Journal of the House

Thursday, April 26, 2012

At nine o'clock and thirty minutes in the forenoon the Speaker called the House to order.

Devotional Exercises

Devotional exercises were conducted by Rev. Norman Macleod of St. James Episcopal Church, Woodstock, VT.

Message from the Senate No. 53

A message was received from the Senate by Mr. Marshall, its Assistant Secretary, as follows:

Mr. Speaker:

I am directed to inform the House that:

The Senate has on its part passed Senate bill of the following title:

S. 233. An act relating to the mandatory age of school attendance and creating flexible pathways to high school completion.

In the passage of which the concurrence of the House is requested.

The Senate has considered bills originating in the House of the following titles:

H. 272. An act relating to maintenance of private roads.

H. 327. An act relating to the uniform principal and income act .

And has passed the same in concurrence.

The Senate has considered House proposals of amendment to Senate bills of the following titles:

S. 222. An act relating to cost-sharing for employer-sponsored insurance assistance plans.

S. 236. An act relating to health care practitioner signature authority.

And has concurred therein.

Senate Bill Referred

S. 233

Senate bill, entitled

An act relating to the mandatory age of school attendance and creating flexible pathways to high school completion

Was read and referred to the committee on Education.

Bill Referred to Committee on Ways and Means

S. 152

House bill, entitled

An act relating to the definition of line of duty in the workers' compensation statutes

Appearing on the Calendar, affecting the revenue of the state, under the rule, was referred to the committee on Ways and Means.

Recess

At ten o'clock in the forenoon, the Speaker declared a recess until ten o'clock and thirty minutes in the forenoon.

At eleven o'clock in the forenoon, the Speaker called the House to order.

Bill Committed

H. 722

House bill, entitled

An act relating to the labeling of food produced with genetic engineering

Appearing on the Calendar for action, was taken up and pending the reading of the report of the committee on Agriculture, on motion of **Rep. Partridge of Windham**, the bill was committed to the committee on Judiciary.

Bill Read Second Time; Consideration Interrupted by Recess

H. 718

Rep. Shand of Weathersfield, for the committee on Commerce and Economic Development, to which had been referred House bill, entitled

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

Reported in favor of its passage when amended by striking all after the enacting clause and inserting in lieu thereof the following:

TO THE HOUSE OF REPRESENTATIVES:

The Committee on Commerce and Economic Development to which was referred House Bill No. 718 entitled "An act relating to the department of public service and the public service board" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Effective Date of the CBES * * *

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

§ 268. COMMERCIAL BUILDING ENERGY STANDARDS

* * *

(c) Revision and interpretation of energy standards. No later than January 1, 2011, the commissioner shall complete rulemaking to amend the commercial building energy standards to ensure that commercial building construction must be designed and constructed in a manner that complies with ANSI/ASHRAE/IESNA standard 90.1-2007 or the 2009 edition of the IECC, whichever provides the greatest level of energy savings. These amendments shall be effective ~~three months~~ one year after final adoption and shall apply to construction commenced on and after the date they become effective. At least every three years after January 1, 2011, the commissioner of public service shall amend and update the CBES by means of administrative rules adopted in accordance with 3 V.S.A. chapter 25. The commissioner shall ensure that appropriate revisions are made promptly after the issuance of updated standards for commercial construction under the IECC or ASHRAE/ANSI/IESNA standard 90.1, whichever provides the greatest level of energy savings. Prior to final adoption of each required revision of the CBES, the department of public service shall convene an advisory committee to include one or more mortgage lenders; builders; building designers; architects; civil, mechanical, and electrical engineers; utility representatives; and other persons with experience and expertise, such as consumer advocates and energy conservation experts. The advisory committee may provide the commissioner of public service with additional recommendations for revision of the CBES.

* * *

(2) ~~Except for the amendments required by this subsection to be adopted by January 1, 2011, each~~ Each time the CBES are amended by the commissioner of public service, the amended CBES shall become effective upon a date specified in the adopted rule, a date that shall not be less than ~~three months~~ one year after the date of adoption. Except for the amendments required by this subsection to be adopted by January 1, 2011, persons

submitting an application for any local permit authorizing commercial construction, or an application for construction plan approval by the commissioner of public safety pursuant to 20 V.S.A. chapter 173, before the effective date of the amended CBES shall have the option of complying with the applicable provisions of the earlier or the amended CBES. After the effective date of the original or the amended CBES, any person submitting such an application for commercial construction in an area subject to the CBES shall comply with the most recent version of the CBES.

* * *

Sec. 2. RETROACTIVE APPLICATION

Sec. 1 of this act shall apply to rules adopted under 21 V.S.A. § 268 (commercial building energy standards) on or after September 1, 2011. The department of public service shall conform to the provisions of Sec. 1 of this act, the effective date contained in those rules under 21 V.S.A. § 268 most recently adopted prior to the effective date of this section. The department shall file a conforming copy of the rules with the secretary of state and the legislative committee on administrative rules. The filing shall be deemed to comply with 3 V.S.A. § 843 (filing of adopted rules) as long as the sole rule revision contained in the filing is the change in the effective date required by this section.

* * * Coordination of Energy Planning * * *

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

§ 202. ELECTRICAL ENERGY PLANNING

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

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

(1) an overview, looking 20 years ahead, of statewide growth and development as they relate to future requirements for electrical energy, including patterns of urban expansion, statewide and service area economic

growth, shifts in transportation modes, modifications in housing types and design, conservation and other trends and factors which, as determined by the director, will significantly affect state electrical energy policy and programs;

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

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

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

(5) specific strategies for reducing electric rates to the greatest extent possible in Vermont over the most immediate ~~five-year~~ six-year period, for the next succeeding ~~five-year~~ six-year period, and long-term sustainable strategies for achieving and maintaining the lowest possible electric rates over the full 20-year planning horizon consistent with the goal of maintaining a financially stable electric utility industry in Vermont.

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

(d) In establishing plans, the director shall:

(1) Consult with:

(A) the public;

(B) Vermont municipal utilities;

(C) Vermont cooperative utilities;

(D) Vermont investor-owned utilities;

(E) Vermont electric transmission companies;

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

(G) industrial customer representatives;

(H) commercial customer representatives;

(I) the public service board;

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

(K) other interested state agencies; and

(L) other energy providers.

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

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

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

(g) The director shall annually review that portion of a plan extending over the next ~~five~~ six years. The department, through the director, shall ~~annually~~ biennially extend the plan by ~~one~~ two additional ~~year~~ years; and from time to

time, ~~but in no~~ and in any event ~~less than~~ every ~~five years~~ sixth year, institute proceedings to review a plan and make revisions, where necessary. The ~~five year~~ six-year review and any interim revisions shall be made according to the procedures established in this section for initial adoption of the plan. The six-year review and any revisions made in connection with that review shall be performed contemporaneously with readoption of the comprehensive energy plan under section 202b of this title.

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

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

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

§ 202b. STATE COMPREHENSIVE ENERGY PLAN

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

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

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

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

stations with transmitting facilities within the state, plus Vermont Public Radio and Vermont Educational Television.

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

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

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

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

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

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

Sec. 5. INTENT; RETROACTIVE APPLICATION

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

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

§ 269. COMPLIANCE PLAN

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

(1) No later than September 1, 2011, issue a plan for achieving compliance with the energy standards adopted under this subchapter no later

than February 1, 2017 in at least 90 percent of new and renovated residential and commercial building space. In preparing this plan, the department shall review enforcement mechanisms for building energy codes that have been adopted in other jurisdictions and shall solicit the comments and recommendations of one or more mortgage lenders; builders; building designers; architects; civil, mechanical, and electrical engineers; utility representatives; environmental organizations; consumer advocates; energy efficiency experts; the attorney general; and other persons who are potentially affected or have relevant expertise.

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

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

(B) Establish a system for measuring the rate of compliance each year with the energy standards adopted under this chapter. Following establishment of this system, the commissioner also shall provide for such annual measurement.

* * * Electronic Filings and Case Management * * *

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

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

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

* * *

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

§ 11a. ELECTRONIC FILING AND ISSUANCE

(a) As used in this section:

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

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

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

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

(5) "Electronic issuance" means:

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

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

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

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

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

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

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

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

access to the filing, order, proposal for decision, notice, or other process through an electronic filing system.

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

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

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

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

* * *

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

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

§ 2222. POWERS AND DUTIES; BUDGET AND REPORT

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

* * *

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

by agency. The plan shall include, for any proposed information technology activity with a cost in excess of $100,000.00:

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

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

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

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

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

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

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

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

* * *

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

§ 901. DEPARTMENT OF INFORMATION AND INNOVATION

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

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

(2) to manage GOVnet;

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

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

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

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

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

(8) to inventory technology assets within state government;

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

* * *

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

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

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

§ 904. STATE WEBSITE AUDITING

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

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

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

(b) The citation shall be served upon each person having any legal interest in the property~~, including each municipality and each planning body where the~~

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

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

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

§ 225. RATE SCHEDULES

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

* * *

* * * CPG: Recommendations of Municipal and

Regional Planning Commissions * * *

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

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

* * *

(f) However, the plans for the construction of such a facility within the state must be submitted by the petitioner to the municipality and regional planning commissions no less than 45 days prior to application for a certificate of public good under this section, unless the municipal and regional planning commissions shall waive such requirement. Such municipal or regional planning commission may hold a public hearing on the proposed plans. Such commissions ~~shall~~ may make recommendations~~, if any,~~ to the public service board and to the petitioner ~~at least seven days prior to filing of the petition~~ within 21 days after the date the petition is filed with the public service board.

* * *

* * * Universal Service Fund Studies * * *

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

§ 7515. HIGH-COST BASIC TELECOMMUNICATIONS SERVICE

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

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

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

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

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

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

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

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

(B) broadening eligibility for the lifeline program; and

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

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

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

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

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

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

(d) The commissioner of public service may contract with a consultant to conduct the study required by this section. Costs incurred in conducting the study shall be reimbursed from the state universal service fund up to $75,000.00.

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

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

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

(1) the retail transactions subject to the charge;

(2) the amount of the charge;

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

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

(5) billing and collection procedures, including:

(A) notice of charges to consumers; and

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

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

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

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

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

* * * Effective Dates * * *

Sec. 18. EFFECTIVE DATES

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

The bill, having appeared on the Calendar one day for notice, was taken up and read the second time.

Pending the question, Shall the House amend the bill as recommended by the committee on Commerce and Economic Development? **Reps Ralston of Middlebury, Young of Glover, Dickinson of St. Albans Town, Scheuermann of Stowe, Buxton of Tunbridge, Campion of Bennington, Taylor of Barre City, Russell of Rutland City and Clarkson of Woodstock**

moved to amend the recommendation of amendment offered by the committeeon Commerce and Economic Development by adding Sec. 17a to read as follows:

Sec. 17a. BUSINESS AND CONSUMER ADVOCACY OFFICE; WORK GROUP AND PROPOSAL

(a) Findings and purpose. Vermonters believe there is a need for an independent voice in regulatory proceedings representing residential ratepayers, small businesses, and municipalities, many of whom do not have the financial resources or expertise to fully participate in and advance their interests in such proceedings. It is the purpose of this section to establish a work group to propose a model for a business and consumer advocacy office (BACAO) to address that need in Vermont.

(b) BACAO work group. There is created the BACAO work group to be convened by the Vermont attorney general or designee. The purpose of the work group shall be to develop a proposal for an independent business and consumer advocacy office to represent residential ratepayers, small businesses, and municipalities in proceedings before the public service board, consistent with the following parameters:

(1) the proposed model shall ensure that BACAO has authority to appeal agency or court decisions;

(2) the work group shall study and determine the forums (regulatory, judicial, state, or federal) in which the advocate may represent its statutorily defined interests;

(3) the work group shall examine and make recommendations regarding the relationship between BACAO and the department of public service, including the department's public advocate and its division of consumer affairs and public information, and shall delineate the advocate's access to departmental records, including utility accounting and financial records, as well as the advocate's direct access to utility information and records;

(4) the work group shall take into consideration consumer advocacy models implemented in other jurisdictions; and

(5) the proposed model shall ensure that the operational costs of BACAO, including expert witness fees and other reasonable costs incurred in the preparation and advocacy of a position relating to an issue in a regulatory or court proceeding, shall be borne by the utility or utilities which initiated the proceeding, as determined by the public service board.

(c) Membership. The work group shall include the attorney general or designee, the commissioner of public service or designee, a member of the

general assembly selected by the speaker of the house, a member of the general assembly selected by the president pro tempore of the senate, and five other members to be selected by the attorney general. In selecting the five other members the attorney general shall consider selecting representatives of regulated utilities, consumer advocacy organizations, and other stakeholders and interested parties so that a diverse range of interests and opinions is represented. The members of the work group shall elect a chair.

(d) Proposal. The BACAO work group shall prepare draft legislation establishing the enabling authority for the office of utility consumer advocacy, as well as a report detailing its findings and recommendations and the rationale for each. The report and draft legislation shall be submitted to the house committees on commerce and economic development and on natural resources and energy and the senate committees on finance and on natural resources and energy not later than December 15, 2012.

(e) Meetings. The work group may meet up to six times or at the call of the chair and shall cease to exist upon the completion of its duties under this section. The meetings of the work group shall be publicly announced and open to the public and reasonable opportunity shall be given to the public to express its opinion on the matters being considered by the work group.

(f) Public review and comment. Prior to reporting to committees of the general assembly under subsection (d) of this section, the work group shall allow for public review and comment on its proposed draft legislation and report.

Thereupon, **Rep. Ralson of Middlebury** asked and was granted leave of the House to withdraw his amendment.

Pending the question, Shall the House amend the bill as recommended by the committee on Commerce and Economic Development? **Reps. Browning of Arlington, Acinapura of Brandon, Andrews of Rutland City, Aswad of Burlington, Batchelor of Derby, Bohi of Hartford, Bouchard of Colchester, Branagan of Georgia, Burditt of West Rutland, Burke of Brattleboro, Buxton of Tunbridge, Campion of Bennington, Canfield of Fair Haven, Christie of Hartford, Clark of Vergennes, Clarkson of Woodstock, Condon of Colchester, Conquest of Newbury, Consejo of Sheldon, Corcoran of Bennington, Dakin of Chester, Davis of Washington, Degree of St. Albans City, Devereux of Mount Holly, Donahue of Northfield, Eckhardt of Chittenden, Fagan of Rutland City, French of Shrewsbury, Greshin of Warren, Helm of Fair Haven, Higley of Lowell, Howard of Cambridge, Howrigan of Fairfield, Hubert of Milton, Johnson of Canaan, Kilmartin of Newport City, Koch of Barre Town, Komline of Dorset, Larocque of Barnet, Lewis of Berlin, McAllister of Highgate,**

McFaun of Barre Town, McNeil of Rutland Town, Miller of Shaftsbury, Mook of Bennington, Moran of Wardsboro, Morrissey of Bennington, Mrowicki of Putney, Myers of Essex, Pearce of Richford, Pearson of Burlington, Peaslee of Guildhall, Perley of Enosburgh, Poirier of Barre City, Ram of Burlington, Reis of St. Johnsbury, Russell of Rutland City, Savage of Swanton, Shaw of Pittsford, Smith of New Haven, South of St. Johnsbury, Strong of Albany, Stuart of Brattleboro, Taylor of Barre City, Till of Jericho, Townsend of Randolph, Turner of Milton, Winters of Williamstown, Woodward of Johnson, Wright of Burlington and Zagar of Barnard moved to amend the recommendation of amendment offered by the committee on Commerce and Economic Development as follows:

By adding Sec. 17a to read as follows:

Sec. 17a. WINDFALL-SHARING MECHANISM; PAYBACK

(a) The public service board may not approve the acquisition of one electric company by another or the merger of electric companies unless, as a condition of such acquisition or merger, any applicable windfall-sharing mechanism previously established by the board results in direct cash repayment of the full amount of funds subject to the windfall-sharing mechanism to current ratepayers, based on their rate class.

(b) Notwithstanding 1 V.S.A. §§ 213 and 214, subsection (a) of this section shall apply to all petitions filed with the public service board on or after September 1, 2011.

Pending the question, Shall the House amend the recommendation of amendment offered by the committee on Commerce and Economic Development as offered by Reps. Browning of Arlington, et al?

Recess

At twelve o'clock and forty-five minutes in the afternoon, the Speaker declared a recess until one o'clock and thirty minutes in the afternoon.

At two o'clock in the afternoon, the Speaker called the House to order.

Consideration Resumed; Bill Amended and Third Reading Ordered

H. 718

Consideration resumed on House bill, entitled

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

Thereupon, **Rep. Browning of Arlington** asked and was granted leave of the House to withdraw her amendment, and the report of the committee on

Commerce and Economic Development was agreed to and third reading ordered.

Proposal of Amendment Agreed to; Third Reading Ordered

S. 148

Rep. Krebs of South Hero, for the committee on Fish, Wildlife & Water Resources, to which had been referred Senate bill, entitled

An act relating to expediting development of small and micro hydroelectric projects

Reported in favor of its passage in concurrence with proposal of amendment as follows:

By striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds:

(1) The existing policy of the state of Vermont is to promote development and use of renewable energy projects, including hydroelectric projects.

(2) Additional capacity exists for development of hydroelectric projects in Vermont, with estimates ranging from 25 megawatts (MW) to 434 MW. The Comprehensive Energy Plan issued in December 2011 by the department of public service (DPS) states in Sec. 5.8.2.1.1:

> Opinions differ on the amount of available hydropower that is available in Vermont. Depending on assumptions used, reports vary from 25 MW at 44 sites (estimated by the ANR [agency of natural resources] in 2008) to 434 MW at 1,291 sites (estimated in a DOE [Department of Energy] study in 2006). A 2007 study for the DPS identified more than 90 MW developable at 300 of the existing 1,200 existing dams.

(3) In a report to the general assembly entitled "The Development of Small Hydroelectric Projects in Vermont" (Jan. 9, 2008) at p. 19, ANR states that most hydroelectric projects in Vermont are smaller than five MW in capacity.

(4) Most hydroelectric projects require approval from the Federal Energy Regulatory Commission (FERC). The length and cost of the process of obtaining a FERC approval do not vary significantly with the capacity of the hydroelectric project. However, the ability of a hydroelectric project to absorb this cost decreases as the capacity of the project grows smaller.

(5) A FERC approval of a hydroelectric project may be in the form of a "license" for a limited term that is not to exceed 50 years and that may be renewed. The majority of the over 1,700 hydroelectric projects regulated by FERC are subject to limited term licenses. These licenses can apply to large hydroelectric projects such as the 15 Mile Falls Hydroelectric Project on the Connecticut River (291 MW) and to small projects such as the Gilman Dam on the Black River in Vermont (0.125 MW). Licensed projects may include "minor water power projects," which FERC defines as any existing or proposed water power project that would have a total installed generation capacity of 1.5 MW or less.

(6) A FERC approval of a hydroelectric project may be in the form of an "exemption," under which the project is exempted from some requirements of the Federal Power Act, including the limited term, but there is still an extensive application and environmental review process. These exemptions therefore are approvals in perpetuity. There are two classes of hydroelectric license "exemptions" granted by FERC:

(A) Small hydropower projects, which are five MW or less, that will be built at an existing dam, or projects that utilize a natural water feature for head or an existing project that has a capacity of five MW or less and proposes to increase capacity.

(B) Conduit exemptions for generating capacities of 15 MW or less for nonmunicipal and 40 MW or less for a municipal project. The conduit must have been constructed primarily for purposes other than power production and be located entirely on nonfederal lands. In this context, "conduit" refers to a human-made water conveyance (e.g., an irrigation canal).

(7) In August 2010, FERC and the state of Colorado, through its energy office, entered into a memorandum of understanding "to streamline and simplify the authorization of small-scale hydropower projects."

(8) In Vermont:

(A) The state energy office is the department of public service, which among other duties advances state energy policy pursuant to the direction provided by statute.

(B) The main agency engaged in environmental regulation is the agency of natural resources (ANR), the duties and expertise of which include science-based analysis of the impacts of projects on water quality, fish, and wildlife. When a FERC license or exemption is sought for a hydroelectric project in Vermont, ANR reviews the project and determines whether to issue a certification under the Clean Water Act, 33 U.S.C. § 1341, that the project will not violate water quality standards adopted under that act.

Sec. 2. MEMORANDUM OF UNDERSTANDING; SMALL HYDROELECTRIC PROJECTS

(a) In consultation with the secretary of natural resources (the secretary), the commissioner of the department of public service (the commissioner) shall seek to enter into a memorandum of understanding (MOU) with the Federal Energy Regulatory Commission (FERC) for a program to expedite the procedures for FERC's granting approvals for projects in Vermont that constitute small conduit hydroelectric facilities and small hydroelectric power projects as defined in 18 C.F.R. § 4.30 (the MOU program). The commissioner also may seek to include minor water power projects, as defined by 18 C.F.R. § 4.30, in the MOU program. By July 15, 2012, the commissioner shall initiate with FERC the process of negotiating this MOU.

(b) In negotiating and entering into an MOU under this section, the commissioner in consultation with the secretary shall offer and agree to prescreening by the state of Vermont of hydroelectric projects participating in the MOU program.

(c) Prior to executing an MOU with FERC under this section, the commissioner shall submit a copy of the MOU, in its final form as the parties intend to execute it, to the house committee on fish, wildlife and water resources and the senate committee on natural resources and energy. The MOU may be submitted electronically to the office of legislative council, which shall distribute it to the members of these committees.

(d) In consultation with the secretary, the commissioner is authorized to sign an MOU under this section on behalf of the department of public service, the agency of natural resources, and other state agencies and departments involved in the review of proposed hydroelectric projects in Vermont.

(e) No later than January 15, 2014 and annually by each second January 15 thereafter, the commissioner shall submit a written report to the general assembly detailing the progress of the MOU program, including an identification of each hydroelectric project participating in the program. After five hydroelectric projects participating in the program are approved and commence operation, reports filed under this subsection shall evaluate and provide lessons learned from the program, including recommendations, if any, on how to improve procedures for obtaining approval of micro hydroelectric projects (100 kilowatts capacity or less). The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be submitted under this subsection.

(f) As necessary and appropriate, the commissioner and the secretary shall seek funding from available sources to support the MOU program under this

section. Inception of the MOU program shall not be contingent on receipt of such funding.

Sec. 3. EFFECTIVE DATE

This act shall take effect on passage.

The bill, having appeared on the Calendar one day for notice, was taken up, read the second time and the recommendation of proposal of amendment agreed to and third reading ordered.

Senate Proposal of Amendment Concurred in

H. 254

The Senate proposed to the House to amend House bill, entitled

An act relating to consumer protection

By striking 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.

Which proposal of amendment was considered and concurred in.

Proposal of Amendment Agreed to; Third Reading Ordered

S. 183

Rep. Fagan of Rutland City, for the committee on Fish, Wildlife & Water Resources, to which had been referred Senate bill, entitled

An act relating to the testing of potable water supplies

Reported in favor of its passage in concurrence with proposal of amendment as follows:

By striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds and declares that:

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

(2) Owners of certain properties in the state with potable water supplies from groundwater currently are not required to test the groundwater source.

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

(4) The state lacks comprehensive groundwater quality data that could be used to develop mapping and a clearinghouse identifying groundwater contamination locations.

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

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

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

§ 1396. RECORDS AND REPORTS

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

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

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

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

(3), (4) [Repealed.]

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

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

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

(2) recommended tests to detect specific contaminants, such as arsenic, lead, uranium, gross alpha radiation, total coliform bacteria, total nitrate or nitrite, fluoride, and manganese.

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

§ 501b. CERTIFICATION OF LABORATORIES

(a) The commissioner may certify a laboratory that meets the standards currently in effect of the National Environmental Laboratory Accreditation Conference and is accredited by an approved National Environmental Laboratory Accreditation Program accrediting authority or its equivalent to perform the testing and monitoring:

(1) required under 10 V.S.A. chapter 56 and the federal Safe Drinking Water Act ~~if such laboratory meets the standards currently in effect of the National Environmental Laboratory Accreditation Conference and is accredited by an approved National Environmental Laboratory Accreditation Program accrediting authority or its equivalent~~; and

(2) of water from a potable water supply, as that term is defined in 10 V.S.A. § 1972(6).

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

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

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

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

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

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

* * *

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

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

§ 616. GROUNDWATER SOURCE TESTING; DISCLOSURE OF INFORMATIONAL MATERIAL

(a) Disclosure of potable water supply informational material. For a contract for the conveyance of real property with a potable water supply, as that term is defined in 10 V.S.A. § 1972(6), that is not served by a public water system, as that term is defined in 10 V.S.A. § 1671(5), executed on or after January 1, 2013, the seller shall, within 72 hours of the execution provide the buyer with informational materials developed by the department of health regarding:

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

(2) the availability of test kits provided by the department of health.

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

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

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

Sec. 6. EFFECTIVE DATE

This act shall take effect on January 1, 2013.

The bill, having appeared on the Calendar one day for notice, was taken up, and read the second time.

Pending the question, Shall the House propose to the Senate to amend the bill as recommended by the committee on Fish, Wildlife and Water Resoruces? **Rep. Fagan of Rutland City** moved to amend the recommendation of proposal of amendment offered by the committee on Fish, Wildlife and Water Resources as follows:

In Sec. 5 by designating the existing language as subsection (a) and by adding subsection (b) to read:

(b) The department of health, after consultation with representatives of licensed real estate brokers, as that term is defined in 26 V.S.A. § 2211, shall propose language to be added to a seller's property information report regarding the requirement under 27 V.S.A. § 616 that a seller of real property with a potable water supply that is not served by a public water system provide the buyer informational material regarding the potential health effects of the consumption of contaminated groundwater and the availability of test kits provided by the department of health.

Which was agreed and the report of the committee on Fish, Wildlife and Warer Resources, as amended, was agreed to and third reading was ordered.

Proposal of Amendment Agreed to; Third Reading Ordered

S. 202

Rep. Deen of Westminster, for the committee on Fish, Wildlife & Water Resources, to which had been referred Senate bill, entitled

An act relating to regulation of flood hazard areas, river corridors, and stream alteration

Reported in favor of its passage in concurrence with proposal of amendment as follows:

By striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 10 V.S.A. chapter 32 is amended to read:

CHAPTER 32. FLOOD HAZARD AREAS

§ 751. PURPOSE

The purpose of this chapter is to minimize and prevent the loss of life and property, the disruption of commerce, the impairment of the tax base, and the extraordinary public expenditures and demands on public service that result from flooding; to ensure that the development of the flood hazard areas of this

state is accomplished in a manner consistent with the health, safety and welfare of the public; ~~to provide state assistance to local government units in management of flood hazard areas;~~ to coordinate federal, state, and local management activities for flood hazard areas; to encourage local government units to manage flood hazard areas and other flood-prone lands; to provide state assistance to local government units in management of flood-prone lands; to comply with National Flood Insurance Program requirements for the regulation of development; to authorize adoption of state rules for management of uses exempt from municipal regulation in a flood hazard area; to maintain the ~~wise~~ agricultural use of flood-prone lands consistent with the National Flood Insurance Program; to carry out a comprehensive statewide flood hazard area management program for the state in order to ~~make the state and units of local government eligible~~ ensure eligibility for flood insurance under the requirements of the ~~federal department of housing and urban development in administering Title XIII of the Housing and Urban Development Act of 1968~~ National Flood Insurance Program.

§ 752. DEFINITIONS

For the purpose of this chapter:

(1) "Agency" means the agency of natural resources.

(2) "Development," for the purposes of flood hazard area management and regulation, shall have the same meaning as "development" under 44 C.F.R. § 59.1.

(3) "Flood hazard area" ~~means an area which would be inundated in a flood of such severity that the flood would be statistically likely to occur once in every hundred years. In appropriate circumstances this might be the 1927 or the 1973 flood. In delineating any flood hazard area for the one hundred year flood based upon prior floods, flood control devices such as, but not limited to dams, canals, and channel work should be considered in the delineation~~ shall have the same meaning as "area of special flood hazard" under 44 C.F.R. § 59.1.

~~(3)~~(4) "Flood proofing" shall have the same meaning as "flood proofing" under 44 C.F.R. § 59.1.

(5) "Floodway" ~~means the channel of a watercourse and adjacent land areas which are required to carry and discharge the one hundred year flood within a regulated flood hazard area without substantially increasing the flood heights delineation~~ shall have the same meaning as "regulatory floodway" under 44 C.F.R. § 59.1.

~~(4) "Flood proofing" means any combination of structural and nonstructural additions, changes, or adjustments to properties and structures,~~

~~primarily for the reduction or elimination of flood damage to lands, water and sanitary facilities, structures and contents of buildings delineation.~~

~~(5)~~(6) "Legislative body" means the ~~board of selectmen~~ selectboard, trustees, mayor, city council, and ~~board of aldermen~~ alderboard of a municipality.

~~(6)~~(7) "Municipality" means any town, city, or incorporated village.

(8) "Uses exempt from municipal regulation" means land use or activities that are exempt from municipal land use regulation under 24 V.S.A. chapter 117.

~~(7)~~(9) ~~"Obstruction" means any natural or artificial condition including but not limited to, real estate which may impede, retard, or change the direction of the flow of water, either in itself or by catching or collecting debris carried by the water, or so situated that the flow of the water might carry it downstream to the damage of life or property~~ "National Flood Insurance Program" means the National Flood Insurance Program under 42 U.S.C. chapter 50 and implementing federal regulations in 44 C.F.R. parts 59 and 60.

~~(8)~~(10) "Regional planning commission" means the regional planning commission of which a municipality is a member or would be a member based upon its location.

(11) "River corridor" means the land area adjacent to a river that is required to accommodate the dimensions, slope, planform, and buffer of the naturally stable channel and that is necessary for the natural maintenance or natural restoration of a dynamic equilibrium condition, as that term is defined in section 1422 of this title, and for minimization of fluvial erosion hazards, as delineated by the agency of natural resources in accordance with river corridor protection procedures.

~~(9)~~(12) "Secretary" means the secretary of ~~the agency of~~ natural resources or the secretary's duly authorized representative.

§ 753. FLOOD HAZARD AREAS; COOPERATION; MAPPING

(a) Cooperation to secure flood insurance. ~~To meet the objective of this chapter and the requirements of 24 V.S.A. § 4412, the designation and management of flood hazard areas shall adhere to the following procedure and schedule. All~~ The secretary and all municipalities, regional planning commissions, and departments and agencies of state government shall mutually cooperate to ~~these ends~~ achieve the purposes of this chapter and to secure flood ~~plain~~ insurance for municipalities and the state of Vermont. All correspondence sent to a municipality pursuant to this chapter shall be sent to the municipal clerk, the municipal manager, if one exists, the legislative body,

~~and~~ the planning commission, and the conservation commission, if one exists. Copies of this correspondence shall be sent to the regional planning commission~~,~~ and the agency of commerce and community development~~, and the state planning office~~.

(b) Notice of designation of flood hazard areas; maps. The secretary shall, as the information becomes available, provide each municipality with a designation of flood hazard areas. The designation shall include a map or maps.

(c) Procedure to authorize review of municipal permit applications. The secretary shall establish a procedure for authorizing a representative of a municipality or a regional planning commission to conduct the review required under 24 V.S.A. § 4424(a)(2)(D), including eligibility requirements for authorization to conduct permit application review and an approved process or list of approved certifications that the secretary shall accept as proof of expertise in the field of floodplain management.

§ 754. FLOOD HAZARD AREA RULES; USES EXEMPT FROM MUNICIPAL REGULATION

(a) Rulemaking authority.

(1) On or before March 15, 2014, the secretary shall adopt rules pursuant to 3 V.S.A. chapter 25 that establish requirements for the issuance and enforcement of permits applicable to uses exempt from municipal regulation that are located within a flood hazard area of a municipality that has adopted a flood hazard bylaw or ordinance under 24 V.S.A. chapter 117.

(2) The secretary shall not adopt rules under this subsection that regulate agricultural activities without the consent of the secretary of agriculture, food and markets, provided that the secretary of agriculture, food and markets shall not withhold consent under this subdivision when lack of such consent would result in the state's noncompliance with the National Flood Insurance Program.

(3) The secretary shall seek the guidance of the Federal Emergency Management Agency in developing and drafting the rules required by this section in order to ensure that the rules are sufficient to meet eligibility requirements for the National Flood Insurance Program.

(b) Required rulemaking content. The rules shall:

(1) set forth the requirements necessary to ensure uses exempt from municipal regulation are regulated by the state in order to comply with the regulatory obligations set forth under the National Flood Insurance Program.

(2) be designed to ensure that the state and municipalities meet

community eligibility requirements for the National Flood Insurance Program.

(3) require that the secretary provide notice to a municipality in which a use exempt from municipal regulation will occur of an application received under this section and a copy of the permit issued, unless a use is authorized to occur without notification of or reporting to the secretary.

(c) Discretionary rulemaking. The rules may establish requirements that exceed the requirements of the National Flood Insurance Program for uses exempt from municipal regulation.

(d) General permit. The rules authorized by this section may establish requirements for a general permit to implement the requirements of this section, including authorization under the general permit to conduct a specified use exempt from municipal regulation without notifying or reporting to the secretary or an agency delegated under subsection (i) of this section.

(e) Consultation with interested parties. Prior to submitting the rules required by this section to the secretary of state under 3 V.S.A. § 838, the secretary shall solicit the recommendations of and consult with affected and interested persons and entities such as: the secretary of commerce and community development; the secretary of agriculture, food and markets; the secretary of transportation; the commissioner of financial regulation; representatives of river protection interests; representatives of fishing and recreational interests; representatives of the banking industry; representatives of the agricultural community; the regional planning commissions; municipal interests; and representatives of municipal associations.

(f) Permit requirement. Beginning July 1, 2014, no person shall commence or conduct a use exempt from municipal regulation in a flood hazard area in a municipality that has adopted a flood hazard area bylaw or ordinance under 24 V.S.A. chapter 117 without a permit issued under the rules required under subsection (a) of this section by the secretary or by a state agency delegated permitting authority under subsection (g) of this section.

(g) Delegation.

(1) The secretary may delegate to another state agency the authority to implement the rules adopted under this section, to issue a permit under subsection (h) of this section, and to enforce the rules and a permit.

(2) A memorandum of understanding shall be entered into between the secretary and a delegated state agency for the purpose of specifying implementation of requirements of this section and the rules adopted under this section, issuance of a permit or coverage under a general permit under this section, and enforcement of the rules and permit required by this section.

(3) Prior to entering a memorandum of understanding, the secretary shall post the proposed memorandum of understanding on its website for 30 days for notice and comment. When the memorandum of understanding is posted, it shall include a summary of the proposed memorandum; the name, telephone number, and address of a person able to answer questions and receive comments on the proposal; and the deadline for receiving comments. A final copy of a memorandum of understanding entered into under this section shall be sent to the chairs of the house and senate committees on natural resources and energy, the house committee on fish, wildlife and water resources, and any other committee that has jurisdiction over an agency that is a party to the memorandum of understanding.

(h) Municipal authority. This section and the rules adopted under it shall not prevent a municipality from adopting substantive requirements for development in a flood hazard area bylaw or ordinance under 24 V.S.A. chapter 117 that are more stringent than the rules required by this section, provided that the bylaw or ordinance shall not apply to uses exempt from municipal regulation.

§ 755. MUNICIPAL EDUCATION; MODEL FLOOD HAZARD AREA BYLAW OR ORDINANCE

(a) Education and assistance. The secretary, in consultation with regional planning commissions, shall provide ongoing education, technical assistance, and guidance to municipalities regarding the requirements under 24 V.S.A. chapter 117 necessary for compliance with the National Flood Insurance Program.

(b) Model flood hazard area bylaw or ordinance. The secretary shall create and make available to municipalities a model flood hazard area bylaw or ordinance for potential adoption by municipalities pursuant to 24 V.S.A. chapter 117 or 24 V.S.A. § 2291. The model bylaw or ordinance shall set forth the minimum provisions necessary to meet the requirements of the National Flood Insurance Program. The model bylaw may include alternatives that exceed the minimum requirements for compliance with the National Flood Insurance Program in order to allow a municipality to elect whether it wants to adopt the minimum requirement or an alternate requirement that further minimizes the risk of harm to life, property, and infrastructure from flooding.

(c) Assistance to municipalities with no flood hazard area bylaw or ordinance. The secretary, in consultation with municipalities, municipal organizations, and regional planning commissions, shall provide education and technical assistance to municipalities that lack a flood hazard area bylaw or ordinance in order to encourage adoption of a flood hazard area bylaw or ordinance that qualifies the municipality for the National Flood Insurance

Program.

* * * Stream Alteration; Emergency Activities * * *

Sec. 2. 10 V.S.A. § 1002 is amended to read:

§ 1002. DEFINITIONS

Wherever used or referred to in this chapter, unless a different meaning clearly appears from the context:

(1) "Artificial regulation of stream flow" means the intermittent or periodic manipulation of water levels and the intermittent or periodic regulation of discharge of water into the stream below the dam.

(2) "Banks" means that land area immediately adjacent to the bed of the stream, which is essential in maintaining the integrity thereof.

(3) "Bed" means the maximum area covered by waters of the stream for not less than 15 consecutive days in one year.

(4) "Board" means the natural resources board.

(5) "Cross section" means the entire channel to the top of the banks.

(6) "Dam" applies to any artificial structure on a stream or at the outlet of a pond or lake, which is utilized for holding back water by ponding or storage together with any penstock, flume, piping or other facility for transmitting water downstream to a point of discharge, or for diverting water from the natural watercourse to another point for utilization or storage.

(7) "Department" means the department of environmental conservation.

(8) ~~[Repealed.]~~ "Instream material" means:

(A) all gradations of sediment from silt to boulders;

(B) ledge rock; or

(C) large woody debris in the bed of a watercourse or within the banks of a watercourse.

(9) "Person" means any individual; partnership; company; corporation; association; unincorporated association; joint venture; trust; municipality; the state of Vermont or any agency, department, or subdivision of the state, any federal agency, or any other legal or commercial entity.

(10) "Watercourse" means any perennial stream. "Watercourse" shall not include ditches or other constructed channels primarily associated with land drainage or water conveyance through or around private or public infrastructure.

(11) "Secretary" means the secretary of the agency of natural resources, or the secretary's duly authorized representative.

(12) "Berm" means a linear fill of earthen material on or adjacent to the bank of a watercourse that constrains waters from entering a flood hazard area or river corridor, as those terms are defined in subdivisions 752(3) and (11) of this title.

(13) "Large woody debris" means any piece of wood within a watercourse with a diameter of 10 or more inches and a length of 10 or more feet that is detached from the soil where it grew.

Sec. 3. 10 V.S.A. § 1021 is amended to read:

§ 1021. ALTERATION PROHIBITED; EXCEPTIONS

(a) A person shall not change, alter, or modify the course, current, or cross section of any watercourse or of designated outstanding resource waters, within or along the boundaries of this state either by movement, fill, or ~~by~~ excavation of ten cubic yards or more of instream material in any year, unless authorized by the secretary. A person shall not establish or construct a berm in a flood hazard area or river corridor, as those terms are defined in subdivisions 752(3) and (11) of this title, unless permitted by the secretary or constructed as an emergency protective measure under subsection (b) of this section.

(b) This subchapter shall not apply to emergency protective measures necessary to preserve life or to prevent severe imminent damage to public or private property, or both. The protective measures shall:

(1) be limited to the minimum amount necessary to remove imminent threats to life or property~~, shall~~;

(2) have prior approval from a member of the municipal legislative body ~~and shall~~;

(3) be reported to the secretary by the legislative body within ~~72~~ 24 hours after the onset of the emergency; and

(4) be implemented in a manner consistent with the rules adopted under section 1027 of this title regarding stream alteration during emergencies.

* * *

Sec. 4. 10 V.S.A. § 1023 is amended to read:

§ 1023. INVESTIGATION, PERMIT

(a) Upon receipt of an application, the secretary shall cause an investigation of the proposed change to be made. Prior to making a decision, a written report shall be made by the secretary concerning the effect of the proposed

change on the watercourse. The permit shall be granted, subject to such conditions determined to be warranted, if it appears that the change:

(1) will not adversely affect the public safety by increasing flood or fluvial erosion hazards;

(2) will not significantly damage fish life or wildlife;

(3) will not significantly damage the rights of riparian owners; and

(4) in case of any waters designated by the board as outstanding resource waters, will not adversely affect the values sought to be protected by designation.

(b) The reasons for the action taken under this section shall be set forth in writing to the applicant. Notice of the action of the secretary shall also be sent to the selectmen of the town in which the proposed change is located, and to each owner of property which abuts or is opposite the land where the alteration is to take place.

(c) If the local legislative body and planning commission determine in writing by majority vote of each that ~~gravel~~ instream material in a watercourse is threatening life or property, due to increased potential for flooding, and that the removal of ~~gravel~~ instream material is necessary to prevent the threat to life or property, and if a complete permit application has been submitted to the secretary, requesting authority to remove ~~gravel~~ instream material in the minimum amount necessary to remove threats to life or property, the local legislative body and the planning commission may request an expedited review of the complete permit application by notifying the secretary and providing copies of their respective decisions. If the secretary fails to approve or deny the application within 45 calendar days of receipt of notice of the decisions, the application shall be deemed approved and a permit shall be deemed to have been granted. ~~Gravel~~ Instream material removed shall be used only for public purposes, and cannot be sold, traded, or bartered. The fact that an application for a permit has been filed under this subsection shall not limit the ability to take emergency measures under subsection 1021(b) of this title. For the purposes of section 1024 of this title, if a permit has been deemed to have been granted under this subsection, that permit shall constitute a decision of the secretary.

(d)(1) The secretary shall conduct training programs or seminars regarding how to conduct stream alteration, water quality review, stormwater discharge, fish and wildlife habitat preservation, and wastewater discharge activities necessary during:

(A) a state of emergency declared under 20 V.S.A. chapter 1;

(B) flooding; or

(C) other emergency conditions that pose an imminent risk to life or a risk of damage to public or private property.

(2) The secretary shall make the training programs or seminars available to agency employees in an agency division other than the watershed management division, employees of other state and federal agencies, regional planning commission members and employees, municipal officers and employees, and state, municipal, and private contractors.

(f) The secretary is authorized to enter into reciprocal mutual aid agreements or compacts with other states to assist the secretary and the state in addressing watershed, river management, and transportation system issues that arise when a state of emergency is declared under 20 V.S.A. chapter 1.

Sec. 5. 10 V.S.A. § 1027 is added to read:

§ 1027. RULEMAKING; EMERGENCY PERMIT

(a) The secretary may adopt rules to implement the requirements of this subchapter.

(b) The secretary shall adopt rules regarding the permitting of stream alteration activities under this subchapter during a state of emergency declared under 20 V.S.A. chapter 1 or during flooding or other emergency conditions that pose an imminent risk to life or a risk of damage to public or private property. Any rule adopted under this subsection shall comply with National Flood Insurance Program requirements. A rule adopted under this subsection shall include a requirement that an activity receive an individual stream alteration emergency permit or receive coverage under a general stream alteration emergency permit.

(1) A rule adopted under this subsection shall establish:

(A) criteria for coverage under an individual permit and criteria for coverage under a general emergency permit;

(B) criteria for different categories of activities covered under a general emergency permit, including the construction of temporary berms as emergency protective measures;

(C) requirements for public notification of permitted activities, including notification after initiation or completion of a permitted activity;

(D) requirements for coordination with state and municipal authorities; and

(E) requirements that the secretary document permitted activity, including, at a minimum, requirements for documenting permit terms,

documenting permit duration, and documenting the nature of an activity when the rules authorize notification of the secretary after initiation or completion of the activity.

(2) A rule adopted under this section may:

(A) establish reporting requirements for categories of activities;

(B) authorize an activity that does not require reporting to the secretary; or

(C) authorize an activity that requires reporting to the secretary after initiation or completion of an activity.

Sec. 6. 10 V.S.A. § 1264 is amended to read:

§ 1264. STORMWATER MANAGEMENT

* * *

(k) The secretary may adopt rules regulating stormwater discharges and stormwater infrastructure repair or maintenance during a state of emergency declared under 20 V.S.A. chapter 1 or during flooding or other emergency conditions that pose an imminent risk to life or a risk of damage to public or private property. Any rule adopted under this subsection shall comply with National Flood Insurance Program requirements. A rule adopted under this subsection shall include a requirement that an activity receive an individual stormwater discharge emergency permit or receive coverage under a general stormwater discharge emergency permit.

(1) A rule adopted under this subsection shall establish:

(A) criteria for coverage under an individual or general emergency permit;

(B) criteria for different categories of activities covered under a general emergency permit;

(C) requirements for public notification of permitted activities, including notification after initiation or completion of a permitted activity;

(D) requirements for coordination with state and municipal authorities;

(E) requirements that the secretary document permitted activity, including, at a minimum, requirements for documenting permit terms, documenting permit duration, and documenting the nature of an activity when the rules authorize notification of the secretary after initiation or completion of the activity.

(2) A rule adopted under this section may:

(A) establish reporting requirements for categories of activities;

(B) authorize an activity that does not require reporting to the secretary; or

(C) authorize an activity that requires reporting to the secretary after initiation or completion of an activity.

Sec. 6a. REPORT ON USE OF VOLUNTARY STORMWATER MANAGEMENT CREDITS FOR HIGH ELEVATION PROJECTS

(a) ANR report on voluntary stormwater management credits. On or before January 15, 2014, the secretary of natural resources shall report to the house committee on fish, wildlife and water resources and the senate committee on natural resources and energy regarding the effectiveness of the use of voluntary stormwater management credits to permit discharges of stormwater from renewable energy projects located at an elevation above 1,500 feet. The report shall:

(1) Summarize available national data regarding the efficacy of alternative stormwater treatment practices similar to the voluntary stormwater management credits;

(2) Evaluate the efficacy of the science and design of the management practices authorized under the voluntary stormwater management credits, including the impact of management practices authorized under the voluntary stormwater management credits on the vegetation and trees, fragile ecosystems, shallow soils, and sensitive streams found in high-elevation settings; and

(3) Recommend whether the voluntary stormwater management credits should be available for the permitting of stormwater discharges from renewable energy project sites located at elevations above 1,500 feet.

(4) Analyze or estimate if financial gains are prevalent to developers who have made use of management practices authorized under the voluntary stormwater management credits.

(5) Estimate the number of acres of soil that have not been disturbed as a result of the application of management practices authorized under the voluntary stormwater management credits.

(6) Recommend whether management practices authorized under the voluntary stormwater management credits should be expanded for discharges below 1,500 feet.

(b) Consultation with interested parties. In developing the report required under subsection (a) of this section, the secretary of natural resources shall

consult with interested parties, including environmental groups.

* * * River Corridor Assessment and Planning * * *

Sec. 7. 10 V.S.A. § 1421 is amended to read:

§ 1421. POLICY

To aid in the fulfillment of the state's role as trustee of its navigable waters and to promote public health, safety, convenience, and general welfare, it is declared to be in the public interest to make studies, establish policies, make plans, make rules, encourage and promote buffers adjacent to lakes, ponds, reservoirs, rivers, and streams of the state, encourage and promote protected river corridors adjacent to rivers and streams of the state, and authorize municipal shoreland and river corridor protection zoning bylaws for the efficient use, conservation, development, and protection of the state's water resources. The purposes of the rules shall be to further the maintenance of safe and healthful conditions; prevent and control water pollution; protect spawning grounds, fish, and aquatic life; control building sites, placement of structures, and land uses; reduce fluvial erosion hazards; reduce property loss and damage; preserve shore cover, natural beauty, and natural stability; and provide for multiple use of the waters in a manner to provide for the best interests of the citizens of the state.

Sec. 8. 10 V.S.A. § 1422 is amended to read:

§ 1422. DEFINITIONS

In this chapter, unless the context clearly requires otherwise:

(1) "Agency" means the agency of natural resources.

* * *

(7) "Secretary" means the secretary of natural resources or the secretary's duly authorized representative.

* * *

(12) "River corridor" means the land area adjacent to a river that is required to accommodate the dimensions, slope, planform, and buffer of the naturally stable channel, and that is necessary to maintain or restore fluvial for the natural maintenance or natural restoration of dynamic equilibrium conditions and minimize for minimization of fluvial erosion hazards, as delineated by the agency of natural resources in accordance with river corridor protection procedures.

(13) "River" means the full length and width, including the bed and banks, of any watercourse, including rivers, streams, creeks, brooks, and branches, which experience perennial flow. "River" does not mean

constructed drainageways, including water bars, swales, and roadside ditches.

(14) "Equilibrium condition" means the width, depth, meander pattern, and longitudinal slope of a stream channel that occurs when water flow, sediment, and woody debris are transported by the stream in such a manner that it generally maintains dimensions, pattern, and slope without unnaturally aggrading or degrading the channel bed elevation.

(15) "Flood hazard area" shall have the same meaning as "area of special flood hazard" under 44 C.F.R. § 59.1.

(16) "Fluvial erosion" means the erosion or scouring of riverbeds and banks during high flow conditions of a river.

(17) "Geomorphic condition" means the degree of departure from the dimensions, pattern, and profile associated with a naturally stable channel representing the unique dynamic equilibrium condition of a river segment.

(18) "Infrastructure" means public and private buildings, roads, and public works, including public and private buildings; state and municipal highways and roads; bridges; sidewalks and other traffic enhancements; culverts; private roads; public and private utility construction, state and municipal public works, cemeteries, and public parks and fields.

(19) "River corridor protection area" means the area within a delineated river corridor subject to fluvial erosion that may occur as a river establishes and maintains the dimension, pattern, and profile associated with its dynamic equilibrium condition and that would represent a hazard to life, property, and infrastructure placed within the area.

(20) "Sensitivity" means the potential of a river, given its inherent characteristics and present geomorphic conditions, to be subject to a high rate of fluvial erosion and other river channel adjustments, including erosion, deposit of sediment, and flooding.

Sec. 9. 10 V.S.A. § 1427 is amended to read:

§ 1427. RIVER CORRIDORS AND BUFFERS

(a) River corridor and floodplain management program. The secretary of natural resources shall establish a river corridor and floodplain management program to aid and support the municipal adoption of river corridor, floodplain, and buffer bylaws. Under the river corridor and floodplain management program, the secretary shall:

(1) ~~upon request, provide municipalities with maps of designated river corridors within the municipality. A river corridor map provided to a municipality shall delineate a recommended buffer that is based on~~

~~site-specific conditions. The secretary shall provide maps under this subdivision based on a priority schedule established by the secretary in procedure; and~~ assess the geomorphic condition and sensitivity of the rivers of the state and identify where the sensitivity of a river poses a probable risk of harm to life, property, or infrastructure.

(2) delineate and map river corridors based on the river sensitivity assessments required under subdivision (1) of this subsection according to a priority schedule established by the secretary by procedure; and

(3) develop recommended best management practices for the management of river corridors, floodplains, and buffers.

(b) River sensitivity assessment; secretary's discretion. ~~No later than February 1, 2011, the secretary of administration, after consultation with the state agencies of relevant jurisdiction, shall offer financial incentives to municipalities through existing grants and pass-through funding programs which encourage municipal adoption and implementation of zoning bylaws that protect river corridors and buffers~~ Notwithstanding the schedule established by the secretary under subdivision (a)(2) of this section, the secretary may complete a sensitivity assessment for a river if, in the secretary's discretion, the sensitivity of a river and the risk it poses to life, property, and infrastructure require an expedited assessment.

(c) ~~No later than February 1, 2011, the agency of natural resources shall define minimum standards for municipal eligibility for any financial incentives established under subsection (b) of this section~~ Municipal consultation during river assessment. Prior to and during an assessment of river sensitivity required under subsection (a) of this section, the secretary shall consult with the legislative body or designee of municipalities and the regional planning commissions in the area in which a river is located.

Sec. 10. 10 V.S.A. § 1428 is added to read:

§ 1428. RIVER CORRIDOR PROTECTION

(a) River corridor maps. Upon completion of a sensitivity assessment for a river or river segment under section 1427 of this title, the secretary shall provide to each municipality and regional planning commission in which the river or river segment is located a copy of the sensitivity assessment and a river corridor map for the municipality and region. A river corridor map provided to a municipality and regional planning commission shall identify floodplains, river corridor protection areas, flood hazard areas, and other areas or zones indicated on a Federal Emergency Management Agency flood insurance rate map, and shall recommend best management practices, including vegetated buffers, based on site-specific conditions. The secretary shall post a copy of

the sensitivity assessment and river corridor map to the agency of natural resources' website. A municipality with a mapped river or river segment shall post a copy of a sensitivity assessment and river corridor map received under this subsection in the municipal offices and on the municipality's website, if the municipality regularly updates its website . A regional planning commission shall post a sensitivity assessment or river corridor map received under this subsection in the commission's offices and on the commission's website. When a sensitivity assessment or a river corridor map is provided to a municipality, provided to a regional planning commission, or posted on the agency website, the agency shall provide all information, including the supportive data, in a digital format.

(b) River corridor protection area bylaw. The secretary shall create and make available to municipalities several alternative model river corridor protection area bylaws or ordinances for potential adoption by municipalities pursuant to 24 V.S.A. chapter 117 or 24 V.S.A. § 2291. The model bylaws or ordinances shall use terminology consistent with the National Flood Insurance Program regulations.

(c) Flood resilient communities program; incentives. No later than February 1, 2013, the secretary of administration, after consultation with the state agencies of relevant jurisdiction, shall offer financial incentives through a flood resilient communities program. The program shall list the existing financial incentives under state law for which municipalities may apply for financial assistance, when funds are available, for municipal adoption and implementation of bylaws under 24 V.S.A. chapter 117 that protect river corridors and floodplains. The secretary of natural resources shall summarize minimum standards for municipal eligibility for any financial incentives established under this subsection.

* * * Municipal Planning; Flood Hazard and River Corridor Protection Areas * * *

Sec. 11. 24 V.S.A. § 4303 is amended to read:

§ 4303. DEFINITIONS

The following definitions shall apply throughout this chapter unless the context otherwise requires:

* * *

(8) "Flood hazard area" for purposes of section 4424 of this title ~~means the land subject to flooding from the base flood. "Base flood" means the flood having a one percent chance of being equaled or exceeded in any given year~~ shall have the same meaning as "area of special flood hazard" under 44 C.F.R. § 59.1. Further, with respect to flood, river corridor protection area, and other

hazard area regulation pursuant to this chapter, the following terms shall have the following meanings:

(A) "Floodproofing" ~~means any combination of structural and nonstructural additions, changes, or adjustments to properties and structures that substantially reduce or eliminate flood damage to any combination of real estate, improved real property, water or sanitary facilities, structures, and the contents of structures~~ shall have the same meaning as "flood proofing" under 44 C.F.R. § 59.1.

(B) "Floodway" ~~means the channel of a river or other watercourse and the adjacent land area that must be reserved in order to discharge the base flood without accumulatively increasing the water surface elevation more than one foot~~ shall have the same meaning as "regulatory floodway" under 44 C.F.R. § 59.1.

(C) "Hazard area" means land subject to landslides, soil erosion, fluvial erosion, earthquakes, water supply contamination, or other natural or human-made hazards as identified within a "local mitigation plan" enacted under section 4424 of this title and in conformance with and approved pursuant to the provisions of 44 C.F.R. ~~section~~ § 201.6.

(D) "National Flood Insurance Program" means the National Flood Insurance Program under 42 U.S.C. chapter 50 and implementing federal regulations in 44 C.F.R. parts 59 and 60.

(E) "New construction" means construction of structures or filling commenced on or after the effective date of the adoption of a community's flood hazard bylaws.

~~(E)~~(F) "Substantial improvement" means any repair, reconstruction, or improvement of a structure, the cost of which equals or exceeds 50 percent of the market value of the structure either before the improvement or repair is started or, if the structure has been damaged and is being restored, before the damage occurred. However, the term does not include either of the following:

(i) Any project or improvement of a structure to comply with existing state or local health, sanitary, or safety code specifications that are solely necessary to assure safe living conditions.

(ii) Any alteration of a structure listed on the National Register of Historic Places or a state inventory of historic places.

(G) "Equilibrium condition" means the width, depth, meander pattern, and longitudinal slope of a stream channel that occurs when water flow, sediment, and woody debris are transported by the stream in such a manner that it generally maintains dimensions, pattern, and slope without

unnaturally aggrading or degrading the channel bed elevation.

(H) "Fluvial erosion" means the erosion or scouring of riverbeds and banks during high flow conditions of a river.

(I) "River" means the full length and width, including the bed and banks, of any watercourse, including rivers, streams, creeks, brooks, and branches which experience perennial flow. "River" does not mean constructed drainageways, including water bars, swales, and roadside ditches.

(J) "River corridor" means the land area adjacent to a river that is required to accommodate the dimensions, slope, planform, and buffer of the naturally stable channel and that is necessary for the natural maintenance or natural restoration of a dynamic equilibrium condition and for minimization of fluvial erosion hazards, as delineated by the agency of natural resources in accordance with river corridor protection procedures.

(K) "River corridor protection area" means the area within a delineated river corridor subject to fluvial erosion that may occur as a river establishes and maintains the dimension, pattern, and profile associated with its dynamic equilibrium condition and that would represent a hazard to life, property, and infrastructure placed within the area.

* * *

Sec. 12. 24 V.S.A. § 4411(b) is amended to read:

(b) All zoning bylaws shall apply to all lands within the municipality other than as specifically limited or exempted in accordance with specific standards included within those bylaws and in accordance with the provisions of this chapter. The provisions of those bylaws may be classified so that different provisions may be applied to different classes of situations, uses, and structures and to different and separate districts of the municipality as may be described by a zoning map made part of the bylaws. The land use map required pursuant to subdivision 4382(a)(2) of this title of any municipality may be designated as the zoning map except in cases in which districts are not deemed by the planning commission to be described in sufficient accuracy or detail by the municipal plan land use map. All provisions shall be uniform for each class of use or structure within each district, except that additional classifications may be made within any district for any or all of the following:

(1) To make transitional provisions at and near the boundaries of districts.

(2) To regulate the expansion, reduction, or elimination of certain nonconforming uses, structures, lots, or parcels.

(3) To regulate, restrict, or prohibit uses or structures at or near any of the following:

* * *

(G) Flood, ~~fluvial erosion~~ or other hazard areas and other places having a special character or use affecting or affected by their surroundings.

(H) River corridors, river corridor protection areas, and buffers, as ~~those terms are~~ the term "buffer" is defined in 10 V.S.A. ~~§§~~ § 1422 ~~and 1427~~.

* * *

Sec. 13. 24 V.S.A. § 4424 is amended to read:

§ 4424. SHORELANDS; RIVER CORRIDOR PROTECTION AREAS; FLOOD OR HAZARD AREA; SPECIAL OR FREESTANDING BYLAWS

(a) Any municipality may adopt freestanding bylaws under this chapter to address particular hazard areas in conformance with the municipal plan or, for the purpose of adoption of a flood hazard area bylaw, a local hazard mitigation plan approved under 44 C.F.R. § 201.6, including the following, which may also be part of zoning or unified development bylaws:

(1) Bylaws to regulate development and use along shorelands.

(2) Bylaws to regulate development and use in flood areas, river corridor protection areas, or other hazard areas. The following shall apply if flood or other hazard area bylaws are enacted:

(A) Purposes.

(i) To minimize and prevent the loss of life and property, the disruption of commerce, the impairment of the tax base, and the extraordinary public expenditures and demands on public service that result from flooding, landslides, erosion hazards, earthquakes, and other natural or human-made hazards.

(ii) To ensure that the design and construction of development in flood, river corridor protection, and other hazard areas are accomplished in a manner that minimizes or eliminates the potential for flood and loss or damage to life and property in a flood hazard area or that minimizes the potential for fluvial erosion and loss or damage to life and property in a river corridor protection area.

(iii) To manage all flood hazard areas designated pursuant to 10 V.S.A. § 753.

(iv) To make the state and municipalities eligible for federal flood

insurance and other federal disaster recovery and hazard mitigation funds as may be available.

(B) Contents of bylaws. Flood, river corridor protection area, and other hazard area bylaws may:

(i) Contain standards and criteria that prohibit the placement of damaging obstructions or structures, the use and storage of hazardous or radioactive materials, and practices that are known to further exacerbate hazardous or unstable natural conditions.

(ii) Require flood, fluvial erosion, and hazard protection through elevation, floodproofing, disaster preparedness, hazard mitigation, relocation, or other techniques.

(iii) Require adequate provisions for flood drainage and other emergency measures.

(iv) Require provision of adequate and disaster-resistant water and wastewater facilities.

(v) Establish other restrictions to promote the sound management and use of designated flood, river corridor protection, and other hazard areas.

(vi) Regulate all land development in a flood hazard area, river corridor protection area, or other hazard area, except for development that is regulated under 10 V.S.A. § 754.

(C) Effect on zoning bylaws. Flood or other hazard area bylaws may alter the uses otherwise permitted, prohibited, or conditional in a flood or other hazard area under a bylaw, as well as the applicability of other provisions of that bylaw. Where a flood hazard bylaw, a hazard area bylaw, or both apply along with any other bylaw, compliance with the flood or other hazard area bylaw shall be prerequisite to the granting of a zoning permit. Where a flood hazard area bylaw or a hazard area bylaw but not a zoning bylaw applies, the flood hazard and other hazard area bylaw shall be administered in the same manner as are zoning bylaws, and a flood hazard area or hazard area permit shall be required for land development covered under the bylaw.

(D)(i) Mandatory provisions. All flood and other hazard area bylaws shall provide that no permit for new construction or substantial improvement shall be granted for a flood or other hazard area until after both the following:

~~(i)~~(I) A copy of the application is mailed or delivered by the administrative officer or by the appropriate municipal panel to the agency of natural resources or its designee.

~~(ii)~~(II) Either 30 days have elapsed following the mailing or the

agency or its designee delivers comments on the application.

(ii) The agency of natural resources may delegate to a qualified representative of a municipality with a flood hazard area bylaw or ordinance or to a qualified representative for a regional planning commission the agency's authority under this subdivision (a)(2)(D) to review and provide technical comments on a proposed permit for new construction or substantial improvement in a flood hazard area. Comments provided by a representative delegated under this subdivision (a)(2)(D) shall not be binding on a municipality.

~~(E) Special exceptions. The appropriate municipal panel, after public hearing, may approve the repair, relocation, replacement, or enlargement of a nonconforming structure within a regulated flood or other hazard area, subject to compliance with applicable federal and state laws and regulations, and provided that the following criteria are met:~~

~~(i) The appropriate municipal panel finds that the repair, relocation, or enlargement of the nonconforming structure is required for the continued economically feasible operation of a nonresidential enterprise.~~

~~(ii) The appropriate municipal panel finds that the repair, relocation, or enlargement of the nonconforming structure will not increase flood levels in the regulatory floodway, increase the risk of other hazard in the area, or threaten the health, safety, and welfare of the public or other property owners.~~

~~(iii) The permit so granted states that the repaired, relocated, or enlarged nonconforming structure is located in a regulated flood or other hazard area, does not conform to the bylaws pertaining to that area, and will be maintained at the risk of the owner.~~

(b) A municipality may adopt a flood hazard area, river corridor protection area, or other hazard area regulation that meets the requirements of this section by ordinance under subdivision 2291(25) of this title.

Sec. 14. 24 V.S.A. § 4469 is amended to read:

§ 4469. APPEAL; VARIANCES

(a) On an appeal under section 4465 or 4471 of this title or on a referral under subsection 4460(e) of this title in which a variance from the provisions of a bylaw or interim bylaw is requested for a structure that is not primarily a renewable energy resource structure, the board of adjustment or the development review board or the environmental division created under 4 V.S.A. chapter 27 shall grant variances and render a decision in favor of the

appellant, if all the following facts are found, and the finding is specified in its decision:

(1) There are unique physical circumstances or conditions, including irregularity, narrowness, or shallowness of lot size or shape, or exceptional topographical or other physical conditions peculiar to the particular property, and that unnecessary hardship is due to these conditions, and not the circumstances or conditions generally created by the provisions of the bylaw in the neighborhood or district in which the property is located.

(2) Because of these physical circumstances or conditions, there is no possibility that the property can be developed in strict conformity with the provisions of the bylaw, and that the authorization of a variance is therefore necessary to enable the reasonable use of the property.

(3) Unnecessary hardship has not been created by the appellant.

(4) The variance, if authorized, will not alter the essential character of the neighborhood or district in which the property is located, substantially or permanently impair the appropriate use or development of adjacent property, reduce access to renewable energy resources, or be detrimental to the public welfare.

(5) The variance, if authorized, will represent the minimum variance that will afford relief and will represent the least deviation possible from the bylaw and from the plan.

(b) On an appeal under section 4465 or 4471 of this title in which a variance from the provisions of a bylaw or interim bylaw is requested for a structure that is primarily a renewable energy resource structure, the board of adjustment or development review board or the environmental division may grant that variance and render a decision in favor of the appellant if all the following facts are found, and the finding is specified in its decision:

(1) It is unusually difficult or unduly expensive for the appellant to build a suitable renewable energy resource structure in conformance with the bylaws.

(2) The hardship was not created by the appellant.

(3) The variance, if authorized, will not alter the essential character of the neighborhood or district in which the property is located, substantially or permanently impair the appropriate use or development of adjacent property, reduce access to renewable energy resources, or be detrimental to the public welfare.

(4) The variance, if authorized, will represent the minimum variance that will afford relief and will represent the least deviation possible from the

bylaws and from the plan.

(c) In rendering a decision in favor of an appellant under this section, a board of adjustment or development review board or the environmental division may attach such conditions to variances as it may consider necessary and appropriate under the circumstances to implement the purposes of this chapter and the plan of the municipality then in effect.

(d) A variance authorized in a flood hazard area shall meet applicable federal and state rules for compliance with the National Flood Insurance Program.

Sec. 15. 24 V.S.A. § 2291 is amended to read:

§ 2291. ENUMERATION OF POWERS

For the purpose of promoting the public health, safety, welfare, and convenience, a town, city, or incorporated village shall have the following powers:

* * *

(25) To regulate by means of an ordinance or bylaw development in a flood hazard area, river corridor protection area, or other hazard area consistent with the requirements of section 4424 of this title and the National Flood Insurance Program.

Sec. 16. 10 V.S.A. § 6086(c) is amended to read:

(c) A permit may contain such requirements and conditions as are allowable proper exercise of the police power and which are appropriate within the respect to subdivisions (1) through (10) of subsection (a), including but not limited to those set forth in 24 V.S.A. §§ 4414(4), 4424(a)(2), 4414(1)(D)(i), 4463(b), and 4464, the dedication of lands for public use, and the filing of bonds to insure compliance. The requirements and conditions incorporated from Title 24 may be applied whether or not a local plan has been adopted. General requirements and conditions may be established by rule of the land use panel.

Sec. 17. ANR REPORT ON FINANCIAL INCENTIVES FOR THE FLOOD RESILIENT COMMUNITIES PROGRAM

As part of the biennial report required by Sec. 8 of No. 110 of the Acts of the 2009 Adj. Sess. (2010), the secretary of natural resources shall identify existing state financing programs or incentives that could be amended so that such programs or incentives could be available to municipalities under the flood resilient communities program for the purpose of flood hazard and river corridor protection planning.

Sec. 18. IMPLEMENTATION; TRANSITION

(a)(1) Prior to the secretary of natural resources' adopting rules under 10 V.S.A. § 754 for the regulation in flood hazard areas of uses exempt from municipal regulation:

(A) state- or community-owned and -operated institutions and facilities shall not be constructed within a flood hazard area, as that term is defined in 10 V.S.A. § 752(3), unless such construction conforms with the development requirements of the National Flood Insurance Program; and

(B) the following new uses or new construction shall not be permitted or certified for construction unless such construction conforms with the development requirements of the National Flood Insurance Program:

(i) a school;

(ii) a hospital;

(iii) a solid waste or hazardous waste facility; or

(v) a power-generating plant or transmission facility regulated under 30 V.S.A. § 248.

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

(b) The consolidated executive branch fee report and request to be submitted on or before the third Tuesday of January 2013 pursuant to 32 V.S.A. § 605 shall include the agency of natural resources' proposed fee or fees to support the agency's services provided under Sec. 1 of this act in 10 V.S.A. § 754 (flood hazard area rules). The proposed fee shall be sufficient to pay for at least 20 percent of the cost to the agency of natural resources of implementing, administering, and enforcing the rules adopted under 10 V.S.A. § 754.

* * * ANR Report on State Water Quality Programs * * *

Sec. 19. AGENCY OF NATURAL RESOURCES WATER QUALITY REMEDIATION, IMPLEMENTATION, AND FUNDING REPORT

(a) Findings. The general assembly finds and declares that:

(1) Clean water is a key factor in Vermont's quality of life.

(2) Preserving, protecting, and restoring the water quality of surface waters are necessary for the clean water, recreation, economic opportunity, wildlife habitat, and ecological value that such waters provide.

(3) Restoring and maintaining river corridor, floodplain, lakeshore, wildlife habitat, and wetland functions serve to protect water quality and

reduce the risk of flood hazards.

(4) The state and its regulatory agencies currently are subject to multiple requirements to respond to, remediate, and prevent water quality problems in the state, including the following:

(A) The federal Clean Water Act requires a total maximum daily load (TMDL) plan for impaired waters. Lake Champlain is impaired due to phosphorus pollution that exceeds the Vermont water quality standards. The U.S. Environmental Protection Agency (EPA) recently disapproved the Lake Champlain phosphorus TMDL. Consequently, the state will be required to amend the TMDL implementation plan in order to incorporate additional water quality measures and controls.

(B) The EPA likely will require the state to meet certain pollution control requirements for nitrogen in the Connecticut River as part of the Long Island Sound TMDL.

(C) The state is required to implement federally required TMDLs for 15 stormwater-impaired waters in the state.

(D) All waters of the state are at risk of pollution or impairment, and under state and federal law, the state is required to prevent impairment or degradation of these waters.

(5) Responding to the multiple water quality requirements to which the state is subject will require significant funding, but the state currently lacks the funding necessary to respond adequately and in a timely way to the demands for remediation and water quality protection.

(6) The development of a statewide mechanism, such as a statewide clean water utility, is necessary to address regulatory demands and to prioritize investment in water quality projects throughout the state so that the protection and improvement of water quality is achieved in the most cost-effective manner.

(7) In order to identify how the state should respond to existing and future demands to remediate and protect state surface waters, the secretary of natural resources should submit to the general assembly recommendations for addressing and funding the multiple water quality requirements to which the state is subject.

(b) Report requirement. On or before December 15, 2012, the secretary of natural resources shall report to the house committee on fish, wildlife and water resources, the house and senate committees on natural resources and energy, the house and senate committees on agriculture, and the house and senate committees on transportation with recommendations on how to

remediate or improve the water quality of the state's surface waters, how to implement remediation or improvement of water quality, and how to fund the remediation or improvement of water quality.

(c) Content of report. In the report required by this section, the secretary shall recommend:

(1) Funding. How to fund statewide and localized water quality remediation and conservation efforts. The secretary shall recommend funding sources or a funding mechanism or mechanisms for ongoing water quality efforts in the state. The recommendation shall address whether the state should implement a statewide assessment or fee, such as a clean water utility fee, an impervious surface fee, a Clean Water Act § 401 (33 U.S.C. § 1341) certification fee, impact fees, or other fees or charges.

(2) Administration. How to design, implement, and administer water quality programs in the state, including whether:

(A) a statewide clean water utility or similar statewide mechanism should be established to address water quality in the state;

(B) implementation of a statewide clean water utility or similar statewide mechanism is more suitable for an independent, nongovernmental entity and, if so:

(i) how an independent, nongovernmental entity would be established and administered; and

(ii) whether such an entity would need rulemaking authority in order to effectively operate and implement a water quality program.

(C) water quality programs could be effectively implemented through regional water quality utilities or similar mechanisms currently authorized under 24 V.S.A. chapters 105 and 121.

(3) Priority award. How available water quality funds should be allocated, including:

(A) whether funds should be allocated according to a science-based system that prioritizes awards to projects or programs in areas of high risk of pollution in impaired, unimpaired, or high quality waters.

(B) whether funds should be available for the development, accommodation, or planning of municipal or regional water quality utilities or mechanisms authorized under 24 V.S.A. chapters 105 and 121.

(C) how to best achieve regional equity in the distribution of water quality funds.

(D) whether additional priority points should be awarded to certain

water quality projects eligible for funding from the special environmental revolving fund under 24 V.S.A. chapter 120.

(4) Agricultural water quality. After consultation with the secretary of agriculture, food and markets and the agricultural community, how regulation of agricultural runoff and application of water quality standards to agricultural operations should be implemented, including whether additional requirements, standards, technical assistance, or financial assistance is necessary to increase compliance with AAPs and whether the AAPs should be amended to require all small farms or a subset of small farms to apply nutrients according to a nutrient management plan or at a more stringent soil loss tolerance than is currently required.

(5) Urban water quality. How regulation of stormwater runoff should be managed and enforced in order to meet the Vermont water quality standards and whether additional requirements, standards, technical assistance, or financial assistance are necessary to improve the management of stormwater runoff in the state.

(6) Lake shoreland protection. How the state should work toward the restoration and protection of shorelands of lakes, including how the state should regulate development in shorelands of lakes, including whether the state should enact statewide regulation for activities within shorelands of lakes and whether any regulation of activities within shorelands should be based on site-specific criteria.

(7)(A) Critical source areas. How to respond to and remediate nutrient pollution from critical source areas. The recommendations shall:

(i) address how to define and identify critical source areas statewide, including the Lake Champlain Basin;

(ii) propose a process and provide a cost estimate for developing site-specific implementation plans to reduce discharges from critical source areas and shall summarize how tactical basin planning will be utilized in such a process.

(B) As used in this subdivision (7), "critical source area" means an area in a watershed with high potential for the release, discharge, or runoff of nutrients or pollutants to the waters of the state.

(8) Response plans or mechanism. A plan or mechanism for prioritizing state response to and remediation of water quality concerns or impairments in identified waters or watersheds, such as St. Albans Bay, including how to prioritize available funding or staffing in a manner that allows discrete water quality issues to be addressed and remediated.

(9) Implementation plan. How the recommendations or plans required under subdivisions (1) through (8) of this subsection will be implemented.

(d) Conduct of report; consultation. In developing the recommendations required by subsection (c) of this section, the secretary of the agency of natural resources shall consult with interested parties for guidance, including but not limited to: the secretary of transportation or his or her designee; the secretary of agriculture, food and markets or his or her designee; the chair of the natural resources board or his or her designee; legislators and legislative staff; representatives of environmental groups; representatives of municipalities or municipal interests; representatives of municipalities subject to the federal Clean Water Act requirements for discharges from municipal separate storm sewer systems; representatives of the agricultural community; representatives of the business community; representatives of municipal stormwater utilities or other municipal stormwater controls; representatives of engineering or consulting firms; and other interested persons or organizations relevant to completion of the report. The secretary shall warn any meeting with interested parties in fulfillment of this section by posting a notice of such a meeting to the website of the agency of natural resources no later than seven days before the meeting.

(e) Format of report to general assembly. The report to the general assembly required by this section shall address each of the report requirements of subsection (c) of this section and may, as part of the report, include recommended draft legislation.

* * * ANR Rulemaking Authority * * *

Sec. 20. 10 V.S.A. § 905b is amended to read:

§ 905b. DUTIES; POWERS

The department shall protect and manage the water resources of the state in accordance with the provisions of this subchapter and shall:

* * *

(18) study and investigate the wetlands of the state and cooperate with municipalities, the general public, other agencies, and the board in collecting and compiling data relating to wetlands, propose to the board specific wetlands to be designated as Class I wetlands, issue or deny permits pursuant to section 6025 of this title and the rules ~~of the panel~~ authorized by this subdivision, issue wetland determinations pursuant to section 914 of this title, issue orders pursuant to section 1272 of this title, and ~~implement the rules adopted by the board governing significant wetlands~~ in accordance with 3 V.S.A. chapter 25, adopt rules to address the following:

(A) the identification of wetlands that are so significant they merit protection. Any determination that a particular wetland is significant will result from an evaluation of at least the following functions and values which a wetland serves:

(i) provides temporary water storage for flood water and storm runoff;

(ii) contributes to the quality of surface and groundwater through chemical action;

(iii) naturally controls the effects of erosion and runoff, filtering silt, and organic matter;

(iv) contributes to the viability of fisheries by providing spawning, feeding, and general habitat for freshwater fish;

(v) provides habitat for breeding, feeding, resting, and shelter to both game and nongame species of wildlife;

(vi) provides stopover habitat for migratory birds;

(vii) contributes to an exemplary wetland natural community, in accordance with the rules of the secretary;

(viii) provides for threatened and endangered species habitat;

(ix) provides valuable resources for education and research in natural sciences;

(x) provides direct and indirect recreational value and substantial economic benefits; and

(xi) contributes to the open-space character and overall beauty of the landscape;

(B) the ability to reclassify wetlands, in general, or on a case-by-case basis;

(C) the protection of wetlands that have been determined under subdivision (A) or (B) of this subdivision (18) to be significant, including rules that provide for the issuance or denial of permits and the issuance of wetland determinations by the department under this chapter; provided, however, that the rules may only protect the values and functions sought to be preserved by the designation. The department shall not adopt rules that restrain agricultural activities without the consent of the secretary of agriculture, food and markets and shall not adopt rules that restrain silvicultural activities without the consent of the commissioner of forests, parks and recreation;

* * *

Sec. 21. 10 V.S.A. § 1252 is amended to read:

§ 1252. CLASSIFICATION OF WATERS; MIXING ZONES

* * *

(b) The secretary may establish mixing zones or waste management zones as necessary in the issuance of a permit in accordance with this section and criteria established by ~~board~~ rule. ~~The board shall adopt these rules by July 1, 1994.~~ Those waters authorized under this chapter, as of July 1, 1992, to receive the direct discharge of wastes which prior to treatment contained organisms pathogenic to human beings are designated waste management zones for those discharges. Those waters that as of July 1, 1992 are Class C waters into which no direct discharge of wastes that prior to treatment contained organisms pathogenic to human beings is authorized, shall become waste management zones for any municipality in which the waters are located that qualifies for a discharge permit under this chapter for those wastes prior to July 1, 1997.

* * *

(e) The ~~board~~ secretary shall adopt standards of water quality to achieve the purposes of the water classifications. Such standards shall be expressed in detailed water quality criteria, taking into account the available data and the effect of these criteria on existing activities, using as appropriate: (1) numerical values, (2) biological parameters; and (3) narrative descriptions. These standards shall establish limits for at least the following: alkalinity, ammonia, chlorine, fecal coliform, color, nitrates, oil and grease, dissolved oxygen, pH, phosphorus, temperature, all toxic substances for which the United States Environmental Protection Agency has established criteria values and any other water quality parameters deemed necessary by the board.

(f) The ~~board~~ secretary may issue declaratory rulings regarding these standards.

* * *

Sec. 22. 10 V.S.A. § 1253 is amended to read:

§ 1253. CLASSIFICATION OF WATERS DESIGNATED, RECLASSIFICATION

* * *

(c) On its own motion, or on receipt of a written request that the ~~board~~ secretary adopt, amend, or repeal a reclassification rule, the ~~board~~ secretary shall comply with 3 V.S.A. § 806 and may initiate a rulemaking proceeding to reclassify all or any portion of the affected waters in the public interest. In the

course of this proceeding, the ~~board~~ secretary shall comply with the provisions of 3 V.S.A. chapter 25, and may hold a public hearing convenient to the waters in question. If the ~~board~~ secretary finds that the established classification is contrary to the public interest and that reclassification is in the public interest, ~~it~~ he or she shall file a final proposal of reclassification in accordance with 3 V.S.A. § 841. If the ~~board~~ secretary finds that it is in the public interest to change the classification of any pond, lake or reservoir designated as Class A waters by subsection (a) of this section, ~~it~~ the secretary shall so advise and consult with the department of health and shall provide in its reclassification rule a reasonable period of time before the rule becomes effective. During that time, any municipalities or persons whose water supply is affected shall construct filtration and disinfection facilities or convert to a new source of water supply.

(d) The ~~board~~ secretary shall determine what degree of water quality and classification should be obtained and maintained for those waters not classified by ~~it~~ the board before 1981 following the procedures in sections 1254 and 1258 of this title. Those waters shall be classified in the public interest. The secretary shall revise all 17 basin plans by January 1, 2006, and update them every five years thereafter. On or before January 1 of each year, the secretary shall report to the house committees on agriculture, on natural resources and energy, and on fish, wildlife and water resources, and to the senate committees on agriculture and on natural resources and energy regarding the progress made and difficulties encountered in revising basin plans. By January 1, 1993, the secretary shall prepare an overall management plan to ensure that the water quality standards are met in all state waters.

(e) In determining the question of public interest, the ~~board~~ secretary shall give due consideration to, and explain ~~its~~ his or her decision with respect to, the following:

* * *

(f) Notwithstanding the provisions of subsection (c) of this section, when reclassifying waters to Class A, the ~~board~~ the secretary need find only that the reclassification is in the public interest.

(g) The ~~board in its~~ secretary under the reclassification rule may ~~direct the secretary to~~ grant permits for only a portion of the assimilative capacity of the receiving waters, or ~~to~~ may permit only indirect discharges from on-site disposal systems, or both.

Sec. 23. 10 V.S.A. § 1424 is amended to read:

§ 1424. USE OF PUBLIC WATERS

(a) The ~~board~~ secretary may establish rules to ~~regulate the use of the public~~

~~waters by~~ implement the provisions of this chapter, including:

(1) Rules to regulate the use of public waters of the state by:

(A) Defining areas on public waters wherein certain uses may be conducted;

~~(2)~~(B) Defining the uses which may be conducted in the defined areas;

~~(3)~~(C) Regulating the conduct in these areas, including ~~but not limited to~~ the size of motors allowed, size of boats allowed, allowable speeds for boats, and prohibiting the use of motors or houseboats;

~~(4)~~(D) Regulating the time various uses may be conducted.

(2) Rules to govern the surface levels of lakes, ponds, and reservoirs that are public waters of the state.

(b) The ~~board~~ secretary in establishing rules under subdivision (a)(2) of this section shall consider the size and flow of the navigable waters, the predominant use of adjacent lands, the depth of the water, the predominant use of the waters prior to regulation, the uses for which the water is adaptable, the availability of fishing, boating, and bathing facilities, the scenic beauty, and recreational uses of the area.

(c) The ~~board~~ secretary shall attempt to manage the public waters so that the various uses may be enjoyed in a reasonable manner, in the best interests of all the citizens of the state. To the extent possible, the ~~board~~ secretary shall provide for all normal uses.

(d) ~~If another agency has jurisdiction over the waters otherwise controlled by this section, that other agency's rules shall apply, if inconsistent with the rules promulgated under this section. The board may not remove the restrictions set forth in 25 V.S.A. §§ 320 and 321.~~

(e) On receipt of a written request that the ~~board~~ secretary adopt, amend, or repeal a rule with respect to the use of public waters signed by not less than one person, the ~~board~~ secretary shall consider the adoption of rules authorized under this section and take appropriate action as required under 3 V.S.A. § 806.

(f) By rule, the ~~board~~ secretary may delegate authority under this section for the regulation of public waters where:

(1) the delegation is to a municipality which is adjacent to or which contains the water; and

(2) the municipality accepts the delegation by creating or amending a bylaw or ordinance for regulation of the water. Appeals from a final act of the municipality under the bylaw or ordinance shall be taken to the environmental

division. The ~~board~~ secretary may terminate a delegation for cause or without cause upon six months' notice to the municipality.

Sec. 24. 10 V.S.A. § 6025 is amended to read:

§ 6025. RULES

* * *

~~(d) The water resources panel may adopt rules, in accordance with the provisions of chapter 25 of Title 3, in the following areas:~~

~~(1) Rules governing surface levels of lakes, ponds, and reservoirs that are public waters of Vermont.~~

~~(2) Rules regarding classification of the waters of the state, in accordance with chapter 47 of this title.~~

~~(3) Rules regarding the establishment of water quality standards, in accordance with chapter 47 of this title.~~

~~(4) Rules regulating the surface use of public waters, and rules pertaining to the designation of outstanding resource waters, in accordance with chapter 49 of this title.~~

~~(5) Rules regarding the identification of wetlands that are so significant that they merit protection. Any determination that a particular wetland is significant will result from an evaluation of at least the following functions and values which a wetland serves:~~

~~(A) provides temporary water storage for flood water and storm runoff;~~

~~(B) contributes to the quality of surface and groundwater through chemical action;~~

~~(C) naturally controls the effects of erosion and runoff, filtering silt and organic matter;~~

~~(D) contributes to the viability of fisheries by providing spawning, feeding, and general habitat for freshwater fish;~~

~~(E) provides habitat for breeding, feeding, resting, and shelter to both game and nongame species of wildlife;~~

~~(F) provides stopover habitat for migratory birds;~~

~~(G) contributes to an exemplary wetland natural community, in accordance with the rules of the panel;~~

~~(H) provides for threatened and endangered species habitat;~~

~~(I) provides valuable resources for education and research in natural sciences;~~

~~(J) provides direct and indirect recreational value and substantial economic benefits; and~~

~~(K) contributes to the open space character and overall beauty of the landscape.~~

~~(6) Rules regarding the ability to reclassify wetlands, in general, or on a case-by-case basis.~~

~~(7) Rules protecting wetlands that have been determined under subdivision (5) or (6) of this subsection to be significant, including rules that provide for the issuance or denial of permits and the issuance of wetland determinations under chapter 37 of this title by the department of environmental conservation; provided, however, that the rules may only protect the values and functions sought to be preserved by the designation. The panel shall not adopt rules that restrain agricultural activities without the consent of the secretary of the agency of agriculture, food and markets and shall not adopt rules that restrain silvicultural activities without the consent of the commissioner of the department of forests, parks and recreation.~~

~~(8) Rules implementing 29 V.S.A. chapter 11, relating to management of lakes and ponds.~~

~~(e) Except for subsection (a) of this section, references to rules adopted by the board shall be construed to mean rules adopted by the appropriate panel of the board, as established by this section.~~

Sec. 25. 29 V.S.A. § 410 is added to read:

§ 410. RULEMAKING; ENCROACHMENTS ON PUBLIC WATERS

The department may adopt rules to implement the requirements of this chapter.

Sec. 26. FORMER WATER RESOURCES PANEL RULES

Rules of the water resources panel of the natural resources board issued pursuant to 10 V.S.A. § 6025(d), as that statute and those rules existed immediately prior to the effective date of this act, shall be deemed rules of the secretary of natural resources, and the secretary may amend those rules in accordance with 3 V.S.A. chapter 25.

Sec. 27. STATUTORY REVISION

To effect the purpose of this act of transferring the rulemaking authority of the water resources panel to the secretary of natural resources, the office of legislative council is directed to revise the existing Vermont Statutes

Annotated and, where applicable, replace the terms "natural resources board," "water resources panel of the natural resources board," "water resources panel," "water resources board," and similar terms with the term "secretary of natural resources," "secretary," "agency of natural resources," "agency," "department of environmental conservation," or "department" as appropriate, including the following revisions:

(1) in 10 V.S.A. §§ 913 and 915, by replacing "panel" with "department";

(2) in 10 V.S.A. chapter 47, by replacing "board" with "secretary" where appropriate;

(3) in 10 V.S.A. §§ 1422 and 1424, by replacing "board" with "secretary" where appropriate; and

(4) in 29 V.S.A. §§ 401, 402, and 403, by replacing "board" with "department" where appropriate.

Sec. 28. PURPOSE AND INTENT; PUBLIC PARTICIPATION IN DEPARTMENT OF ENVIRONMENTAL CONSERVATION RULEMAKING

It is the purpose and intent of the general assembly that, in addition to the public participation requirements of 3 V.S.A. chapter 25 and prior to submitting a proposed rule to the secretary of state under 3 V.S.A. § 838, the department of environmental conservation shall engage in an expanded public participation process with affected stakeholders and other interested persons in a dialogue about intent, method, and outcomes of a proposed rule for the purpose of resolving concerns and differences regarding proposed rules. The department of environmental conservation is encouraged to use workshops, focused work groups, dockets, meetings, or other forms of communication to meet the participation requirements of this section.

* * * Agricultural Water Quality * * *

Sec. 29. 10 V.S.A. § 303 is amended to read:

§ 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;

(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 protection of lands for multiple conservation purposes, including the protection of surface waters and associated natural resources;

(G) the development of capacity on the part of an eligible applicant to engage in an eligible activity.

(4) "Eligible applicant" means any:

(A) municipality~~,~~;

(B) ~~department of state government~~ state agency as defined in ~~subsection 6302(a)~~ section 6301a of this title~~,~~;

(C) nonprofit organization qualifying under Section 501(c)(3) of the Internal Revenue Code; or

(D) cooperative housing organization, the purpose of which is the creation or retention of affordable housing for lower income Vermonters and the bylaws of which require that such housing be maintained as affordable housing for lower income Vermonters on a perpetual basis.

* * *

* * * State Revolving Loan Fund; Stormwater Projects * * *

Sec. 30. 24 V.S.A. § 4752(3) is amended to read:

(3) "Municipality" means any city, town, village, town school district, incorporated school district, union school district or other school district, fire district, consolidated sewer district, consolidated water district ~~or~~, solid waste district, or statewide or regional water quality utility or mechanism organized under laws of the state.

* * * Land Application of Septage * * *

Sec. 31. 10 V.S.A. § 6605(g) is amended to read:

(g)(1) Emergency sludge and septage disposal approval. Notwithstanding any other provision of this section, the secretary may authorize the land disposal or management of sludge or septage by an applicant at any certified site or facility with available capacity, provided the secretary finds:

(A) that the applicant needs to dispose of accumulated sludge or septage promptly, and that delay would likely cause public health, or environmental damage, or nuisance conditions, or would result in excessive and unnecessary cost to the public, and that the applicant has lost authority to use previously certified sites through no act or omission of the applicant; and

(B) that at the certified site or facility to be used:

(i) the certificate holder agrees in writing to allow use of the site or facility by the applicant;

(ii) management of the applicant's sludge or septage is compatible with the site or facility certificate;

(iii) all terms and conditions of the original certification will continue to be met with addition of the applicant's sludge or septage; and

(iv) beginning January 1, 2013, any sludge or septage applied to land shall be applied according to a nutrient management plan approved by the secretary.

(2) The secretary shall, following his or her issuance of approval of emergency sludge or septage disposal under this subsection, provide public notice of that action.

Sec. 32. 10 V.S.A. § 1386 is amended to read:

§ 1386. IMPLEMENTATION PLAN FOR THE LAKE CHAMPLAIN TOTAL MAXIMUM DAILY LOAD PLAN

(a) ~~On or before January 15, 2010,~~ Within 12 months after the issuance of a phosphorus total maximum daily load plan (TMDL) for Lake Champlain by the U.S. Environmental Protection Agency, the secretary of natural resources shall issue a ~~revised~~ Vermont-specific implementation plan for the Lake Champlain TMDL. ~~Beginning January 15, 2013, and every~~ Every four years ~~thereafter~~ after issuance of the Lake Champlain TMDL by the U.S. Environmental Protection Agency, the secretary of natural resources shall amend and update the Vermont-specific implementation plan for the Lake Champlain TMDL. Prior to issuing, amending, or updating the implementation plan, the secretary shall consult with the agency of agriculture, food and markets, all statewide environmental organizations that express an interest in the plan, the Vermont League of Cities and Towns, all business organizations that express an interest in the plan, the University of Vermont

Rubenstein ecosystem science laboratory, and other interested parties. The implementation plan shall include a comprehensive strategy for implementing the Lake Champlain ~~total maximum daily load (TMDL)~~ TMDL plan and for the remediation of Lake Champlain. The implementation plan shall be issued as a document separate from the Lake Champlain TMDL. The implementation plan shall:

(1) Include or reference the elements set forth in 40 C.F.R. § 130.6(c) for water quality management plans;

(2) Comply with the requirements of section 1258 of this title and administer a permit program to manage discharges to Lake Champlain consistent with the federal Clean Water Act;

(3) Develop a process for identifying critical source areas for non-point source pollution in each subwatershed. As used in this subdivision, "critical source area" means an area in a watershed with high potential for the release, discharge, or runoff of phosphorus to the waters of the state;

(4) Develop site-specific plans to reduce point source and non-point source load discharges in critical source areas identified under subdivision (3) of this subsection;

(5) Develop a method for identifying and prioritizing on public and private land pollution control projects with the potential to provide the greatest water quality benefits to Lake Champlain;

(6) Develop a method of accounting for changes in phosphorus loading to Lake Champlain due to implementation of the TMDL and other factors;

(7) Develop phosphorus reduction targets related to phosphorus reduction for each water quality program and for each segment of Lake Champlain, including benchmarks for phosphorus reduction that shall be achieved. The implementation plan shall explain the methodology used to develop phosphorus reduction targets under this subdivision;

(8) Establish a method for the coordination and collaboration of water quality programs within the state;

(9) Develop a method for offering incentives or disincentives to wastewater treatment plants for maintaining the 2006 levels of phosphorus discharge to Lake Champlain;

(10) Develop a method of offering incentives or disincentives for reducing the phosphorus contribution of stormwater discharges within the Lake Champlain basin.

(b) In amending the Vermont-specific implementation plan of the Lake Champlain TMDL under this section, the secretary of natural resources shall comply with the public participation requirements of 40 C.F.R. § 130.7(c)(1)(ii).

(c) ~~On or before January 15, 2010, the secretary of natural resources shall report to the house committee on fish, wildlife and water resources, the senate committee on natural resources, and the house and senate committees on agriculture with a summary of the contents of and the process leading to the adoption under subsection (a) of this section of the implementation plan for the Lake Champlain TMDL.~~ On or before January ~~15, 2013, and~~ 15 in the year following issuance of the implementation plan under subsection (a) of this section and every four years thereafter, the secretary shall report to the house committee on fish, wildlife and water resources, the senate committee on natural resources, and the house and senate committees on agriculture regarding the execution of the implementation plan. The report shall include:

(1) ~~with the~~ The amendments or revisions to the implementation plan for the Lake Champlain TMDL required by subsection (a) of this section. Prior to ~~issuing~~ submitting a report required by this subsection that includes amendments to revisions to the implementation plan, the secretary shall hold at least three public hearings in the Lake Champlain watershed to describe the amendments and revisions to the implementation plan for the Lake Champlain TMDL. The secretary shall prepare a responsiveness summary for each public hearing. ~~Beginning January 15, 2013, a report required by this subsection shall include:~~

~~(1)~~(2) An assessment of the implementation plan for the Lake Champlain TMDL based on available data, including an evaluation of the efficacy of the implementation plan~~;~~.

~~(2)~~(3) ~~An assessment of the hydrologic base period used to determine the phosphorus loading capacities for the Lake Champlain TMDL based on available data, including an evaluation of the adequacy of the hydrologic base period for the TMDL;~~ Recommendations, if any, for amending the implementation plan or for reopening the Lake Champlain TMDL.

~~(3) Recommendations, if any, for amending the implementation plan or reopening the Lake Champlain TMDL.~~

(d) Beginning February 1, ~~2009~~ 2014 and annually thereafter, the secretary, after consultation with the secretary of agriculture, food and markets, shall submit to the house committee on fish, wildlife and water resources, the senate committee on natural resources and energy, and the house and senate committees on agriculture a ~~clean and clear program~~ summary ~~reporting on~~ of activities and measures of progress ~~for each program supported by funding~~

~~under the Clean and Clear Action Plan~~ of water quality ecosystem restoration programs.

Sec. 33. REPEAL

10 V.S.A. § 1385 (Lake Champlain TMDL plan) is repealed.

* * * Enforcement, Appeals, Transition; Effective Dates * * *

Sec. 34. 10 V.S.A. § 8003 is amended to read:

§ 8003. APPLICABILITY

(a) The secretary may take action under this chapter to enforce the following statutes and rules, permits, assurances, or orders implementing the following statutes:

(1) ~~[Deleted.]~~ 10 V.S.A. chapter 23, relating to air quality;

(2) 10 V.S.A. chapter ~~23, relating to air quality~~ 32, relating to flood hazard areas;

* * *

(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.

* * *

Sec. 35. 10 V.S.A. § 8503(a) is amended to read:

(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 32 (flood hazard areas).

* * *

Sec. 36. REPEAL

25 V.S.A. §§ 142–144 (general provisions relating to rivers and streams) are repealed.

Sec. 37. 30 V.S.A. § 34 is added to read:

§ 34. PUBLIC EDUCATION ON PROPANE TANK SAFETY

The general assembly finds that there is a need for a coordinated public safety message on the normal storage and handling of propane tanks and fuel oil tanks, and for the recovery of propane tanks and fuel oil tanks that are displaced by a natural disaster, such as flooding. The department of public service, the division of fire safety, and the agency of natural resources shall cooperate with relevant municipal, professional, and industry organizations to develop a variety of educational materials for distribution to the public to provide information on any special treatment of propane tanks that might be required in the event of a natural disaster, such as flooding.

Sec. 38. EFFECTIVE DATES

This act shall take effect on passage except that:

(1) Sec. 29 (VHCB; conservation easements) of this act shall take effect on July 1, 2012.

(2) Sec. 3 (stream alteration; prohibitions and exceptions) of this act shall take effect on March 1, 2013.

(3) Sec. 34 (ANR enforcement) of this act shall take effect on July 1, 2013.

The bill, having appeared on the Calendar one day for notice, was taken up, read the second time and the report of the committee on Fish, Wildlife and Water Resources agreed to.

Pending the question, Shall the bill be read a third time? **Rep. Jewett of Ripton** demanded the Yeas and Nays, which demand was sustained by the Constitutional number. The Clerk proceeded to call the roll and the question, Shall the bill be read a third time? was decided in the affirmative. Yeas, 123. Nays, 14.

Those who voted in the affirmative are:

Acinapura of Brandon
Ancel of Calais
Andrews of Rutland City
Atkins of Winooski
Bartholomew of Hartland
Batchelor of Derby
Bissonnette of Winooski
Bohi of Hartford
Botzow of Pownal
Bouchard of Colchester
Branagan of Georgia
Browning of Arlington
Burditt of West Rutland
Burke of Brattleboro
Buxton of Tunbridge
Campion of Bennington
Canfield of Fair Haven
Cheney of Norwich
Christie of Hartford
Clarkson of Woodstock *
Condon of Colchester
Conquest of Newbury
Consejo of Sheldon
Copeland-Hanzas of Bradford
Corcoran of Bennington
Courcelle of Rutland City
Dakin of Chester
Davis of Washington
Deen of Westminster
Donaghy of Poultney
Donahue of Northfield
Donovan of Burlington
Edwards of Brattleboro
Ellis of Waterbury
Emmons of Springfield
Evans of Essex
Fagan of Rutland City
Fisher of Lincoln
Frank of Underhill
French of Shrewsbury
French of Randolph
Grad of Moretown
Greshin of Warren
Haas of Rochester

Head of South Burlington
Heath of Westford
Hebert of Vernon
Helm of Fair Haven
Hooper of Montpelier
Howard of Cambridge
Howrigan of Fairfield
Jerman of Essex
Jewett of Ripton
Johnson of South Hero
Johnson of Canaan
Kilmartin of Newport City
Kitzmiller of Montpelier
Klein of East Montpelier
Koch of Barre Town
Komline of Dorset
Krebs of South Hero
Krowinski of Burlington
Kupersmith of South Burlington
Lanpher of Vergennes
Larocque of Barnet
Lenes of Shelburne
Leriche of Hardwick
Lewis of Berlin
Lippert of Hinesburg
Macaig of Williston
Malcolm of Pawlet
Manwaring of Wilmington
Marek of Newfane
Martin of Springfield
Martin of Wolcott
Masland of Thetford
McAllister of Highgate
McCullough of Williston
McFaun of Barre Town
Miller of Shaftsbury
Mook of Bennington
Moran of Wardsboro
Mrowicki of Putney
Munger of South Burlington
Myers of Essex
Nuovo of Middlebury
Olsen of Jamaica
O'Sullivan of Burlington
Partridge of Windham
Pearce of Richford
Pearson of Burlington
Peltz of Woodbury
Perley of Enosburgh
Poirier of Barre City
Potter of Clarendon
Pugh of South Burlington
Ralston of Middlebury
Ram of Burlington
Reis of St. Johnsbury
Russell of Rutland City
Scheuermann of Stowe
Shand of Weathersfield
Sharpe of Bristol
Shaw of Pittsford
Spengler of Colchester
Stevens of Waterbury
Stevens of Shoreham
Stuart of Brattleboro
Sweaney of Windsor
Taylor of Barre City
Till of Jericho
Toll of Danville
Townsend of Randolph
Trieber of Rockingham
Waite-Simpson of Essex
Webb of Shelburne
Wilson of Manchester
Wizowaty of Burlington
Woodward of Johnson
Wright of Burlington
Yantachka of Charlotte
Young of Glover
Zagar of Barnard

Those who voted in the negative are:

Clark of Vergennes *
Crawford of Burke
Devereux of Mount Holly
Dickinson of St. Albans Town
Eckhardt of Chittenden *
Higley of Lowell
Hubert of Milton
Lawrence of Lyndon
Lewis of Derby
Marcotte of Coventry
Peaslee of Guildhall
Savage of Swanton
Smith of New Haven
Strong of Albany

Those members absent with leave of the House and not voting are:

Aswad of Burlington
Brennan of Colchester
Degree of St. Albans City
Gilbert of Fairfax
Keenan of St. Albans City
Lorber of Burlington
McNeil of Rutland Town
Morrissey of Bennington
O'Brien of Richmond
South of St. Johnsbury
Turner of Milton
Winters of Williamstown

Rep. Clarke of Vergennes explained his vote as follows:

"Mr. Speaker:

I can't support H.202 until the promised fiscal note is presented."

Rep. Clarkson of Woodstock explained her vote as follows:

"Mr. Speaker:

After experiencing the disaster that tropical storm Irene wrought on our communities I am pleased to vote 'yes' on S.202 – to improving regulations on our flood hazard areas and to encouraging our towns to increase their flood resiliency for the future."

Rep. Eckhardt of Chittenden explained his vote as follows:

"Mr. Speaker:

I cannot vote for this bill in clear conscience without first taking a look at how much it is going to cost. I will await the fiscal note."

Action on Resolution Postponed

J.R.H. 37

Joint resolution, entitled

Joint resolution expressing the General Assembly's expectation that the full range of concerns and issues raised by the general public regarding the merger of Central Vermont Public Service Corporation and Green Mountain Power Corporation will be given full consideration, and that the final agreement must be in the best interests of the ratepayers and people of the State of Vermont

Was taken up and pending the question, Shall the resolution be adopted? on motion of **Rep. Canfield of Fair Haven**, action on the bill was postponed until the next legislative day.

House Resolution Adopted

H.R. 20

House resolution, entitled

House resolution encouraging the Vermont fish and wildlife board to amend the state administrative rules pertaining to fishing in order to authorize additional year-round fishing opportunities and the transporting of baitfish under designated circumstances

Which was taken up and adopted.

Rules Suspended; Senate Proposal of Amendment Not Concurred in; Committee of Conference Requested and Appointed; Rules Suspended and Bill Ordered Messaged to the Senate Forthwith

H. 559

On motion of **Rep. Savage of Swanton**, the rules were suspended and House bill, entitled

An act relating to health care reform implementation

Appearing on the Calendar for notice, was taken up for immediate consideration.

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

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

§ 1802. DEFINITIONS

For purposes of this subchapter:

* * *

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

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

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

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

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

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

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

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

* * *

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

§ 1804. QUALIFIED EMPLOYERS

~~[Reserved.]~~

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

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

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

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

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

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

(b) A qualified health benefit plan shall provide the following benefits:

(1)(A) The essential benefits package required by Section 1302(a) of the Affordable Care Act and any additional benefits required by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

(B) Notwithstanding subdivision (1)(A) of this subsection, a health insurer or a stand-alone dental insurer, including a nonprofit dental service corporation, may offer a plan that provides only limited dental benefits, either separately or in conjunction with a qualified health benefit plan, if it meets the requirements of Section 9832(c)(2)(A) of the Internal Revenue Code and provides pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act. Said plans may include child-only policies or family policies. If permitted under federal law, a qualified health benefit plan offered in conjunction with a stand-alone dental plan providing

pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act shall be deemed to meet the requirements of this subsection.

(2) At least the ~~silver~~ bronze level of coverage as defined by Section 1302 of the Affordable Care Act and the cost-sharing limitations for individuals provided in Section 1302 of the Affordable Care Act, as well as any more restrictive cost-sharing requirements specified by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

* * *

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

(b) Navigators shall have the following duties:

* * *

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

Sec. 2c. EXCHANGE OPTIONS

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

Sec. 2d. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

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

* * *

(17) Establishing procedures 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.

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 of financial regulation. The commissioner of of financial regulation shall define, by rule, the acceptable time frame for provision of information in accordance with this subdivision.

* * *

Sec. 2f. 33 V.S.A. § 1806(g) is added to read:

(g) The Vermont health benefit exchange shall clearly display on each page of the exchange website on which a bronze-level plan is available for purchase a notice to prospective purchasers regarding the actuarial value of such plan. The notice shall alert prospective purchasers that a bronze plan will cover only 60 percent of their health care expenses, with the beneficiary responsible for the remaining 40 percent through a combination of deductibles, co-payments, and coinsurance.

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

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

(a) As used in this section:

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

small employer. The term does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage in which benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

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

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

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

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

(c) No person may provide a health benefit plan to an individual or small employer unless such person is a registered carrier. The commissioner of financial regulation shall establish, by rule, the minimum financial, marketing,

service and other requirements for registration. Such registration shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

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

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

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

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

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

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

(B) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to

programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health, the director of the Blueprint for Health, and the commissioner of Vermont health access in the development of health promotion and disease prevention rules that are consistent with the Blueprint for Health. Such rules shall:

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

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

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

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

(C) The commissioner's rules shall include:

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

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

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

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

the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

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

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

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

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

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

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

§ 4080g. GRANDFATHERED PLANS

(a) Application. Notwithstanding the provisions of 33 V.S.A. § 1811, on and after January 1, 2014, the provisions of this section shall apply to an individual, small group, or association plan that qualifies as a grandfathered health plan under Section 1251 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) ("Affordable Care Act"). In the event that a plan no longer qualifies as a grandfathered health plan under the Affordable Care Act, the provisions of this section shall not apply and the provisions of 33 V.S.A. § 1811 shall govern the plan.

(b) Small group plans.

(1) Definitions. As used in this subsection:

(A) "Small employer" means an employer who, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 50 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include

a part-time employee who works fewer than 30 hours per week. The provisions of this subsection shall continue to apply until the plan anniversary date following the date that the employer no longer meets the requirements of this subdivision.

(B) "Small group" means:

(i) a small employer; or

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

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

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

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

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

(4)(A) A registered small group carrier shall guarantee acceptance of all small groups for any small group plan offered by the carrier. A registered small group carrier shall also guarantee acceptance of all employees or

members of a small group and each dependent of such employees or members for any small group plan it offers.

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

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

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

(I) is not providing coverage; and

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

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

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

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

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

(ii) geographic area rating;

(iii) industry rating;

(iv) medical underwriting and screening;

(v) experience rating;

(vi) tier rating; or

(vii) durational rating.

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

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

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

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

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

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

describe the discount program the availability of a reasonable alternative standard.

(iii) The commissioner's rules shall include:

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

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

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

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

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

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

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

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

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

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

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

(8) A registered small group carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the

carrier's compliance with this subsection. The requirements for certification shall be as the commissioner by rule prescribes.

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

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

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

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

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

(12) This subsection shall apply to the provisions of small group plans. This subsection shall not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy; provided that no person may offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of this subsection. The commissioner shall adopt, by rule, standards and a process to carry out the provisions of this subsection.

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

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

(c) Nongroup health benefit plans.

(1) Definitions. As used in this subsection:

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

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

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

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

(3) No person may provide a nongroup plan unless such person is a registered nongroup carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service, and other requirements for registration.

Registration under this subsection shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A nongroup carrier may withdraw its registration upon at least six months' prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

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

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

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

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

(I) is not providing coverage; and

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

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

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

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

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

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

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

(ii) geographic area rating;

(iii) industry rating;

(iv) medical underwriting and screening;

(v) experience rating;

(vi) tier rating; or

(vii) durational rating.

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

(ii) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, and rebates or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in

return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health and the commissioner of Vermont health access in the development of health promotion and disease prevention rules. Such rules shall:

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

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

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

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

(iii) The commissioner's rules shall include:

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

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

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

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

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

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

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

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

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

* * * Green Mountain Care Board * * *

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

§ 9374. BOARD MEMBERSHIP; AUTHORITY

* * *

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

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

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

(B) 15 percent by the hospitals;

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

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

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

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

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the board to perform its duties, the chair of the board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however, any person subject to the board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the chair upon properly being ordered to do so may be assessed an administrative penalty by the chair of not more

than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

Sec. 5a. BILL-BACK REPORT

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

* * * Unified Health Care Budget * * *

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

§ 9373. DEFINITIONS

* * *

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

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

Sec. 7. 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 financial regulation. The division shall assist the commissioner in carrying out the policies of the state regarding health care delivery, cost, and quality~~,~~ by providing oversight of health care quality and expenditures through the ~~certificate of need program and the unified health care budget for the state or with respect to Vermont residents~~, establishment and maintenance of consumer

protection functions~~,~~ and oversight of quality assurance within the health care system. The division shall also establish and maintain a data base with information needed to carry out the commissioner's duties and obligations under this chapter and Title 8.

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

(b) On or before July 1, 2005, the commissioner, in consultation with the secretary of human services, shall submit to the governor a four-year health resource allocation plan. The plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

(1) The plan shall include:

* * *

(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the commissioner shall consider at least the following factors: the values and goals reflected in the state health plan; the needs of the population on a statewide basis; the needs of particular geographic areas of the state, as identified in the state health plan; the needs of uninsured and underinsured populations; the use of Vermont facilities by out-of-state residents; the use of out-of-state facilities by Vermont residents; the needs of populations with special health care needs; the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; the cost impact of these resource requirements on health care expenditures; the services appropriate for the four categories of hospitals described in subdivision 9402(12) of this title; the overall quality and use of health care services as reported by the Vermont program for quality in health care and the Vermont ethics network; the overall quality and cost of services as reported in the annual hospital community reports; individual hospital four-year capital budget projections; ~~the unified health care budget;~~ and the four-year projection of health care expenditures prepared by the division.

* * *

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

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

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

~~(1) The budget shall:~~

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

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

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

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

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

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

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

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

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

~~expenditures with the applicable projections for the prior year, and an evaluation of the efficacy of any cost containment efforts the plan has made.~~

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

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

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

§ 9375a. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET

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

(1) The budget shall:

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

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

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

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

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

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

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

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

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

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

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

* * * Claims Edit Standards * * *

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

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

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

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

(1) The CPT, HCPCS, and NCCI;

(2) National specialty society edit standards; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The payment percentages for modifiers; and

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

(i) Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide the information in subsection (h) of this

section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

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

(k) ~~Prior to the effective date of subsections (b) and (c) of this section, MVP Healthcare is requested to convene~~ 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 financial regulation shall develop performance quality indicators to evaluate and ensure that health insurers, including managed care organizations that contract with health insurers to administer the insurers' mental health benefits, comply with the provisions of 8 V.S.A. § 4089b and related rules.

(b) The departments of health and of mental health shall develop clinical and performance quality measures to evaluate and ensure that health care professionals and health care facilities in Vermont provide high quality mental health and substance abuse treatment services to their patients.

§ 9462. QUALITY IMPROVEMENT PROJECTS

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

Sec. 11c. PARITY FOR PRIMARY MENTAL HEALTH CARE SERVICES; RECOMMENDATIONS

No later than January 15, 2013, the commissioner of financial regulation or designee shall recommend to the house committee on health care and the senate committees on health and welfare and on finance guidelines for distinguishing between primary and specialty mental health services, taking into consideration factors such as mental health care providers' scope of practice and patterns of patient visitation. In addition, the commissioner or designee shall provide the committees with an estimate of the impact on health insurance premiums if such guidelines are enacted into law.

Sec. 11d. 8 V.S.A. § 4089b(c) is amended to read:

(c) A health insurance plan shall provide coverage for treatment of a mental health condition and shall:

(1) not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment for other health conditions, including no greater co-payment for primary mental health care or services than the co-payment applicable to care or services provided by a primary care provider under an insured's policy and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under an insured's policy;

* * *

Sec. 11e. PARITY FOR MENTAL HEALTH CO-PAYMENTS; RULEMAKING

No later than October 1, 2013, the commissioner of financial regulation shall adopt rules pursuant to 3 V.S.A. chapter 25 establishing the guidelines for distinguishing between primary and specialty mental health services developed pursuant to Sec. 11c of this act, taking into account any recommendations received from the committees of jurisdiction.

Sec. 11f. 18 V.S.A. § 7259 is added to chapter 174 to read:

§ 7259. MENTAL HEALTH CARE OMBUDSMAN

(a) The department of mental health shall establish the office of the mental health care ombudsman within the agency designated by the governor as the protection and advocacy system for the state pursuant to 42 U.S.C. § 10801 et seq. The agency may execute the duties of the office of the mental health care ombudsman, including authority to assist individuals with mental health conditions and to advocate for policy issues on their behalf.

(b) The agency may provide a report annually to the general assembly regarding the implementation of this section.

(c) In the event the protection and advocacy system ceases to provide federal funding to the agency for the purposes described in this section, the general assembly may allocate sufficient funds to maintain the office of the mental health care ombudsman.

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

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

(a) Except as otherwise specified, as used in this subchapter:

* * *

(15) "Prior authorization" means the process used by a health plan to determine the medical necessity, medical appropriateness, or both, of otherwise covered drugs, medical procedures, medical tests, and health care services. The term "prior authorization" includes preadmission review, pretreatment review, and utilization review.

(16) "Procedure codes" means a set of descriptive codes indicating the procedure performed by a health care provider and includes the American Medical Association's Current Procedural Terminology codes (CPT), the Healthcare Common Procedure Coding System Level II Codes (HCPCS), the American Society of Anesthesiologists' (ASA) current procedural terminology, and the American Dental Association's current dental terminology.

~~(16)~~(17) "Product" means, to the extent permitted by state and federal law, one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

* * *

* * * Prior Authorization * * *

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

§ 9418b. PRIOR AUTHORIZATION

* * *

(g)(1) 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 clear, uniform, and readily accessible prior authorization form for prior authorization requests for medical procedures and medical tests.

(B) No later than September 1, 2013, the department of financial regulation shall develop clear, uniform, and readily accessible forms for prior authorization requests for prescription drugs after determining the appropriate number of forms.

(3) Each uniform prior authorization form developed pursuant to subdivision (2) of this subsection shall meet the following criteria, where applicable:

(A) The form shall include the core set of common data requirements for 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 48 hours for urgent requests and within 120 hours for non-urgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If a health plan does not, within the time limits set forth in this section, respond to a completed prior authorization request, acknowledge receipt of the request for prior authorization, or request missing information, the prior authorization request shall be deemed to have been granted.

* * * Certificate of Need * * *

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

(b) The board shall have the following duties:

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

* * *

(6) ~~Review and approve recommendations from the commissioner~~ of financial regulation~~, within 10 business~~ Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of ~~such recommendations and~~ a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board~~, on:~~

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

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

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

~~(7)~~(9) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

~~(8)~~(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

* * *

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

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

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

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

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

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

* * *

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

* * *

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

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

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

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

§ 9412. ENFORCEMENT

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

* * *

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

(b) In order to carry out the policy goals of this subchapter, the ~~department~~ board shall adopt by rule by ~~October 1, 2005~~ January 1, 2013, certificate of need procedural guidelines to assist in its decision-making. The guidelines shall be consistent with the state health plan and the health resource allocation plan.

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

§ 9433. ADMINISTRATION

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

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

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

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

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

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

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

* * *

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

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

* * *

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

* * *

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

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

* * *

(c) In the case of a project which requires a certificate of need under this section, expenditures for which are anticipated to be in excess of $30,000,000.00, the applicant first shall secure a conceptual development phase certificate of need, in accordance with the standards and procedures established in this subchapter, which permits the applicant to make expenditures for architectural services, engineering design services, or any other planning services, as defined by the ~~commissioner~~ board, needed in connection with the project. Upon completion of the conceptual development phase of the project, and before offering or further developing the project, the applicant shall secure a final certificate of need, in accordance with the standards and procedures established in this subchapter. Applicants shall not be subject to sanctions for failure to comply with the provisions of this subsection if such failure is solely the result of good faith reliance on verified project cost estimates issued by qualified persons, which cost estimates would have led a reasonable person to conclude the project was not anticipated to be in excess of $30,000,000.00 and therefore not subject to this subsection. The provisions of this subsection notwithstanding, expenditures may be made in preparation for obtaining a conceptual development phase certificate of need, which expenditures shall not exceed $1,500,000.00 for non-hospitals or $3,000,000.00 for hospitals.

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

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

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

§ 9435. EXCLUSIONS

* * *

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

* * *

(e) Upon request under 8 V.S.A. § 5102(f) by a Program for All-Inclusive Care for the Elderly (PACE) authorized under federal Medicare law, or by a Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) established in accordance with federal Medicare or Medicaid laws and regulations, the ~~commissioner~~ board may approve the exemption of the PACE program, PIHP, or PAHP from the provisions of this subchapter and from any other provisions of this chapter if the ~~commissioner~~ board determines that the purposes of this subchapter and the purposes of any other provision of this chapter will not be materially and adversely affected by the exemption. In approving an exemption, the ~~commissioner~~ board may prescribe such terms and conditions as the ~~commissioner~~ board deems necessary to carry out the purposes of this subchapter and this chapter.

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

§ 9437. CRITERIA

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

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

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

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

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

* * *

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

§ 9439. COMPETING APPLICATIONS

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

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

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

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

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

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

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

§ 9440. PROCEDURES

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

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

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

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

(C) the applicant's financial statements;

(D) third party reimbursement data;

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

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

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

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

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

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

(c) The application process shall be as follows:

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

(2)(A) Prior to filing an application for a certificate of need, an applicant shall file an adequate letter of intent with the ~~commissioner~~ board no less than 30 days or, in the case of review cycle applications under section 9439 of this title, no less than 45 days prior to the date on which the application is to be filed. The letter of intent shall form the basis for determining the applicability

of this subchapter to the proposed expenditure or action. A letter of intent shall become invalid if an application is not filed within six months of the date that the letter of intent is received or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule. Except for requests for expedited review under subdivision (5) of this subsection, public notice of such letters of intent shall be provided in newspapers having general circulation in the region of the state affected by the letter of intent. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application or petition to intervene must be filed. In addition, a copy of the public notice shall be sent to the clerk of the municipality in which the health care facility is located. Upon receipt, the clerk shall post the notice in or near the clerk's office and in at least two other public places in the municipality.

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

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

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

(5) An applicant seeking expedited review of a certificate of need application may simultaneously file a letter of intent and an application with

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

(6) If an applicant fails to respond to an information request under subdivision (4) of this subsection within six months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule, the application will be deemed inactive unless the applicant, within six months, requests in writing that the application be reactivated and the ~~commissioner~~ board grants the request. If an applicant fails to respond to an information request within 12 months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule, the application will become invalid unless the applicant requests, and the ~~commissioner~~ board grants, an extension.

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

good cause exists for the extension. Once interested party status is granted, the ~~commissioner~~ board shall provide the information necessary to enable the party to participate in the review process~~. Such information includes~~, including information about procedures, copies of all written correspondence, and copies of all entries in the application record.

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

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

(d) The review process shall be as follows:

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

(A) The application materials provided by the applicant.

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

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

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

(4) After reviewing each application, the ~~commissioner~~ board shall make a decision either to issue or to deny the application for a certificate of need. The decision shall be in the form of an approval in whole or in part, or an approval subject to such conditions as the ~~commissioner~~ board may impose in furtherance of the purposes of this subchapter, or a denial. In granting a partial approval or a conditional approval the ~~commissioner~~ board shall not

mandate a new health care project not proposed by the applicant or mandate the deletion of any existing service. Any partial approval or conditional approval must be directly within the scope of the project proposed by the applicant and the criteria used in reviewing the application.

(5) If the ~~commissioner~~ board proposes to render a final decision denying an application in whole or in part, or approving a contested application, the ~~commissioner~~ board shall serve the parties with notice of a proposed decision containing proposed findings of fact and conclusions of law, and shall provide the parties an opportunity to file exceptions and present briefs and oral argument to the ~~commissioner~~ board. The ~~commissioner~~ board may also permit the parties to present additional evidence.

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

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

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

(f) Any applicant, competing applicant, or interested party aggrieved by a final decision of the ~~commissioner~~ board under this section may appeal ~~the decision to the supreme court~~ pursuant to the provisions of section 9381 of this title.

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

that a violation be corrected or remediated before the certificate may take effect.

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

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

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

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

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

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

§ 9440b. INFORMATION TECHNOLOGY; REVIEW PROCEDURES

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

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

§ 9441. FEES

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

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

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

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

§ 9442. BONDS

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

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

§ 9443. EXPIRATION OF CERTIFICATES OF NEED

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

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

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

* * *

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

§ 9444. REVOCATION OF CERTIFICATES; MATERIAL CHANGE

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

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

(2) Applicants shall notify the ~~commissioner~~ board of a nonmaterial change to the approved project. If the ~~commissioner~~ board decides to review a nonmaterial change, ~~he or she~~ the board may provide for any necessary process, including a public hearing, before approval. Where the ~~commissioner~~ board decides not to review a change, such change will be deemed to have been granted a certificate of need.

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

§ 9445. ENFORCEMENT

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

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

(2) The ~~commissioner~~ board may order that payments or reimbursements to the entity for claims made under any health insurance policy, subscriber contract, or health benefit plan offered or administered by any public or private health insurer, including the Medicaid program and any other health benefit program administered by the state be denied, reduced, or

limited, and in the case of a hospital that the hospital's annual budget approved under subchapter 7 of this chapter be adjusted, modified, or reduced.

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

(c) After notice and an opportunity for hearing, the ~~commissioner~~ board may impose on a person who knowingly violates a provision of this subchapter, or a rule or order adopted pursuant to this subchapter or 8 V.S.A. § 15, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the health care facility, whichever is greater, which shall not be reimbursed under subdivision (a)(2) of this section, and the ~~commissioner~~ board may order the entity to cease and desist from further violations, and to take such other actions necessary to remediate a violation. A person aggrieved by a decision of the ~~commissioner~~ board under this subdivision may appeal ~~the commissioner's decision to the supreme court~~ under section 9381 of this title.

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

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

§ 9446. HOME HEALTH AGENCIES; GEOGRAPHIC SERVICE AREAS

The terms of a certificate of need relating to the boundaries of the geographic service area of a home health agency may be modified by the ~~commissioner~~ board, in consultation with the commissioner of aging and independent living, after notice and opportunity for hearing, or upon written application to the ~~commissioner~~ board by the affected home health agencies or

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

* * * Hospital Budgets * * *

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

Subchapter 7. Hospital Budget Review

* * *

§ 9453. POWERS AND DUTIES

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

* * *

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

§ 9454. HOSPITALS; DUTIES

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

* * *

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

* * *

§ 9456. BUDGET REVIEW

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

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

* * *

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

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

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

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

* * *

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

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

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

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

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

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

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

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

(g) The ~~commissioner~~ board may request, and a hospital shall provide, information determined by the ~~commissioner~~ board to be necessary to determine whether the hospital is operating within a budget established under this section. For purposes of this subsection, subsection (h) of this section, and

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

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

(2)(A) After notice and an opportunity for hearing, the ~~commissioner~~ board may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

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

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

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

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

(ii) Orders issued under this subdivision (2)(B) shall be issued after notice and an opportunity to be heard, except where the ~~commissioner~~ board finds that a hospital's financial or other emergency circumstances pose an immediate threat of harm to the public or to the financial condition of the hospital. Where there is an immediate threat, the ~~commissioner~~ board may issue orders under this subdivision (2)(B) without written or oral notice to the hospital. Where an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. The hearing shall be held within 30 days of receipt of the hospital's request for a hearing, and a decision shall be issued within 30 days after conclusion of the hearing. The ~~commissioner~~ board may increase the time to hold the hearing or to render the

decision for good cause shown. Hospitals may appeal any decision in this subsection to superior court. Appeal shall be on the record as developed by the ~~commissioner~~ board in the administrative proceeding and the standard of review shall be as provided in 8 V.S.A. § 16.

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

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

* * *

* * * Provider Bargaining Groups * * *

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

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

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

* * *

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

* * * Medical Malpractice Reform * * *

Sec. 24a. 12 V.S.A. § 1051 is added to read:

§ 1051. CERTIFICATE OF MERIT

(a) No civil action shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after February 1, 2013, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action files a certificate of merit simultaneously with the filing of the complaint. In the certificate of merit, the attorney or plaintiff shall certify that he or she has consulted with a health care provider qualified pursuant to the requirements of Rule 702 of the Vermont Rules of Evidence and any other applicable standard, and that, based on the information reasonably available at the time the opinion is rendered, the health care provider has:

(1) Described the applicable standard of care;

(2) Indicated that based on reasonably available evidence, there is a reasonable likelihood that the plaintiff will be able to show that the defendant failed to meet that standard of care; and

(3) Indicated that there is a reasonable likelihood that the plaintiff will be able to show that the defendant's failure to meet the standard of care caused the plaintiff's injury.

(b) A plaintiff may satisfy this requirement through multiple consultations that collectively meet the requirements of subsection (a) of this section.

(c) A plaintiff must certify to having consulted with a health care provider as set forth in subsection (a) of this section with respect to each defendant identified in the complaint.

(d) Upon petition to the clerk of the court where the civil action will be filed, an automatic 90-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by this section.

(e) The failure to file the certificate of merit as required by this section shall be grounds for dismissal of the action without prejudice, except in the rare instances in which a court determines that expert testimony is not required to establish a case for medical malpractice.

(f) The requirements set forth in this section shall not apply to claims where the sole allegation against the health care provider is failure to obtain informed consent.

Sec. 24b. [DELETED]

Sec. 24c. 12 V.S.A. chapter 215, subchapter 2 is added to read:

Subchapter 2. Mediation Prior to Filing a Complaint of Malpractice

§ 7011. PURPOSE

The purpose of mediation prior to filing a medical malpractice case is to identify and resolve meritorious claims and reduce areas of dispute prior to litigation, which will reduce the litigation costs, reduce the time necessary to resolve claims, provide fair compensation for meritorious claims, and reduce malpractice-related costs throughout the system.

§ 7012. PRE-SUIT MEDIATION; SERVICE

(a) A potential plaintiff may serve upon each known potential defendant a request to participate in pre-suit mediation prior to filing a civil action in tort or in contract alleging that an injury or death resulted from the negligence of a health care provider and to recover damages resulting from the personal injury or wrongful death.

(b) Service of the request required in subsection (a) of this section shall be in letter form and shall be served on all known potential defendants by certified mail. The date of mailing such request shall toll all applicable statutes of limitations.

(c) The request to participate in pre-suit mediation shall name all known potential defendants, contain a brief statement of the facts that the potential plaintiff believes are grounds for relief, and be accompanied by a certificate of merit prepared pursuant to section 1051 of this title, and may include other documents or information supporting the potential plaintiff's claim.

(d) Nothing in this chapter precludes potential plaintiffs and defendants from pre-suit negotiation or other pre-suit dispute resolution to settle potential claims.

§ 7013. MEDIATION RESPONSE

(a) Within 60 days of service of the request to participate in pre-suit mediation, each potential defendant shall accept or reject the potential plaintiff's request for pre-suit mediation by mailing a certified letter to counsel or if the party is unrepresented to the potential plaintiff.

(b) If the potential defendant agrees to participate, within 60 days of the service of the request to participate in pre-suit mediation, each potential defendant shall serve a responsive certificate on the potential plaintiff by mailing a certified letter indicating that he or she, or his or her counsel, has consulted with a qualified expert within the meaning of section 1643 of this title and that expert is of the opinion that there are reasonable grounds to defend the potential plaintiff's claims of medical negligence. Notwithstanding the potential defendant's acceptance of the request to participate, if the potential defendant does not serve such a responsive certificate within the

60-day period, then the potential plaintiff need not participate in the pre-suit mediation under this title and may file suit. If the potential defendant is willing to participate, pre-suit mediation may take place without a responsive certificate of merit from the potential defendant at the plaintiff's election.

§ 7014. PROCESS; TIME FRAMES

(a) The mediation shall take place within 60 days of the service of all potential defendants' acceptance of the request to participate in pre-suit mediation. The parties may agree to an extension of time. If in good faith the mediation cannot be scheduled within the 60-day time period, the potential plaintiff need not participate and may proceed to file suit.

(b) If pre-suit mediation is not agreed to, the mediator certifies that mediation is not appropriate, or mediation is unsuccessful, the potential plaintiff may initiate a civil action as provided in the Vermont Rules of Civil Procedure. The action shall be filed:

(1) within 90 days of the potential plaintiff's receipt of the potential defendant's letter refusing mediation, the failure of the potential defendant to file a responsive certificate of merit within the specified time period, or the mediator's signed letter certifying that mediation was not appropriate or that the process was complete; or

(2) prior to the expiration of the applicable statute of limitations, whichever is later.

(c) If pre-suit mediation is attempted unsuccessfully, the parties shall not be required to participate in mandatory mediation under Rule 16.3 of the Vermont Rules of Civil Procedure.

§ 7015. CONFIDENTIALITY

All written and oral communications made in connection with or during the mediation process set forth in this chapter shall be confidential. The mediation process shall be treated as a settlement negotiation under Rule 408 of the Vermont Rules of Evidence.

Sec. 24d. SUNSET

12 V.S.A. chapter 215, subchapter 2 shall be repealed on February 1, 2015.

Sec. 24e. REPORT

On or before September 1, 2014, the secretary of administration or designee shall report to the senate committees on health and welfare and on judiciary and the house committees on health care and on judiciary on the impacts of Secs. 24a (certificate of merit) and 24c (pre-suit mediation) of this act. The report shall address the impacts that these reforms have had on:

(1) consumers, physicians, and the provision of health care services;

(2) the rights of consumers to due process of law and to access to the court system; and

(3) any other service, right, or benefit that was or may have been affected by the establishment of the medical malpractice reforms in Secs. 24a and 24c of this act.

Sec. 24f. 18 V.S.A. § 1919 is amended to read:

§ 1919. INCLUSION OF DATA IN HOSPITAL COMMUNITY REPORTS

The commissioner shall consult with the commissioner of banking, insurance, securities, and health care administration, 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~~ of financial regulation concerning which data should be included in the hospital community reports required by section 9405b of this title. Beginning in 2013, the community reports shall include at a minimum data from all Vermont hospitals of reportable adverse events aggregated in a manner that protects the privacy of the patients involved and does not identify the individual hospitals in which an event occurred together with analysis and explanatory comments about the information contained in the report to facilitate the public's understanding of the data. The commissioner shall make such recommendations no more than 18 months after data collection is initiated.

* * * Insurance Rate Reviews * * *

Sec. 25. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, health maintenance organization, or a managed care organization and not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until:

(A) a copy of the form, premium rates, and rules for the classification of risks pertaining thereto have been filed with the commissioner of ~~banking, insurance, securities, and health care administration~~ financial regulation; ~~nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, or in the case of a request for a rate increase, until~~ and

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

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

(B) The Green Mountain Care board shall review rate requests forwarded by the commissioner pursuant to subdivision (A) of this subdivision (2) and shall approve, modify, or disapprove ~~the~~ a rate ~~increase~~ request within ~~10 business~~ 30 days of receipt of the commissioner's recommendation or, in the absence of a recommendation from the commissioner, the expiration of the 30-day period following the department's receipt of the completed application. In the event that the board does not approve or disapprove a rate within 30 days, the board shall be deemed to have approved the rate request.

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

~~(2)~~(3) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this state. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer.

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

(b) The commissioner may, after a hearing of which at least 20 days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. For premium rates, such withdrawal may occur at any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section. ~~Such disapproval~~ Disapproval pursuant to this subsection shall

be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

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

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

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

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

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

(B) the review standards in subdivision ~~(a)(2)~~ (a)(3) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and

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

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

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

Sec. 25a. 8 V.S.A. § 5104 is amended to read:

§ 5104. FILING AND APPROVAL OF RATES AND FORMS; SUPPLEMENTAL ORDERS

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

(2) The commissioner shall refuse to approve, or to seek the Green Mountain Care board's approval of, the form of evidence of coverage, filing, or rate if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of the state or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered

to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

(b) In connection with a rate decision, the commissioner may also, with the prior approval of the Green Mountain Care board established in 18 V.S.A. chapter 220, make reasonable supplemental orders and may attach reasonable conditions and limitations to such orders as the commissioner finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at reasonable cost under efficient and economical management of the organization. The commissioner shall not set the rate of payment or reimbursement made by the organization to any physician, hospital or health care provider.

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

§ 9381. APPEALS

(a)(1) The Green Mountain Care board shall adopt procedures for administrative appeals of its actions, orders, or other determinations. Such procedures shall provide for the issuance of a final order and the creation of a record sufficient to serve as the basis for judicial review pursuant to subsection (b) of this section.

(2) Only decisions by the board shall be appealable under this subsection. Recommendations to the board by the commissioner of financial regulation pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.

* * *

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

Sec. 26a. CONSUMER PROTECTION REPORT

No later than January 15, 2013, the department of financial regulation, in collaboration with the state health care ombudsman and the agency of human services, shall report to the house committee on health care and the senate committees on health and welfare and on finance regarding:

(1) recommendations on how best to represent the public interest before the Green Mountain Care board and other regulatory agencies and estimates of resource needs;

(2) recommendations on how best to coordinate, consolidate, or both the consumer protection efforts of the ombudsman's office, the department, and the agency; and

(3) the ombudsman's current and projected funding and resource needs to meet existing statutory responsibilities and suggestions for funding mechanisms to meet those needs.

* * * Payment Reform Pilots * * *

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

§ 9377. PAYMENT REFORM; PILOTS

* * *

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

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

~~(3)~~ Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:

* * *

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

* * *

(e) The board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments, to advise the board in developing and implementing the pilot projects and to advise the Green Mountain Care board in setting overall policy goals.

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

(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the department of financial regulation to the same extent as the requirement to participate in the Blueprint for Health pursuant to 8 V.S.A. § 4088h.

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of 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~~ of financial regulation and the chair of the Green Mountain Care board.

(b)(1)(A) The commissioner of Vermont health access shall establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall include the commissioner of health; the commissioner of mental health; a representative from the ~~department of banking, insurance, securities, and health care administration~~ Green Mountain Care board; a representative from the department of Vermont health access; an individual appointed jointly by the president pro tempore of the senate and the speaker of the house of representatives; a representative from the Vermont medical society; a representative from the Vermont nurse practitioners association; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine professions; a primary care professional serving low income or uninsured Vermonters; a licensed mental health professional with clinical experience in Vermont; a representative of the Vermont council of developmental and mental health services; a representative of the Vermont assembly of home health agencies who has clinical experience; a representative from a self-insured employer who offers a health benefit plan to its employees; and a representative of the state employees' health plan, who shall be designated by the commissioner of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan.

* * *

Sec. 28a. BLUEPRINT PARTICIPATION; LEGISLATIVE INTENT

It is the intent of the general assembly that:

(1) Health insurer and Medicaid payments for a community health team and access by patients and medical practices to the team should begin at least six months prior to the scheduled date to score a medical practice for Blueprint recognition.

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

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

* * * HMO Reporting Requirement * * *

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

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

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

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

§ 9416. VERMONT PROGRAM FOR QUALITY IN HEALTH CARE

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

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

* * *

* * * Discretionary Clauses * * *

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

§ 4062f. DISCRETIONARY CLAUSES PROHIBITED

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

(b) As used in this section:

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

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

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

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

(c) No policy, contract, certificate, or agreement offered or issued in this state by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and on and after July 1, 2012, any such provision on and after July 1, 2012, in a policy, contract, certificate, or agreement shall be null and void.

(d) No policy, contract, certificate, or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are

inconsistent with the laws of this state, and on and after July 1, 2012, any such provision in a policy, contract, certificate, or agreement shall be null and void.

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

* * * Prescription Drug Cost-Sharing * * *

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

§ 4089i. PRESCRIPTION DRUG COVERAGE

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

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

(c) A health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall limit a beneficiary's out-of-pocket expenditures for prescription drugs, including specialty drugs, to no more for self-only and family coverage per year than the minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively.

(d) For prescription drugs benefits offered in conjunction with a high-deductible health plan (HDHP), the plan may not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles in effect for self-only and family coverage under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection (c) of this section.

(e) As used in this section:

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

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

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

(f) The department of financial regulation shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

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

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(12) "Prescribed product" means a drug or device as defined in section 201 of the federal Food, Drug and Cosmetic Act, 21 U.S.C. § 321, a compound drug or drugs, ~~or~~ a biological product as defined in section 351 of the Public Health Service Act, 42 U.S.C. § 262, for human use, or a combination product as defined in 21 C.F.R. § 3.2(e), but shall not include prescription eyeglasses, prescription sunglasses, or other prescription eyewear.

* * *

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

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

(A) Samples of a prescribed product or reasonable quantities of an over-the-counter drug, a nonprescription medical device, ~~or~~ an item of nonprescription durable medical equipment, an item of medical food as defined in the federal Orphan Drug Act, as amended, 21 U.S.C. § 360ee(b)(3), or infant formula as defined in Section 201(z) of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321, provided to a health care provider for free distribution to patients.

* * *

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

(i) prescription drugs;

(ii) over-the-counter drugs;

(iii) medical devices;

(iv) biological products;

(v) combination products;

(vi) medical food;

(vii) infant formula; or

(viii) medical equipment or supplies.

* * *

(d) The attorney general may bring an action in ~~Washington superior court~~ the civil division of the Washington unit of the superior court for injunctive relief, costs, and attorney's fees and may impose on a manufacturer that violates this section a civil penalty of no more than $10,000.00 per violation. Each unlawful gift shall constitute a separate violation. In any action brought pursuant to this section, the attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Fraud Act, 9 V.S.A. chapter 63.

Sec. 32b. 18 V.S.A. § 4632 is amended to read:

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

(a)(1)(A) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year the value, nature, purpose, and recipient information of any allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title to any health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title, except:

* * *

(B) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year if the manufacturer is reporting other allowable expenditures or permitted gifts pursuant to subdivision (a)(1)(A) of this section, the product, dosage, number of units, and recipient information of over-the-counter drugs, nonprescription medical devices, ~~and~~ items of

nonprescription durable medical equipment, medical food, and infant formula provided to a health care provider for free distribution to patients pursuant to subdivision 4631a(b)(2)(A) of this title; provided that any public reporting of such information shall not include information that allows for the identification of individual recipients of ~~samples~~ such products or connects individual recipients with the monetary value of the ~~samples~~ products provided.

* * *

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

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

* * *

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

(A) Information on allowable expenditures and permitted gifts required to be disclosed under this section, which shall present information in aggregate form by selected types of health care providers or individual health care providers, as prioritized each year by the office; and showing the amounts expended on the Green Mountain Care board established in chapter 220 of this title. In accordance with subdivisions (1)(B), (1)(D), and (2)(A) of this subsection, information on samples and donations to free clinics of prescribed products and of over-the-counter drugs, nonprescription medical devices, ~~and~~ items of nonprescription durable medical equipment, medical food, and infant formula shall be presented in aggregate form.

* * *

(c) The attorney general may bring an action in ~~Washington superior court~~ the civil division of the Washington unit of the superior court for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer of prescribed products that fails to disclose as required by subsection (a) of this section a

civil penalty of no more than $10,000.00 per violation. Each unlawful failure to disclose shall constitute a separate violation. In any action brought pursuant to this section, the attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Fraud Act, 9 V.S.A. chapter 63.

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

* * * Medicaid Waiver Approval * * *

Sec. 33. DUAL ELIGIBLE PROJECT PROPOSAL

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

(b)(1) The agency of human services may seek a waiver or waivers from CMS to enable the agency to better serve individuals who are eligible for both Medicare and Medicaid ("dual eligibles") through a consolidated program operated by the agency of human services or by a department of the agency of human services. The waiver or waivers sought pursuant to this section may be consolidated with or filed in conjunction with Vermont's Medicaid Section 1115 Global Commitment to Health waiver renewal, any Choices for Care waiver modifications, or a state children's health insurance program (SCHIP) waiver. Any modifications of the Choices for Care waiver shall be consistent with No. 56 of the Acts of 2005.

(2) The agency may seek permission to serve the dual eligibles population 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 committees on health and welfare and on finance 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 the 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 an objectively reasonable belief under the circumstances that the athlete has sustained a concussion or other head injury during the training session or competition.

(2) A coach shall not permit a youth athlete who has been prohibited from training or competing pursuant to subdivision (1) of this subsection to train or compete with a school athletic team ~~if the athlete has been removed or prohibited from participating in a training session or competition associated with the school athletic team due to symptoms of a concussion or other head injury~~ until the athlete has been examined by and received written permission to participate in athletic activities from a health care provider licensed pursuant to Title 26 and trained in the evaluation and management of concussions and other head injuries.

* * * Rulemaking Authority * * *

Sec. 40. HOSPITAL BUDGET REVIEW RULES

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

Sec. 40a. RULEMAKING

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

* * * Position Transfer * * *

Sec. 40b. TRANSFER OF POSITION

On or before January 1, 2013, one health care administrator position shall be transferred from the department of financial regulation to the Green Mountain Care board.

* * * Maximizing Federal Funds * * *

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

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

* * * Health Access Oversight Committee * * *

Sec. 40d. 2 V.S.A. chapter 24 is amended to read:

CHAPTER 24. HEALTH ~~ACCESS~~ CARE OVERSIGHT COMMITTEE

§ 851. CREATION OF COMMITTEE

(a) A legislative health ~~access~~ care oversight committee is created. The committee shall be appointed biennially and consist of ten members: five members of the house appointed by the speaker, not all from the same political party, and five members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include ~~two members~~ one member from the house committee on human services, ~~two members~~ one member from the house committee on health care, ~~and~~ one member from the house committee on appropriations, and two at-large members. The senate appointees shall include ~~three members~~ one member from the senate committee on health and welfare, one member from the senate committee on finance, ~~and~~ one member from the senate committee on appropriations, and two at-large members.

(b) The committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The health ~~access~~ care oversight committee shall ~~carry on~~ monitor, oversee, and provide a continuing review of ~~the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs~~ health care and human services programs

in Vermont when the general assembly is not in session, including programs and initiatives related to mental health, substance abuse treatment, and health care reform.

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

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

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

(3) The department of Vermont health access.

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

* * * Repeals * * *

Sec. 41. REPEALS

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

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

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

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

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

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

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

(h) 33 V.S.A. chapter 19, subchapter 3 (Vermont Health Access Plan; employer-sponsored insurance assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage by the

department of Vermont health access as authorized by the Centers on Medicare and Medicaid Services.

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

(j) 8 V.S.A. §§ 4062d (market security trust), 4077 (industrial policies), and 4078 (franchise plan policies) are repealed on July 1, 2012.

(k) Sec. 141c of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as amended (mental health oversight committee), is repealed.

Sec. 41a. TRANSITIONAL PROVISIONS; IMPLEMENTATION

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

(2) Notwithstanding subdivision (1) of this subsection, the commissioner of financial regulation may, in his or her discretion, allow for the extension of a small group or association plan beyond the plan's renewal date in order to ensure a smooth and orderly transition from health plans offered in the small group and association markets in 2013 to health plans offered in the small group market through the Vermont health benefit exchange in 2014.

(b) Except as otherwise provided in subsections (c) and (d) of this section, individuals in the nongroup market may enroll in health insurance plans offered though the Vermont health benefit exchange beginning at the earliest on October 1, 2013 and at the latest on March 31, 2014, pursuant to federal law.

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

regulation and the Green Mountain Care board shall maintain their authority pursuant to this subsection until the exchange is able to enroll all qualified individuals and small employers who apply for coverage through the exchange.

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

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

(f) To the extent permitted under the Affordable Care Act, in implementing the Vermont health benefit exchange, it is the intent of the general assembly not to impair the health care coverage provided to Vermonters through collective bargaining agreements entered into prior to January 1, 2013 and in effect on January 1, 2014 until the date that any such collective bargaining agreement relating to such health care coverage terminates.

(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.

41b. MEDICARE SUPPLEMENTAL INSURANCE; WEB PORTAL

Nothing in this act shall be construed to prohibit the department of Vermont health access from allowing Medicare supplemental insurance to be offered on the web portal for the Vermont health benefit exchange, nor to require that the cost of providing such offerings on the web portal be paid in whole or in part with federal funds. Prior to allowing Medicare supplemental insurance to be

offered on the Vermont health benefit exchange web portal, the department shall seek the input of consumers, insurers, and other stakeholders.

Sec. 42. EFFECTIVE DATES

(a) Secs. 5 (Green Mountain Care board authority), 5a (bill-back report), 6–11 (unified health care budget), 11a (claims edit standards), 11c (parity for primary mental health care services), 12–14 (Green Mountain Care board duties, health care administration), 23 (hospital budgets), 24 (provider bargaining groups), 24g (pretrial screening feasibility analysis), 25–26 (insurance rate reviews), 26a (consumer protection report), 27 (payment reform pilot projects, 28 (Blueprint for Health), 28a (Blueprint intent), 29 (HMO reporting requirements), 33–35a (waivers), 35c (transition planning and exchange updates), 36 (health access eligibility unit), 36a (preconditions for Green Mountain Care), 36b (JFO review), 37–39 (technical/clarifying changes), 40b (transfer of position), 40c (maximizing federal funds), 41 (repeals), 41a (transitional provisions), and 41b (Medicare supplemental policies) of this act and this section shall take effect on passage.

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

(c) Secs. 1 and 2 (50 employees or fewer), 2a (qualified health benefit plans), 2b (navigators), 2c (exchange options), 2d (brokers and agents), 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 July 1, 2012 and shall apply to all policies, contracts, certificates, and agreements renewed, offered, or issued in this state with effective dates on or after such date.

(f)(1) Secs. 32(a), (e), and (f) (prescription drug coverage); 32a and 32b (prescribed products); 35b (Medicaid and exchange advisory committee); 39a (sports injuries); and 40d (health care 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 financial regulation and the Green Mountain Care board may adopt rules as needed before that date to ensure that enrollment in the health insurance plans will be available no later than October 1, 2013; and

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

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

(i) Secs. 11b (mental health and substance abuse quality assurance), 11e (rulemaking; mental health co-payment parity), 11f (mental health ombudsman), 11g (payment; definitions), and 11h (prior authorization) of this act shall take effect on July 1, 2012.

(j) Secs. 24a–24f (medical malpractice reform) shall take effect on February 1, 2013, except that Sec. 24b(f) (Sorry Works! rulemaking) shall take effect on passage.

(k) Sec. 11d (parity for mental health co-payments) of this act shall take effect on January 1, 2014, and shall apply to health insurance plans on and after January 1, 2014 on such date as a health insurer issues, offers, or renews the health insurance plan, but in no event later than January 1, 2015.

Pending the question, Will the House concur in the Senate proposal of amendmfent? **Rep. Fisher of Lincoln** moved that the House refuse to concur and ask for a Committee of Conference, which was agreed to, and the Speaker appointed as members of the Committee of Conference on the part of the House:

Rep. Fisher of Lincoln
Rep. Copeland-Hanzas of Bradford
Rep. Dakin of Chester

On motion of **Rep. Savage of Milton**, the rules were suspended and the bill was ordered messaged to the Senate forthwith.

Adjournment

At five o'clock and forty minutes in the afternoon, on motion of **Rep. Savage of Swanton**, the House adjourned until tomorrow at nine o'clock and thirty minutes in the forenoon.