. 18 V.S.A. § 9381 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 banking, insurance, securities, and health care administration 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. HEALTH CARE OMBUDSMAN REPORT

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

* * * Payment Reform Pilots * * *

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

§ 9377. PAYMENT REFORM; PILOTS

* * *

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

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

~~(3)~~ Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:

* * *

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

* * *

(e) The board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments, to advise the board in developing and

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

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

(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the department of banking, insurance, securities, and health care administration to the same extent as the requirement to participate in the Blueprint for Health pursuant to 8 V.S.A. § 4088h.

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of banking, insurance, securities, and health care administration. Health insurers shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(3) In the event that the secretary of human services is denied permission from the Centers for Medicare and Medicaid Services to include financial participation by Medicare in the pilot projects, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.

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

* * * Blueprint for Health * * *

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

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

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

(2) The director of the Blueprint, in collaboration with the ~~commissioner~~ commissioners of health, of mental health, ~~and the commissioner~~ of Vermont health access, and of disabilities, aging, and independent living, shall oversee the development and implementation of the Blueprint for Health, including a strategic plan describing the initiatives and implementation time lines and

strategies. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration and the chair of the Green Mountain Care board.

(b)(1)(A) The commissioner of Vermont health access shall establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall include the commissioner of health; the commissioner of mental health; a representative from the ~~department of banking, insurance, securities, and health care administration~~ Green Mountain Care board; a representative from the department of Vermont health access; an individual appointed jointly by the president pro tempore of the senate and the speaker of the house of representatives; a representative from the Vermont medical society; a representative from the Vermont nurse practitioners association; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine professions; a primary care professional serving low income or uninsured Vermonters; a licensed mental health professional with clinical experience in Vermont; a representative of the Vermont assembly of home health agencies who has clinical experience; a representative from a self-insured employer who offers a health benefit plan to its employees; and a representative of the state employees' health plan, who shall be designated by the commissioner of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan.

* * *

Sec. 28a. BLUEPRINT PARTICIPATION; LEGISLATIVE INTENT

It is the intent of the general assembly that:

(1) 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 any such provision in a policy, contract, certificate, or agreement shall be null and void.

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

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

* * * Prescription Drug Cost-Sharing * * *

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

§ 4089i. PRESCRIPTION DRUG COVERAGE

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

(b) A health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall not include an annual 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 banking, insurance, securities, and health care administration shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

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

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(12) "Prescribed product" means a drug or device as defined in section 201 of the federal Food, Drug and Cosmetic Act, 21 U.S.C. § 321, a compound drug or drugs, ~~or~~ a biological product as defined in section 351 of the Public Health Service Act, 42 U.S.C. § 262, for human use, or a combination product as defined in 21 C.F.R. § 3.2(e), 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 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 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 as a public managed care organization or through another administrative mechanism that enables the agency to integrate services for the dual eligibles, pursue administrative flexibility and simplification, or otherwise align health coverage programs. The agency shall seek permission to implement payment mechanisms that ensure the health coverage provided under the waiver or waivers is consistent with and supportive of the payment reform initiatives established by the Green Mountain Care board.

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

(A) includes eligibility standards, methodologies, and procedures that are neither more restrictive than the standards, methodologies, and procedures in effect as of January 1, 2012 nor more restrictive than the standards,

methodologies, and procedures for dual eligible individuals who are not enrolled in this consolidated program.

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

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

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

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

(F) if the agency contracts with an integrated service provider (ISP) 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 ISP and a choice of providers for services that are not offered through the individual's ISP.

(G) unless otherwise appropriated by the general assembly, invests at least 50 percent of the remaining funds at the end of the state fiscal year 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; or

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

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

(5) If the agency of human services contracts with an ISP, the agency or designee shall include the following provisions in its ISP contracts:

(A) A broad range of services for individuals, to be provided by the ISP or through contracts between the ISP and other service providers, and coordination between the ISP and other service or health care providers who are not participants in the ISP, as appropriate. Examples of entities that are unlikely to be part of an ISP include the individual's medical home and the Blueprint for Health community health teams.

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

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

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

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

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

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

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

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

(b) The secretary of human services or designee 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 access oversight committee upon request. The secretary or designee shall be available to the health access oversight committee on a monthly basis to provide an update in person or by telephone on the status of 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 access 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 access 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 committee on health and welfare shall 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 may meet up to four times, at the call of the chairs of both committees, or more often with the approval of the speaker of the house of representatives and the president pro tempore of the senate; provided, however, that the committees shall meet no less frequently than once every 90 days. To the extent practicable, such meetings shall coincide with scheduled meetings of the health access 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 access 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 borne by health care providers, health insurers, and the state of Vermont 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 banking, insurance, securities, and health care administration, as that rule exists on the effective date of this section, until March 1, 2013 or the board's adoption of a permanent rule on hospital budget reviews pursuant to Sec. 40a of this act, whichever is earlier.

Sec. 40a. RULEMAKING

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

* * * Position Transfer * * *

Sec. 40b. TRANSFER OF POSITION

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

* * * Maximizing Federal Funds * * *

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

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

* * * Health Access Oversight Committee * * *

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

§ 852. FUNCTIONS AND DUTIES

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

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

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

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

(3) The department of Vermont health access.

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

(5) The department of health.

(6) The department for children and families.

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

(8) The department of mental health.

(9) The agency of human services.

(10) The agency of administration.

(11) The Green Mountain Care board.

(12) The director of health care reform.

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

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

(15) The long-term care ombudsman.

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

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

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to ~~the state Medicaid program and other state~~ health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the general assembly.

* * * Repeals * * *

Sec. 41. REPEALS

(a) 8 V.S.A. § 4089b(h) (insurance quality task force) is repealed July , 012.

(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 is repealed July 1, 2012.

Sec. 41a. TRANSITIONAL PROVISIONS; IMPLEMENTATION

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

(b) Except as otherwise provided in subsections (c) and (d) of this section, individuals in the nongroup market may enroll in health insurance plans offered though the Vermont health benefit exchange beginning at the earliest on October 1, 2013 and at the latest on 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 banking, insurance, securities, and health care administration and the Green Mountain Care board may continue to approve rates and forms for nongroup and small group health insurance plans under the statutes and rules in effect prior to the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. In the alternative, the department of banking, insurance, securities, and health care administration may allow individuals and small employers to extend coverage under an existing health insurance plan. The department of banking, insurance, securities, and health care administration and the Green Mountain Care board shall maintain their authority pursuant to this subsection until the exchange is able to enroll all qualified individuals and small employers who apply for coverage through the exchange.

(d) Notwithstanding Sec. 41(h) of this act, repealing the Vermont health access plan and employer-sponsored insurance assistance, the department of Vermont health access may continue to provide employer-sponsored insurance assistance and coverage through the Vermont health access plan to eligible individuals beyond the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. The

department of Vermont health access shall maintain its authority to administer these programs until the exchange is able to enroll all qualified applicants who apply for coverage through the exchange.

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

(f) To the extent permitted under the Affordable Care Act, in implementing the Vermont health benefit exchange, it is the intent of the general assembly not to impair the health care coverage provided to Vermonters through collective bargaining agreements entered into prior to January 1, 2013 and in effect on January 1, 2014 until the date that any such collective bargaining agreement relating to such health care coverage terminates.

Sec. 42. EFFECTIVE DATES

(a) Secs. 5 (Green Mountain Care board authority), 5a (bill-back report), 6–11 (unified health care budget), 11a (claims edit standards), 11d (rulemaking on primary mental health care parity), 12–14 (Green Mountain Care board duties, health care administration), 23 (hospital budgets), 24 (provider bargaining groups), 24g (pretrial screening feasibility analysis), 25 and 26 (insurance rate reviews), 26a (ombudsman's report), 27 (payment reform pilot projects, 28 (Blueprint for Health), 28a (Blueprint intent), 29 (HMO reporting requirements), 33–35a (waivers), 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), and 41a (transitional provisions) of this act and this section shall take effect on passage.

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

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

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

(e) Sec. 31 (prohibition on discretionary clauses) shall take effect on January 1, 2013 and shall apply to all policies, contracts, certificates, and

agreements renewed, offered, or issued in this state with effective dates on or after such date.

(f)(1) Secs. 32(a), (e), and (f) (prescription drug coverage); 32a and 32b (prescribed products); 35b (Medicaid and exchange advisory committee); 39a (sports injuries); and 40d (health access oversight committee) 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 banking, insurance, securities, and health care administration and the Green Mountain Care board may adopt rules as needed before that date to ensure that enrollment in the health insurance plans will be available no later than October 1, 2013; and

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

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

(i) Secs. 11b (mental health and substance abuse quality assurance), 11e (mental health ombudsman), and 11f (prior authorization) shall take effect on July 1, 2012.

(j) Sec. 11c (parity for primary mental health care services) shall apply to health insurance plans on or after July 1, 2013, on such date as a health insurer issues, offers, or renews the health insurance plan, but in no event later than July 1, 2014.

(k) Secs. 24a–24f (medical malpractice reform) shall take effect on February 1, 2013, except that Sec. 24b(f) (Sorry Works! rulemaking) shall take effect on passage.

(For House amendments, see House Journal for February 23, 2012, page 406.)

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

The Committee recommends that the Senate propose to the House to amend the bill as recommended by the Committee on Health and Welfare with the following amendments thereto:

First: By replacing "of banking, insurance, securities, and health care administration" wherever it appears with "of financial regulation"

Second: In Sec. 2, 33 V.S.A. § 1804, in subdivisions (a)(1) and (b)(1), following the word "calendar", each time it appears, by striking out the word "quarter" and inserting in lieu thereof the word "year"

Third: By striking out Sec. 2d, 33 V.S.A. § 1805, in its entirety and inserting in lieu thereof the following:

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 that allow licensed insurance agents and brokers to be appropriately compensated for:

(A) facilitating 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.

Fourth: In Sec. 3, 33 V.S.A. § 1811, in subdivisions (a)(3)(A) and (B), following the word "calendar", each time it appears, by striking out the word "quarter" and inserting in lieu thereof the word "year"

Fifth: By striking out Secs. 11c and 11d in their entirety and inserting in lieu thereof the following:

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.

Sixth: By inserting a new Sec. 11e to read as follows:

Sec. 11e. 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:

* * *

and by redesignating the current Sec. 11e to be Sec. 11d

Seventh: By striking out Sec. 11f in its entirety and inserting in lieu thereof the following:

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

§ 9418b. PRIOR AUTHORIZATION

* * *

(g)(1) 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:

(A) The HIPAA 278 standard transaction for sending or receiving authorizations electronically; or

(B) a uniform prior authorization form 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 uniform 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 uniform 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 prior authorization included in the HIPAA 278 standard transaction.

(B) The form shall be made available electronically by the department and by the health plan.

(C) The completed form may be submitted electronically from the prescribing health care provider to the health plan.

(D) The department shall develop the form 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 two business days for urgent requests and within seven business days 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.

Eighth: In Sec. 12, 18 V.S.A. § 9375(b), in subdivision (6), following "Approve", by inserting ", modify,"

Ninth: By striking out Sec. 25, 8 V.S.A. § 4062, in its entirety and inserting in lieu thereof the following:

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) 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.

Tenth: By adding a Sec. 25a to read as follows:

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.

Eleventh: By striking out Sec. 26a in its entirety and inserting in lieu thereof the following:

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.

Twelfth: In Sec. 28, 18 V.S.A. § 702, in subdivision (b)(1)(A), following "with clinical experience in Vermont;", by inserting "a representative of the Vermont council of developmental and mental health services;"

Thirteenth: In Sec. 31, 8 V.S.A. § 4062f, in subsections (c), (d), and (e), preceding "any such provision", each time it appears, by inserting "on and after July 1, 2012,"

Fourteenth: In Sec. 32b, 18 V.S.A. § 4632, in subdivisions (a)(1)(B) and (a)(5)(A), by striking out the word "and" preceding the word "items", each time it appears, and following the word "equipment", by inserting ", medical food, and infant formula" in both places

Fifteenth: In Sec. 35c, Exchange Implementation and Transition Planning; Updates, in subsection (a), in the first sentence, following the word "senate", by striking the word "committee" and inserting in lieu thereof the word "committees" and following the word "welfare", by inserting the words "and on finance"; and in the second sentence, following the words "the chairs of", by striking out the word "both" and inserting in lieu thereof the word "the"

Sixteenth: By striking out Sec. 40d, 2 V.S.A. § 852, in its entirety and inserting in lieu thereof the following:

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~~ financial regulation.

(5) The department of health.

(6) The department for children and families.

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

(8) The department of mental health.

(9) The agency of human services.

(10) The agency of administration.

(11) The Green Mountain Care board.

(12) The director of health care reform.

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

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

(15) The long-term care ombudsman.

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

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

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to ~~the state Medicaid program and other state~~ health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the general assembly.

§ 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.

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

(j) 8 V.S.A. §§ 4062d (market security trust), 4077 (industrial policies), and 4078 (franchise plan policies) are repealed on July 1, 2012.

and by adding a subsection (k) to read as follows:

(k) Sec. 141c of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as amended (mental health oversight committee), is repealed.

Eighteenth: In Sec. 41a, Transitional Provisions; Implementation, by redesignating the current subsection (a) to be subdivision (a)(1); in the new subdivision (a)(1), following the word "purchased", by inserting the words "that took effect"; and by adding a subdivision (a)(2) to read as follows:

(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.

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

Sec. 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.

Twentieth: In Sec. 42, Effective dates, in subsection (a), by striking out "11d (rulemaking on primary mental health parity)" and inserting in lieu thereof "11c (parity for primary mental health care services)", by striking out "25 and 26" and inserting in lieu thereof "25–26", following "26a", by striking out "(ombudsman's report)" and inserting in lieu thereof "(consumer protection report)", by striking out the word "and" preceding "41a", and following "(transitional provisions)", by inserting ", and 41b (Medicare supplemental policies)"; in subsection (e), by striking out "January 1, 2013" and inserting in lieu thereof "July 1, 2012"; in subdivision (f)(1), preceding the word "oversight", by striking out the word "access" and inserting in lieu thereof the word "care"; in subsection (i), by striking out "11e" preceding "(mental health ombudsman)" and inserting in lieu thereof "11d", and following "(mental health ombudsman),", by inserting "11e (payment; definitions),"; and by striking out subsection (j) in its entirety and redesignating current subsection (k) to be subsection (j)

(Committee vote: 5-2-0)

(For House amendments, see House Journal for February 23, 2012, page 406; February 24, 2012, page 420.)

H. 745.

An act relating to the Vermont prescription monitoring system.

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

The Committee recommends that the Senate propose to the House to amend the bill by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. PURPOSE

It is the purpose of this act to maximize the effectiveness and appropriate utilization of the Vermont prescription monitoring system, which serves as an important tool in promoting public health by providing opportunities for

treatment for and prevention of abuse of controlled substances without interfering with the legal medical use of those substances.

Sec. 1a. 18 V.S.A. § 4201~~(26)~~ is amended to read:

§ 4201. DEFINITIONS

As used in this chapter, unless the context otherwise requires:

* * *

(26) "Prescription" means an order for a regulated drug made by a physician, advanced practice registered nurse, dentist, or veterinarian licensed under this chapter to prescribe such a drug which shall be in writing except as otherwise specified ~~herein~~ in this subdivision. Prescriptions for such drugs shall be made to the order of an individual patient, dated as of the day of issue and signed by the prescriber. The prescription shall bear the full name ~~and~~, address, and date of birth of the patient, or if the patient is an animal, the name and address of the owner of the animal and the species of the animal. Such prescription shall also bear the full name, address, and registry number of the prescriber and shall be written with ink, indelible pencil, or typewriter; if typewritten, it shall be signed by the ~~physician~~ prescriber. A written or typewritten prescription for a controlled substance, as defined in 21 C.F.R. Part 1308, shall contain the quantity of the drug written both in numeric and word form.

* * *

Sec. 2. 18 V.S.A. § 4215b is added to read:

§ 4215b. IDENTIFICATION

Prior to dispensing a prescription for a Schedule II, III, or IV controlled substance, a pharmacist shall require the individual receiving the drug to provide a signature and show valid and current government-issued photographic identification as evidence that the individual is the patient for whom the prescription was written, the owner of the animal for which the prescription was written, or the bona fide representative of the patient or animal owner. If the individual does not have valid, current government-issued photographic identification, the pharmacist may request alternative evidence of the individual's identity, as appropriate.

Sec. 3. 18 V.S.A. § 4218 is amended to read:

§ 4218. ENFORCEMENT

* * *

(d) Nothing in this section shall authorize the department of public safety and other authorities described in subsection (a) of this section to have access

to VPMS (Vermont prescription monitoring system) created pursuant to chapter 84A of this title, except as provided in that chapter.

(e) Notwithstanding subsection (d) of this section, a drug diversion investigator, as defined in section 4282 of this title, with a warrant may request VPMS data from the department of health pursuant to subdivision 4284(b)(2)(F) of this title.

(f) The department of public safety shall adopt a written policy and protocols for accessing pharmacy records through the authority granted in this section. These policies and protocols shall be a public record.

Sec. 3a. DEPARTMENT OF PUBLIC SAFETY; REPORTING POLICIES AND PROTOCOLS

No later than December 15, 2012, the commissioner of public safety shall submit to the house and senate committees on judiciary, the house committee on human services, and the senate committee on health and welfare the department's written policy and protocols used to access pharmacy records at individual pharmacies pursuant to 18 V.S.A. § 4218. Subsequently, if the policy and protocols are substantively amended by the department, it shall submit the amended policy and protocols to the same committees as soon as practicable.

Sec. 4. [Deleted.]

Sec. 5. 18 V.S.A. § 4282 is amended to read:

§ 4282. DEFINITIONS

As used in this chapter:

* * *

(5) "Delegate" means an individual employed by a health care facility or pharmacy, in the office of the chief medical examiner, or in the office of the medical director of the department of Vermont health access and authorized by a health care provider or dispenser, the chief medical examiner, or the medical director to request information from the VPMS relating to a bona fide current patient of the health care provider or dispenser, to a bona fide investigation or inquiry into an individual's death, or to a patient for whom a Medicaid claim for a Schedule II, III, or IV controlled substance has been submitted.

(6) "Department" means the department of health.

(7) "Drug diversion investigator" means an employee of the department of public safety whose primary duties include investigations involving violations of laws regarding prescription drugs or the diversion of prescribed controlled substances, and who has completed a training program established by the department of health by rule that is designed to ensure that officers have

the training necessary to use responsibly and properly any information that they receive from the VPMS.

(8) "Evidence-based" means based on criteria and guidelines that reflect high-quality, cost-effective care. The methodology used to determine such guidelines shall meet recognized standards for systematic evaluation of all available research and shall be free from conflicts of interest. Consideration of the best available scientific evidence does not preclude consideration of experimental or investigational treatment or services under a clinical investigation approved by an institutional review board.

Sec. 6. 18 V.S.A. § 4283 is amended to read:

§ 4283. CREATION; IMPLEMENTATION

(a) ~~Contingent upon the receipt of funding, the~~ The department ~~may establish~~ shall maintain an electronic database and reporting system for monitoring Schedules II, III, and IV controlled substances, as defined in 21 C.F.R. Part 1308, as amended and as may be amended, that are dispensed within the state of Vermont by a health care provider or dispenser or dispensed to an address within the state by a pharmacy licensed by the Vermont board of pharmacy.

* * *

(e) It is not the intention of the department that a health care provider or a dispenser shall have to pay a fee or tax or purchase hardware or proprietary software required by the department specifically for the use, establishment, maintenance, or transmission of the data. The department shall seek grant funds and take any other action within its financial capability to minimize any cost impact to health care providers and dispensers.

*** * ***

Sec. 7. 18 V.S.A. § 4284 is amended to read:

§ 4284. PROTECTION AND DISCLOSURE OF INFORMATION

(a) The data collected pursuant to this chapter and all related information and records shall be confidential, except as provided in this chapter, and shall not be subject to public records law. The department shall maintain procedures to protect patient privacy, ensure the confidentiality of patient information collected, recorded, transmitted, and maintained, and ensure that information is not disclosed to any person except as provided in this section.

(b)(1) The department shall ~~be authorized to provide data to only~~ provide only the following persons with access to query the VPMS:

~~(1) A patient or that person's health care provider, or both, when VPMS reveals that a patient may be receiving more than a therapeutic amount of one or more regulated substances.~~

~~(2)~~(A) A health care provider ~~or~~, dispenser, or delegate who ~~requests information~~ is registered with the VPMS and certifies that the requested information is for the purpose of providing medical or pharmaceutical treatment to a bona fide current patient.

(B) Personnel or contractors, as necessary for establishing and maintaining the VPMS.

(C) The medical director of the department of Vermont health access, for the purposes of Medicaid quality assurance, utilization, and federal monitoring requirements with respect to Medicaid recipients for whom a Medicaid claim for a Schedule II, III, or IV controlled substance has been submitted.

(D) A medical examiner from the office of the chief medical examiner, for the purpose of conducting an investigation or inquiry into the cause, manner, and circumstances of an individual's death.

(E) A health care provider or medical examiner licensed to practice in another state, to the extent necessary to provide appropriate medical care to a Vermont resident or to investigate the death of a Vermont resident.

(2) The department shall provide reports of data available to the department through the VPMS only to the following persons:

(A) A patient or that person's health care provider, or both, when VPMS reveals that a patient may be receiving more than a therapeutic amount of one or more regulated substances.

~~(3)~~(B) A designated representative of a board responsible for the licensure, regulation, or discipline of health care providers or dispensers pursuant to a bona fide specific investigation.

~~(4)~~(C) A patient for whom a prescription is written, insofar as the information relates to that patient.

~~(5)~~(D) The relevant occupational licensing or certification authority if the commissioner reasonably suspects fraudulent or illegal activity by a health care provider. The licensing or certification authority may report the data that are the evidence for the suspected fraudulent or illegal activity to a ~~trained law enforcement officer~~ drug diversion investigator.

~~(6)~~(E)(i) The commissioner of public safety, personally, or the deputy commissioner of public safety, personally, if the commissioner of health, personally, or the deputy commissioner for alcohol and drug abuse programs,

personally, makes the disclosure, has consulted with at least one of the patient's health care providers, and believes that the disclosure is necessary to avert a serious and imminent threat to a person or the public.

(ii) The commissioner of public safety, personally, or the deputy commissioner of public safety, personally, when he or she requests data from the commissioner of health, and the commissioner of health believes, after consultation with at least one of the patient's health care providers, that disclosure is necessary to avert a serious and imminent threat to a person or the public.

(iii) The commissioner or deputy commissioner of public safety may disclose such data received pursuant to this subdivision (E) as is necessary, in his or her discretion, to avert the serious and imminent threat.

~~(7) Personnel or contractors, as necessary for establishing and maintaining the VPMS.~~

(F) A drug diversion investigator, as defined in section 4282 of this section, with a warrant.

(G) A prescription monitoring system or similar entity in another state pursuant to a reciprocal agreement to share prescription monitoring information with the Vermont department of health as described in section 4288 of this title.

(c) A person who receives data or a report from VPMS or from the department shall not share that data or report with any other person or entity not eligible to receive that data pursuant to subsection (b) of this section, except as necessary and consistent with the purpose of the disclosure and in the normal course of business. Nothing shall restrict the right of a patient to share his or her own data.

(d) The commissioner shall offer health care providers and dispensers training in the proper use of information they may receive from VPMS. Training may be provided in collaboration with professional associations representing health care providers and dispensers.

(e) ~~A trained law enforcement officer who may receive information pursuant to this section shall not have access to VPMS except for information provided to the officer by the licensing or certification authority.~~ [Deleted.]

(f) The department is authorized to use information from VPMS for research, trend analysis, and other public health promotion purposes provided that data are aggregated or otherwise de-identified. The department shall post the results of trend analyses on its website for use by health care providers, dispensers, and the general public. When appropriate, the department shall

send alerts relating to identified trends to health care providers and dispensers by electronic mail.

(g) Knowing disclosure of transmitted data to a person not authorized by subsection (b) of this section, or obtaining information under this section not relating to a bona fide specific investigation, shall be punishable by imprisonment for not more than one year or a fine of not more than $1,000.00, or both, in addition to any penalties under federal law.

(h) All information and correspondence relating to the disclosure of information by the commissioner to a patient's health care provider pursuant to subdivision (b)(2)(A) of this section shall be confidential and privileged, exempt from the public access to records law, immune from subpoena or other disclosure, and not subject to discovery or introduction into evidence.

(i) Each request for disclosure of data pursuant to subdivision (b)(2)(B) of this section shall document a bona fide specific investigation and shall specify the name of the person who is the subject of the investigation.

(j) Each request for disclosure of data pursuant to a warrant or to subdivision (b)(2)(E) of this section shall document a bona fide specific investigation and shall specify the name of the person who is the subject of the investigation.

Sec. 8. 18 V.S.A. § 4286 is amended to read:

§ 4286. ADVISORY COMMITTEE

(a)(1) The commissioner shall establish an advisory committee to assist in the implementation and periodic evaluation of VPMS.

(2) The department shall consult with the committee concerning any potential operational or economic impacts on dispensers and health care providers related to transmission system equipment and software requirements.

(3) The committee shall develop guidelines for use of VPMS by dispensers ~~and~~, health care providers, and delegates, and shall make recommendations concerning under what circumstances, if any, the department shall or may give VPMS data, including data thresholds for such disclosures, to law enforcement personnel. The committee shall also review and approve advisory notices prior to publication.

(4) The committee shall make recommendations regarding ways to improve the utility of the VPMS and its data.

(5) The committee shall have access to aggregated, de-identified data from the VPMS.

* * *

(d) The committee shall issue a report to the senate and house committees on judiciary, the senate committee on health and welfare, and the house committee on human services no later than January 15th in 2008, 2010, ~~and~~ 2012, and 2014.

(e) This section shall sunset on July 1, ~~2012~~ 2014 and thereafter the committee shall cease to exist.

Sec. 9. 18 V.S.A. § 4287 is amended to read:

§ 4287. RULEMAKING

The department shall adopt rules for the implementation of VPMS as defined in this chapter consistent with 45 C.F.R. Part 164, as amended and as may be amended, that limit the disclosure to the minimum information necessary for purposes of this act ~~and shall keep the senate and house committees on judiciary, the senate committee on health and welfare, and the house committee on human services advised of the substance and progress of initial rulemaking pursuant to this section~~.

Sec. 10. 18 V.S.A. § 4288 is added to read:

§ 4288. RECIPROCAL AGREEMENTS

The department of health may enter into reciprocal agreements with other states that have prescription monitoring programs so long as access under such agreement is consistent with the privacy, security, and disclosure protections in this chapter.

Sec. 11. 18 V.S.A. § 4289 is added to read:

§ 4289. STANDARDS AND GUIDELINES FOR HEALTH CARE PROVIDERS AND DISPENSERS

(a) Each professional licensing authority for health care providers shall develop evidence-based standards to guide health care providers in the appropriate prescription of Schedules II, III, and IV controlled substances for treatment of chronic pain and for other medical conditions to be determined by the licensing authority.

(b)(1) Each health care provider who prescribes any Schedule II, III, or IV controlled substances shall register with the VPMS.

(2) If the VPMS shows that a patient has filled a prescription for a controlled substance written by a health care provider who is not a registered user of VPMS, the commissioner of health shall notify such provider by mail of the provider's registration requirement pursuant to subdivision (1) of this subsection.

(3) The commissioner of health shall develop additional procedures to ensure that all health care providers who prescribe controlled substances are registered in compliance with subdivision (1) of this subsection.

(c) Each dispenser who dispenses any Schedule II, III, or IV controlled substances shall register with the VPMS.

(d)(1) Each professional licensing authority for health care providers and dispensers authorized to prescribe or dispense Schedules II, III, and IV controlled substances shall adopt standards regarding the frequency and circumstances under which their respective licensees shall query the VPMS.

(2) Each professional licensing authority for dispensers shall adopt standards regarding the frequency and circumstances under which its licensees shall report to the VPMS, which shall be no less than once every seven days.

(3) Each professional licensing authority for health care providers and dispensers shall consider the standards adopted pursuant to this section in disciplinary proceedings when determining whether a licensee has complied with the applicable standard of care.

(4) No later than January 15, 2013, each professional licensing authority subject to this subsection shall submit its standards to the VPMS advisory committee established in section 4286 of this title.

Sec. 12. 18 V.S.A. § 4290 is added to read:

§ 4290. REPLACEMENT PRESCRIPTIONS AND MEDICATIONS

(a) As used in this section, "replacement prescription" means an unscheduled prescription request in the event that the document on which a patient's prescription was written or the patient's prescribed medication is reported to the prescriber as having been lost or stolen.

(b) When a patient or a patient's parent or guardian requests a replacement prescription for a Schedule II, III, or IV controlled substance, the patient's health care provider shall query the VPMS prior to writing the replacement prescription to determine whether the patient may be receiving more than a therapeutic dosage of the controlled substance.

(c) When a health care provider writes a replacement prescription pursuant to this section, the provider shall clearly indicate as much by writing the word "REPLACEMENT" on the face of the prescription.

(d) When a dispenser fills a replacement prescription, the dispenser shall report the required information to the VPMS and shall indicate that the prescription is a replacement by completing the VPMS field provided for such purpose. In addition, the dispenser shall report to the VPMS the name of the person picking up the replacement prescription, if not the patient.

(e) The VPMS shall create a mechanism by which individuals authorized to access the system pursuant to section 4284 of this title may search the database for information on all or a subset of all replacement prescriptions.

Sec. 13. UNIFIED PAIN MANAGEMENT SYSTEM ADVISORY COUNCIL

(a) There is hereby created a unified pain management system advisory council for the purpose of advising the commissioner of health on matters relating to the appropriate use of controlled substances in treating chronic pain and addiction and in preventing prescription drug abuse.

(b) The unified pain management system advisory council shall consist of the following members:

(1) the commissioner of health or designee, who shall serve as chair;

(2) the deputy commissioner of health for alcohol and drug abuse programs or designee;

(3) the commissioner of mental health or designee;

(4) the director of the Blueprint for Health or designee;

(5) the chair of the board of medical practice or designee, who shall be a clinician;

(6) a representative of the Vermont state dental society, who shall be a dentist;

(7) a representative of the Vermont board of pharmacy, who shall be a pharmacist;

(8) a faculty member from the academic detailing program at the University of Vermont's College of Medicine;

(9) a faculty member from the University of Vermont's College of Medicine with expertise in the treatment of addiction or chronic pain management;

(10) a representative of the Vermont Medical Society, who shall be a primary care clinician;

(11) a representative of the American Academy of Family Physicians, Vermont chapter, who shall be a primary care clinician;

(12) a representative of the federally qualified health centers, who shall be a primary care clinician selected by the Bi-State Primary Care Association;

(13) a representative of the Vermont Ethics Network;

(14) a representative of the Hospice and Palliative Care Council of Vermont;

(15) a representative of the office of the health care ombudsman;

(16) the medical director for the department of Vermont health access;

(17) a clinician who works in the emergency department of a hospital, to be selected by the Vermont Association of Hospitals and Health Systems in consultation with any nonmember hospitals;

(18) a member of the Vermont board of nursing subcommittee on APRN practice, who shall be an advanced practice registered nurse;

(19) a representative from the Vermont Assembly of Home Health and Hospice Agencies;

(20) a psychologist licensed pursuant to 26 V.S.A. chapter 55 who has experience in treating chronic pain, to be selected by the board of psychological examiners;

(21) a drug and alcohol abuse counselor licensed pursuant to 33 V.S.A. chapter 8, to be selected by the deputy commissioner of health for alcohol and drug abuse programs; and

(22) a consumer representative who is either a consumer in recovery from prescription drug abuse or a consumer receiving medical treatment for chronic noncancer-related pain.

(c) Advisory council members who are not employed by the state shall be entitled to per diem and expenses as provided by 32 V.S.A. § 1010.

(d) A majority of the members of the advisory council shall constitute a quorum. The advisory council shall act only by a majority vote of the members present and voting and only at meetings called by the chair or by any three of the members.

(e) To the extent funds are available, the advisory council shall have the following duties:

(1) to develop and recommend principles and components of a unified pain management system, including the appropriate use of controlled substances in treating noncancer-related chronic pain and addiction and in preventing prescription drug abuse;

(2) to identify and recommend components of evidence-based training modules and minimum requirements for the continuing education of all licensed health care providers in the state who treat chronic pain or addiction or prescribe controlled substances in Schedule II, III, or IV consistent with a unified pain management system;

(3) to identify and recommend evidence-based training modules for all employees of the agency of human services who have direct contact with recipients of services provided by the agency or any of its departments; and

(4) to identify and recommend system goals and planned assessment tools to ensure that the initiative's progress can be monitored and adapted as needed.

(f) The commissioner of health may designate subcommittees as appropriate to carry out the work of the advisory council.

(g) On or before January 15, 2013, the advisory council shall submit its recommendations to the senate committee on health and welfare, the house committee on human services, and the house committee on health care.

Sec. 14. UNUSED DRUG DISPOSAL PROGRAM

No later than January 15, 2013, the commissioners of health and of public safety shall establish a drug disposal program for unused over-the-counter and prescription drugs, which program shall be available to Vermont residents throughout the state at no charge to the consumer. The commissioners shall take steps to publicize the program and to make all Vermont residents aware of opportunities to avail themselves of it.

Sec. 15. ADVISORY COMMITTEE REPORT

No later than January 15, 2013, the VPMS advisory committee established in 18 V.S.A. § 4286 shall provide recommendations to the house committee on human services and the senate committee on health and welfare regarding ways to maximize the effectiveness and appropriate use of the VPMS database, including adding new reporting capabilities, in order to improve patient outcomes and avoid prescription drug diversion.

Sec. 16. SPENDING AUTHORITY

Providing financial support for the unified pain management system advisory council established in Sec. 13 of this act, upgrading the VPMS software, and implementing enhancements to the VPMS shall all be acceptable uses of the monies in the evidence-based education and advertising fund established in 33 V.S.A. § 2004a. The commissioner of health shall seek excess receipts authority to make expenditures as needed from the evidence-based education and advertising fund for these purposes.

Sec. 17. INTEGRATION; LEGISLATIVE INTENT

It is the intent of the general assembly that the initiatives described in this act should be integrated to the extent possible with the Blueprint for Health and the mental health system of care.

Sec. 18. EFFECTIVE DATES

(a) This section and Sec. 8 of this act (18 V.S.A. § 4286) shall take effect on passage and shall apply retroactively as of January 15, 2012.

(b) Secs. 10 (18 V.S.A. § 4288; reciprocal agreements), 11 (18 V.S.A. § 4289; standards and guidelines), and 12 (18 V.S.A. § 4290; replacement prescriptions) and Sec. 7(b)(2)(G) (18 V.S.A. § 4284(b)(2)(G); interstate data sharing) shall take effect on October 1, 2012.

(c) The remaining sections of this act shall take effect on July 1, 2012.

(Committee vote: 4-0-1)

Reported favorably with recommendation of proposal of amendment by Senator Sears for the Committee on Appropriations.

The Committee recommends that the Senate propose to the House to amend the bill as recommended by the Committee on Health and Welfare, with the following amendment thereto:

In Sec. 13, Unified Pain Management System Advisory Council, in subsection (c), following "state", by inserting the following: or whose participation is not supported through their employment or association

(Committee vote: 6-0-1)

(For House amendments, see House Journal of March 20, 2012, page 728.)

PROPOSAL OF AMENDMENT TO H. 745 TO BE OFFERED BY SENATORS SEARS, CUMMINGS, SNELLING AND WHITE

Senators Sears, Cummings, Snelling and White move that the recommendation of amendment of the Committee on Health and Welfare be amended as follows:

First: By striking out Secs. 3 and 3a in their entirety and inserting in lieu thereof a new Sec. 3 and 3a to read as follows:

Sec. 3. 18 V.S.A. § 4218 is amended to read:

§ 4218. ENFORCEMENT

* * *

(d) Nothing in this section shall authorize the department of public safety and other authorities described in subsection (a) of this section to have access to VPMS (Vermont prescription monitoring system) created pursuant to chapter 84A of this title, except as provided in that chapter.

(e) Notwithstanding subsection (d) of this section, a drug diversion investigator, as defined in section 4282 of this title, may request VPMS data from the department of health pursuant to subdivision 4284(b)(3) of this title.

(f) The department of public safety shall adopt standard operating guidelines for accessing pharmacy records through the authority granted in this section. Any person authorized to access pharmacy records pursuant to subsection (a) of this section shall follow the department of public safety's guidelines. These guidelines shall be a public record.

Sec. 3a. DEPARTMENT OF PUBLIC SAFETY; REPORTING STANDARD OPERATING GUIDELINES

No later than December 15, 2012, the commissioner of public safety shall submit to the house and senate committees on judiciary, the house committee on human services, and the senate committee on health and welfare the department's written standard operating guidelines used to access pharmacy records at individual pharmacies pursuant to 18 V.S.A. § 4218. Subsequently, if the guidelines are substantively amended by the department, it shall submit the amended guidelines to the same committees as soon as practicable.

Second: In Sec. 7, 18 V.S.A. § 4284, subsection (b), by striking out subdivision (2)(F) in its entirety and relettering the remaining subdivision to be alphabetically correct

Third: In Sec. 7, 18 V.S.A. § 4284, subsection (b), by adding a new subdivision (3) to read as follows:

(3)(A) The department shall provide data available to the department through the VPMS to a drug diversion investigator in accordance with this subdivision (3). The department shall release data pursuant to a request by an officer conducting:

(i) an investigation with a reasonable, good faith belief that it could lead to the filing of criminal proceedings related to a violation of this title; or

(ii) an investigation that is ongoing and continuing and for which there is a reasonable, good faith anticipation of securing an arrest or prosecution related to a violation of this title in the foreseeable future.

(B) An investigation under subdivision (A) of this subdivision (3) shall be based upon a report from a pharmacist or a health care provider.

(C) Upon a request in compliance with subdivision (A) of this subdivision (3), the department shall provide the officer with only the following information:

(i) Name and date of birth of the subject of the request.

(ii) The name and address of any pharmacy that has provided a Schedule II, III, or IV regulated drug to the subject of the request.

(iii) The name and address of any health care provider who has prescribed a Schedule II, III, or IV regulated drug to the subject of the request.

(D) An investigation under this subdivision shall be identified by a law enforcement case number for tracking and documentation purposes.

Fourth: In Sec. 7, 18 V.S.A. § 4284, by striking out subsection (j) in its entirety

Fifth: By adding Secs. 4a–4d to read as follows:

Sec. 4a. 7 V.S.A. § 656 is amended to read:

§ 656. MINORS MISREPRESENTING AGE, PROCURING, POSSESSING, OR CONSUMING LIQUORS; FIRST OFFENSE; CIVIL VIOLATION

(a) A minor 16 years of age or older shall not:

(1) falsely represent his or her age for the purpose of procuring or attempting to procure malt or vinous beverages or spirituous liquor from any licensee, state liquor agency, or other person or persons;

(2) possess malt or vinous beverages or spirituous liquor for the purpose of consumption by himself or herself or other minors, except in the regular performance of duties as an employee of a licensee licensed to sell alcoholic liquor; or

(3) consume malt or vinous beverages or spirituous liquors. A violation of this subdivision may be prosecuted in a jurisdiction where the minor has consumed malt or vinous beverages or spirituous liquors, or in a jurisdiction where the indicators of consumption are observed.

(b)(1) A law enforcement officer shall issue a notice of violation, in a form approved by the court administrator, to a person who violates this section if the person has not previously been adjudicated in violation of this section or convicted of violating section 657 of this title. The notice of violation shall require the person to provide his or her name and address, and shall explain procedure under this section, including that:

(A) the person must contact the diversion board in the county where the offense occurred within 15 days;

(B) failure to contact the diversion board within 15 days will result in the case being referred to the judicial bureau, where the person, if found liable for the violation, will be subject to a penalty of $300.00 and a 90-day suspension of the person's operator's license, and may face substantially increased insurance rates;

(C) no money should be submitted to pay any penalty until after adjudication; and

(D) the person shall notify the diversion board if the person's address changes.

(2) When a person is issued a notice of violation under subdivision (1) of this subsection, the law enforcement officer shall complete a summons and complaint for the offense and send it to the diversion board in the county where the offense occurred. The summons and complaint shall not be filed with the judicial bureau at that time.

(3) Within 15 days after receiving a notice of violation issued under subdivision (1) of this subsection, the person shall contact the diversion board in the county where the offense occurred and register for the teen alcohol and drug safety program. If the person fails to do so, the diversion board shall file the summons and complaint with the judicial bureau for adjudication under 4 V.S.A. chapter 29 ~~of Title 4~~. The diversion board shall provide a copy of the summons and complaint to the law enforcement officer who issued the notice of violation, and shall provide two copies to the person charged with the violation.

(c) A person who violates this section commits a civil violation and shall be subject to a civil penalty of $300.00, and the person's operator's license and privilege to operate a motor vehicle shall be suspended for a period of 90 days. The state may obtain a violation under this section or a conviction under section 657 of this title, but not both.

(d) If a person fails to pay a penalty imposed under this section by the time ordered, the judicial bureau shall notify the commissioner of motor vehicles, who shall suspend the person's operator's license and privilege to operate a motor vehicle until payment is made.

(e) Upon adjudicating a person in violation of this section, the judicial bureau shall notify the commissioner of motor vehicles, who shall maintain a record of all such adjudications which shall be separate from the registry maintained by the department for motor vehicle driving records. The identities of persons in the registry shall only be revealed to a law enforcement officer determining whether the person has previously violated this section.

(f)(1) Upon receipt from a law enforcement officer of a summons and complaint completed under subdivision (b)(2) of this section, the diversion board shall send the person a notice to report to the diversion board. The notice to report shall provide that:

(A) The person is required to complete all conditions related to the offense imposed by the diversion board, including substance abuse screening

and, if deemed appropriate following the screening, substance abuse education or substance abuse counseling, or both.

(B) If the person does not satisfactorily complete the substance abuse screening, any required substance abuse education or substance abuse counseling, or any other conditions related to the offense imposed by the diversion board, the case will be referred to the judicial bureau, where the person, if found liable for the violation, shall be assessed a penalty of $300.00, the person's driver's license will be suspended for 90 days, and the person's automobile insurance rates may increase substantially.

(C) If the person satisfactorily completes the substance abuse screening, any required substance abuse education or substance abuse counseling, and any other conditions related to the offense imposed by the diversion board, no penalty shall be imposed and the person's operator's license will not be suspended.

(2)(A) Upon being contacted by a person who has been issued a notice of violation under subdivision (b)(1) of this section, the diversion board shall register the person in the teen alcohol and drug safety program. Pursuant to the teen alcohol and drug safety program, the diversion board shall impose conditions on the person. The conditions imposed shall include only conditions related to the offense, and in every case shall include a condition requiring satisfactory completion of substance abuse screening and, if deemed appropriate following the screening, substance abuse education or substance abuse counseling, or both. If the screener recommends substance abuse counseling, the person shall choose a state-certified or state-licensed substance abuse counselor or substance abuse treatment provider to provide the services.

(B) Substance abuse screening required under this subsection shall be completed within 60 days after the diversion board receives a summons and complaint completed under subdivision (b)(2) of this section. The person shall complete all conditions at his or her own expense.

(3) When a person has satisfactorily completed substance abuse screening, any required substance abuse education or substance abuse counseling, and any other conditions related to the offense which the diversion board has imposed, the diversion board shall:

(A) void the summons and complaint with no penalty due; and

(B) send copies of the voided summons and complaint to the judicial bureau and to the law enforcement officer who completed them. Before sending copies of the voided summons and complaint to the judicial bureau under this subdivision, the diversion board shall redact all language containing the person's name, address, social security number or any other information which identifies the person.

(4) If a person does not satisfactorily complete substance abuse screening, any required substance abuse education or substance abuse counseling, or any other conditions related to the offense imposed by the diversion board, or if the person fails to pay the diversion board any required program fees, the diversion board shall file the summons and complaint with the judicial bureau for adjudication under 4 V.S.A. chapter 29 ~~of Title 4~~. The diversion board shall provide a copy of the summons and complaint to the law enforcement officer who issued the notice of violation, and shall provide two copies to the person charged with the violation.

(5) A person aggrieved by a decision of the diversion board or alcohol counselor may seek review of that decision pursuant to Rule 75 of the Vermont Rules of Civil Procedure.

(g) The state's attorney may dismiss without prejudice a violation brought under this section.

Sec. 4b. 18 V.S.A. § 4230 is amended to read:

§ 4230. MARIJUANA

(a) Possession and cultivation.

(1) A person knowingly and unlawfully possessing marijuana in an amount consisting of one or more preparations, compounds, mixtures, or substances of an aggregate weight of more than one ounce containing any marijuana shall be imprisoned not more than six months or fined not more than $500.00, or both. A person convicted of a second or subsequent offense under this subdivision shall be imprisoned not more than two years or fined not more than $2,000.00, or both. Upon an adjudication of guilt for a first offense under this subdivision, the court may defer sentencing as provided in 13 V.S.A. § 7041 except that the court may in its discretion defer sentence without the filing of a presentence investigation report and except that sentence may be imposed at any time within two years from and after the date of entry of deferment. The court may prior to sentencing, order that the defendant submit to a drug assessment screening which may be considered at sentencing in the same manner as a presentence report.

* * *

Sec. 4c. 18 V.S.A. § 4230a is added to read:

§ 4230a. MARIJUANA; CIVIL PENALTY

(a) No person shall knowingly and unlawfully possess marijuana in an amount consisting of one or more preparations, compounds, mixtures, or substances of an aggregate weight of one ounce or less containing any marijuana.

(b) A person 21 years of age or older who violates this section shall be assessed a civil penalty of not more than $100.00. For a fifth or subsequent violation of this section, a person 21 years of age or older shall be fined not more than $500.00.

(c) Except as otherwise provided in this section, a person under the age of 21 who violates subsection (a) of this section shall be punished in accordance with the provisions set forth in 7 V.S.A. §§ 656 and 657 regarding minors misrepresenting age and procuring, possessing, or consuming liquors.

(d)(1) Except as otherwise provided in this section, a person who possesses one ounce or less of marijuana or who possesses paraphernalia for marijuana use shall not be penalized or sanctioned in any manner by the state or any of its political subdivisions or denied any right or privilege under state law, including:

(A) denying the offender student financial aid, unemployment benefits, public housing, or any other form of public financial assistance;

(B) denying the offender's right to operate a motor vehicle; or

(C) disqualifying an offender from serving as a foster or adoptive parent.

(2) A violation of this section shall not result in the creation of a criminal history record of any kind, and information about the violation shall not be maintained in any criminal record or database.

(e) This section shall not:

(1) exempt any person from arrest or prosecution for being under the influence of marijuana while operating a vehicle of any kind;

(2) be construed to repeal or modify existing laws or policies concerning the operation of vehicles of any kind while under the influence of marijuana;

(3) be construed to prohibit a municipality from regulating, prohibiting, or providing additional penalties for the use of marijuana in public places;

(4) be construed to limit the authority of primary and secondary schools to impose noncriminal penalties for the possession of marijuana on school property;

(5) be construed to affect the search and seizure laws afforded to duly authorized law enforcement officers under the laws of this state.

(f) If a person suspected of violating this section challenges the presence of cannabinoids, the person may request that the state crime laboratory test the substance at the person's expense. If the substance tests negative for the presence of cannabinoids, the state shall reimburse the person at state expense.

(g) Upon request by a law enforcement officer who reasonably suspects that a person has committed or is committing a violation of this section, the person shall give his or her name and address to the law enforcement officer and shall produce a Vermont operator's license, a Vermont identification card, a passport, or another suitable form of identification.

(h) The enforcement of this section by villages, towns, and cities shall be by a local law enforcement officer or a law enforcement officer by contract with the village, town, or city. Law enforcement officers under this subsection shall have met minimum training requirements as provided in 20 V.S.A. § 2358.

(i) Fifty percent of the fines and penalties imposed by the judicial bureau for violations of this section shall be retained by the state for the funding of law enforcement officers on the drug task force, except for a $12.50 administrative charge for each violation which shall be retained by the state. The remaining 50 percent shall be paid to the court diversion program for funding of the teen alcohol and drug and safety program.

Sec. 4d. 4 V.S.A. § 1102 is amended to read:

§ 1102. JUDICIAL BUREAU; JURISDICTION

* * *

(b) The judicial bureau shall have jurisdiction of the following matters:

* * *

(23) Violations of 18 V.S.A. § 4230a, relating to possession of one ounce or less of marijuana.

* * *

Sixth: By striking Sec. 14 in its entirety and inserting a new Sec. 14 to read as follows:

Sec. 14. UNUSED DRUG DISPOSAL PROGRAM PROPOSAL

(a) No later than October 15, 2012, the commissioners of health and of public safety shall provide recommendations to the house and senate committees on judiciary, the house committee on human services, and the senate committee on health and welfare regarding implementation of a statewide drug disposal program for unused over-the-counter and prescription drugs at no charge to the consumer. In preparing their recommendations, the commissioners shall consider successful unused drug disposal programs in Vermont, including the Bennington County sheriff's department's program, and in other states.

(b) The commissioners of health and of public safety shall take steps toward implementing a program prior to October 15, 2012, if practicable.

Seventh: By adding a Sec. 14a to read as follows:

Sec. 14a. TRACK AND TRACE PILOT PROJECT

(a) The departments of health and of Vermont health access shall establish a track and trace pilot project with one or more manufacturers of buprenorphine to create a high-integrity monitoring tool capable of use across disciplines. The tool shall be designed to identify irregularities related to dosing and quality in a manner that disrupts practice operations to the least extent possible. The departments shall work with all willing Medicaid-enrolled prescribing practices and pharmacies to utilize the tool.

(b) No later than January 15, 2013, the commissioners of health and of Vermont health access shall provide testimony on the status of the pilot project established pursuant to this section to the house committees on human services and on judiciary and the senate committees on health and welfare and on judiciary.

Eighth: By adding a Sec. 14b to read as follows:

Sec. 14b. DEPARTMENT OF HEALTH REPORT; OPIOID ANTAGONISTS

No later than November 15, 2012, the department of health shall report to the general assembly detailed recommendations for permitting a practitioner to lawfully prescribe and dispense naloxone or another opioid antagonist to a person at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist a person at risk of experiencing an opiate-related overdose.

H. 769.

An act relating to department of environmental conservation fees.

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

The Committee recommends that the Senate propose to the House to amend the bill as follows:

First: In Sec. 1, 3 V.S.A. § 2822(j)(1)(B) by striking out ", provided that a plant producing renewable energy as defined in 30 V.S.A. § 8002 shall pay an annual fee not exceeding $64,000.00"

Second: By striking out Sec. 3 and inserting a new Sec. 3 to read:

Sec. 3. 10 V.S.A. § 1943 is amended to read:

§ 1943. PETROLEUM TANK ASSESSMENT

(a) Each owner of a category one tank used for storage of petroleum products shall remit to the secretary on October 1 of each year ~~beginning October 1, 1988,~~ a fee that shall be deposited in the petroleum cleanup fund established under section 1941 of this title.

(1) For retail gasoline outlets that sell 40,000 gallons or more of motor fuel per month the fee shall be:

(A) $100.00 per double-wall tank~~, which shall be deposited to the petroleum cleanup fund established by section 1941 of this title, except that:~~ system;

(B) $150.00 per combination tank system on October 1, 2012; $250.00 on October 1, 2013; $350.00 on October 1, 2014; and

(C) $200.00 per single-wall tank system on October 1, 2012; $400.00 on October 1, 2013; $600.00 on October 1, 2014.

~~(1)~~(2) ~~The fee shall be $50.00 per tank for~~ For retail gasoline outlets that sell less than 40,000 gallons of motor fuel per month, the fee shall be:

(A) $75.00 per double-wall tank system;

(B) $125.00 per combination tank system on October 1, 2012; $200.00 on October 1, 2013; $275.00 on October 1, 2014; and

(C) $175.00 per single-wall tank system on October 1, 2012; $300.00 on October 1, 2013; $425.00 on October 1, 2014.

~~(2)~~(3) The fee shall be reduced by 50 percent if the owner or permittee provides to the satisfaction of the secretary evidence of financial responsibility to allow the taking of corrective action in the amount of $100,000.00 per occurrence and the compensation of third parties for bodily injury and property damage in the amount of $300,000.00 per occurrence.

~~(3)~~(4) The fee shall be relieved if the owner provides to the satisfaction of the secretary, evidence of financial responsibility to allow the taking of corrective action and the compensation of third parties for bodily injury and property damage each in the amount of $1,000,000.00 per occurrence.

~~(4)~~(5) The fee for retail motor fuel outlets selling 20,000 gallons or less per month ~~shall not exceed $100.00 per year for all tanks at a single location~~ shall be:

(A) $50.00 per double-wall tank system;

(B) $75.00 per combination tank system on October 1, 2012; $125.00 on October 1, 2013; $175.00 on October 1, 2014; and

(C) $100.00 per single-wall tank system on October 1, 2012; $200.00 on October 1, 2013; $300.00 on October 1, 2014.

~~(5)~~(6) ~~The fee shall be $50.00 per tank for~~ For any municipality that uses an annual average of less than ~~an annual average of~~ 40,000 gallons of motor fuel per month, provided that all of the tanks of that municipality meet the requirements of this chapter, the fee shall be:

(A) $50.00 per double-wall tank system;

(B) $100.00 per combination tank system on October 1, 2012; $150.00 on October 1, 2013; $200.00 on October 1, 2014; and

(C) $150.00 per single-wall tank system on October 1, 2012; $250.00 on October 1, 2013; $350.00 on October 1, 2014.

(b) For purposes of this section, an occurrence is an accident, including continuous or repeated exposure to conditions, which results in the release of petroleum from one or more underground storage tanks at the same site.

(c) This tank assessment shall terminate on July 1, 2014.

(d) The secretary shall establish forms and procedures for the payment of the petroleum tank assessment, including a notice of the obligation 30 days prior to being due. Failure to receive notice shall not waive the payment obligation.

Third: In Sec. 4, Petroleum advisory committee report, by adding a new subdivision (5) to read:

(5) Current tank technology and its impact on safety and the rate of current tank fees.

Fourth: By striking Sec. 8 and inserting a new Sec. 8 to read:

Sec. 8. 10 V.S.A. § 6083a is amended to read:

§ 6083a. ACT 250 FEES

(a) All applicants for a land use permit under section 6086 of this title shall be directly responsible for the costs involved in the publication of notice in a newspaper of general circulation in the area of the proposed development or subdivision and the costs incurred in recording any permit or permit amendment in the land records. In addition, applicants shall be subject to the following fees for the purpose of compensating the state of Vermont for the direct and indirect costs incurred with respect to the administration of the Act 250 program:

* * *

(4) For projects involving the extraction of earth resources, including

but not limited to sand, gravel, peat, topsoil, crushed stone, or quarried material, the greater of (a) a fee as determined under subdivision (1) of this subsection or (b) a fee equivalent to the rate of ~~$0.20~~ $0.02 per cubic yard of ~~maximum estimated annual extraction whichever is greater~~ the first million cubic yards of the total volume of earth resources to be extracted over the life of the permit, and $.01 per cubic yard of any such earth resource extraction above one million cubic yards. Extracted material that is not sold or does not otherwise enter the commercial marketplace shall not be subject to the fee. The fee assessed under this subdivision for an amendment to a permit shall be based solely upon any additional volume of earth resources to be extracted under the amendment.

* * *

Fifth: By striking Secs. 9 and 11 in their entirety

Sixth: By adding Secs. 12, 13, 14, 15, 16, 17, and 18 to read:

Sec. 12. 3 V.S.A. § 2809 is amended to read:

§ 2809. REIMBURSEMENT OF AGENCY COSTS

(a)(1) The secretary may require an applicant for a permit, license, certification, or order issued under a program that the secretary enforces under 10 V.S.A. § 8003(a) to pay for the cost of research, scientific, or engineering expertise or regulatory services ~~that~~ provided by the agency of natural resources ~~does not have when such expertise or services are~~ required for the processing of the application for the permit, license, certification, or order.

(2) The secretary may require an applicant under 10 V.S.A. chapter 151 ~~of Title 10~~ to pay for the time of agency of natural resources personnel providing research, scientific, or engineering services or for the cost of expert witnesses when agency personnel or expert witnesses are required for the processing of the permit application.

(3) ~~Except as~~ In addition to the authority set forth under 10 V.S.A. chapters 59 and 159 ~~of Title 10~~ and 10 V.S.A. § 1283, the secretary may require a person who caused the agency to incur expenditures or a person in violation of a permit, license, certification, or order issued by the secretary to pay for the time of agency personnel or the cost of other research, scientific, or engineering services incurred by the agency in response to a threat to public health or the environment presented by an emergency or exigent circumstance.

* * *

(d) The following apply to the authority established under subsection (a) of this section:

(1) ~~The secretary may assess costs under subdivisions (a)(1) and (2) of this section to the applicant or applicants for the permit only with the approval of the governor. Costs assessed under subdivision (a)(3) shall not require approval of the governor.~~

~~(2) The secretary may require reimbursement only of costs in excess of $3,000.00.~~

~~(3)~~ The secretary may revise estimates previously noticed as necessary from time to time during the progress of the work and shall notify the applicant in writing of any revision.

~~(4)~~(2) The secretary shall provide the applicant with a detailed statement of a final assessment under this section showing the total amount of money expended or contracted for in the work and directing the manner and timing of payment by the applicant.

~~(5)~~(3) All funds collected from applicants shall be paid into the state treasury.

* * *

(g) Concerning an application for a permit to discharge stormwater runoff from a telecommunications facility as defined in 30 V.S.A. § 248a that is filed before July 1, 2014~~:~~

~~(1) Under subdivision (a)(1) of this section, the agency shall not require an applicant to pay more than $10,000.00 with respect to a facility.~~

~~(2) The~~, the provisions of subsection (c)(mandatory meeting) of this section shall not apply.

Sec. 13. 24 V.S.A. § 4753(a)(9) is added to read:

(9) The Vermont wastewater and potable water revolving loan fund which shall be used to provide loans to individuals, in accordance with section 4763a of this title, for the design and construction of repairs to or replacement of wastewater systems and potable water supplies when the wastewater system or potable water supply is a failed system or supply as defined in 10 V.S.A. § 1972. The amount of $275,000.00 from the fees collected pursuant to 3 V.S.A. § 2822(j)(4) shall be deposited on an annual basis into this fund.

Sec. 14. 24 V.S.A. § 4763a is added to read:

§ 4763a. LOANS TO INDIVIDUALS FOR FAILED WASTEWATER SYSTEMS AND FAILED POTABLE WATER SUPPLIES

(a) Notwithstanding any other provision of law, when the wastewater system or potable water supply serving only one single-family residence on its own lot meets the definition of a failed supply or system, the secretary of

natural resources may lend monies to the owner of the residence from the Vermont wastewater and potable water revolving loan fund established in section 4753 of this title. In such cases, the following conditions shall apply:

(1) loans may only be made to households with an income equal to or less than 200 percent of the state average median household income;

(2) loans may only be made to households where the recipient of the loan resides in the residence on a year-round basis;

(3) loans may only be made if the owner of the residence has been denied financing for the repair, replacement, or construction due to involuntary disconnection by at least two other financing entities;

(4) no construction loan shall be made to an individual under this subsection, nor shall any part of any revolving loan made under this subsection be expended, until all of the following take place:

(A) the secretary of natural resources determines that if a wastewater system and potable water supply permit is necessary for the design and construction of the project to be financed by the loan, the permit has been issued to the owner of the failed system or supply; and

(B) the individual applying for the loan certifies to the secretary of natural resources that the proposed project has secured all state and federal permits, licenses, and approvals necessary to construct and operate the project to be financed by the loan.

(5) all funds from the repayment of loans made under this section shall be deposited into the Vermont wastewater and potable water revolving loan fund.

(b) The secretary of natural resources shall establish standards, policies, and procedures as necessary for the implementation of this section.

Sec. 15. 24 V.S.A. § 4753a is amended to read:

§ 4753a. AWARDS FROM REVOLVING LOAN FUNDS

(a) Pollution control. The general assembly shall approve all categories of awards made from the special funds established by section 4753 of this title for water pollution control facility construction, in order to assure that such awards conform with state policy on water quality and pollution abatement, and with the state policy that~~, except as provided in subsection (c) of this section,~~ municipal entities shall receive first priority in the award of public monies for such construction, including monies returned to the revolving funds from previous awards. To facilitate this legislative oversight, the secretary of natural resources shall annually no later than January 15 report to the house and senate committees on institutions and on natural resources and energy on

all awards made from the relevant special funds during the prior and current fiscal years, and shall report on and seek legislative approval of all the types of projects for which awards are proposed to be made from the relevant special funds during the current or any subsequent fiscal year. Where feasible, the specific projects shall be listed.

(b) Water supply. The secretary of natural resources shall no later than January 15, 2000 recommend to the house ~~and senate committees on institutions and~~ committee on corrections and institutions, the senate committee on institutions, and the house and senate committees on natural resources and energy a procedure for reporting to and seeking the concurrence of the legislature with regard to the special funds established by section 4753 of this title for water supply facility construction.

(c) ~~Notwithstanding other priorities established in law, the secretary may award up to $500,000.00 of the funds from the Vermont environmental protection agency control fund and the Vermont pollution control revolving fund, combined, to a state agency, the Vermont housing finance agency, or a municipality for the administration of loans to households with income equal to or less than 200 percent of the state average median household income for the repair or replacement of failed wastewater systems and failed potable water supplies, as those terms are defined in section 1972 of Title 10. Upon award of funds under this section, the state agency, Vermont housing finance agency, or municipality shall agree, pursuant to a memorandum of understanding with the secretary of natural resources, to repay the funds awarded to the special fund from which they were drawn.~~

Sec. 16. ANR REPORT ON ENVIRONMENTAL IMPACT OF GROUNDWATER WITHDRAWALS FOR BOTTLING WATER

(a) On or before January 15, 2013, the secretary of natural resources shall report to the senate and house committees on natural resources and energy, the senate committee on finance, and the house committee on ways and means regarding the impact of groundwater withdrawals by public water systems for the purposes of transfer out of the state for bottling. The report shall include:

(1) An analysis of the environmental effect of withdrawing and transferring out of the state large volumes of groundwater for the purposes of bottling, including the impact of such withdrawals on drinking water supplies, agricultural use, groundwater tables, and surface water recharge.

(2) A summary of the fees charged by other states for the withdrawal of groundwater for bottling or bulk water transfer and a comparison of the fees of other states to the groundwater withdrawal fees charged in Vermont.

(b) In preparing the report required under subsection (a) of this section, the secretary of natural resources shall consult with interested parties, including

owners of property in the proximity of public water systems withdrawing groundwater for the purposes of bottling water, public water systems, bottled water companies, environmental groups, and representatives of agriculture.

(c) As used in this section, "public water system" shall be defined as provided in 10 V.S.A. § 1671.

Sec. 17. STUDY; DEPARTMENT OF PUBLIC SAFETY

(a) The department of public safety shall study how it assesses fees or charges for services provided by the department to municipalities, fire departments, and other entities. The study shall also examine how fees or charges can be equitably assessed and what mechanism can be employed to collect fees or charges.

(b) The department shall report its findings and any recommendations to the house committee on ways and means and the senate committee on finance by January 15, 2013.

Sec. 18. REPORT; AGENCY OF NATURAL RESOURCES; AGENCY OF TRANSPORTATION

On or before January 15, 2013, the secretary of natural resources (ANR) and the secretary of transportation (AOT) shall jointly report to the house committee on ways and means and the senate committee on finance with a recommendation as to whether or not agency of natural resources fees and agency of transportation fees should be adjusted so that air pollution fees paid to ANR proportionally reflect the contribution of ANR permittees to state air pollution and so that air-pollution-related fees paid to AOT proportionally reflect the contribution of AOT licensees and permittees to state air pollution. If making adjustments to ANR and AOT fees is recommended for this purpose, the report shall recommend which fees should be adjusted and by what amount.

and by renumbering the sections to be numerically correct

(Committee vote: 7-0-0)

(No House amendments.)

House Proposal of Amendment to Senate Proposal of Amendment

H. 403

An act relating to foreclosure of mortgages

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

First: By striking out Sec. 3 in its entirety and inserting in lieu thereof the following:

Sec. 3. [DELETED]

Second: By striking out Sec. 4 in its entirety and inserting in lieu thereof a new Sec. 4 to read as follows:

Sec. 4. 12 V.S.A. § 2903(b) is amended to read:

(b) A judgment which is renewed or revived pursuant to section 506 of this title shall constitute a lien on real property for eight years from the issuance of the renewed or revived judgment if recorded in accordance with this chapter. The renewed or revived judgment ~~and~~ shall relate back to the date on which the original lien was first recorded if a copy of the complaint to renew the judgment was recorded in the land records where the property lies within eight years after the rendition of the judgment, and the renewed or revived judgment is subsequently recorded in accordance with this chapter.

ORDERED TO LIE

H. 774.

An act relating to meat inspection, delivery of liquid fuels, dairy operations, and animal foot baths.

PENDING ACTION: Second Reading

CONCURRENT RESOLUTIONS FOR ACTION

S.C.R. 45 (For text of Resolution, see Senate Calendar for Thursday, April 19, 2012, page 2426)

H.C.R. 336-369 (For text of Resolutions, see Addendum to House Calendar for April 19, 2012)

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. (2/24/12)

Bonnie Johnson-Aten of Montpelier – Member of the State Board of Education – By Sen. Doyle for the Committee on Education. (4/20/12)