

# House Calendar

---

Friday, April 16, 2010

102nd DAY OF ADJOURNED SESSION

House Convenes at 9:30 A.M.

---

## TABLE OF CONTENTS

---

**Page No.**

### **ACTION CALENDAR**

#### **Third Reading**

<b>H. 770</b> Approval of amendments to the charter of the city of Barre.....	1366
<b>H. 781</b> Renewable energy .....	1366
<b>H. 792</b> Implementation of challenges for change .....	1366
Rep. Browning Amendment .....	1366
Rep. Lippert Amendment .....	1366
Rep. Zuckerman Amendment.....	1369
Rep. Sweaney Amendment.....	1369
Rep. Martin of Wolcott Amendment.....	1370
Rep. Kilmartin Amendment.....	1371
Rep. Marcotte Amendment.....	1390
Rep. Higley Amendment .....	1390
Rep. Kilmartin Amendment.....	1391

#### **Favorable with amendment**

<b>S. 239</b> Retiring outdoor wood-fired boilers that do not meet the 2008 emission standard for particulate matter.....	1391
Rep. Weston for Natural Resources and Energy	
Rep. Winters for Appropriations .....	1392
<b>S. 268</b> The building bright futures council.....	1392
Rep. Frank for Human Services	

#### **Senate Proposal of Amendment**

<b>H. 540</b> Motor vehicles passing vulnerable users on the highway and to bicycle operation .....	1397
<b>H. 648</b> Harassment and hazing policies at independent colleges.....	1400

## NOTICE CALENDAR

### Favorable with Amendment

- S. 88** Health care financing and universal access to health care in Vermont 1400  
Rep. Maier for Health Care
- S. 237** Operational standards for salvage yards..... 1457  
Rep. McCullough for Fish, Wildlife and Water Resources
- S. 287** The licensing and regulation of loan servicers..... 1464  
Rep. Clerkin for Commerce and Economic Development
- J.R.S. 50** Urging expedited federal initiation of the National Environmental  
Policy Act process relating to the proposed federal acquisition of Eagle Point  
Farm in Derby, Vermont ..... 1465  
Rep. Lewis for Fish, Wildlife and Water Resources

### Senate Proposal of Amendment

- H. 408** Improving nutrition programs ..... 1468

### Ordered to Lie

- H.R. 19** Urging the agency of natural resources to retain delegated authority to  
administer the federal Clean Water Act in Vermont ..... 1468

### Consent Calendar

- H.C.R. 317** Honoring Carl Johnson for his outstanding half century of public  
service as a law enforcement officer and for his dedicated work as a Franklin  
County historian ..... 1469
- H.C.R. 318** Congratulating the 2010 Windsor High School Yellow Jackets  
Division III girls' basketball championship team ..... 1469
- H.C.R. 319** Designating April 28, 2010, as National Walk@Lunch Day in  
Vermont ..... 1469
- H.C.R. 320** Honoring Meredith Sumner for her dedicated public service as a  
legislative council attorney ..... 1469
- H.C.R. 321** Honoring E. Anne Winchester's extraordinary public service as a  
legislative council drafter and policy analyst ..... 1469
- H.C.R. 322** Honoring Stanley Michael Slater on the conclusion of his  
outstanding legislative council career ..... 1469
- H.C.R. 323** Congratulating the 2010 Norwich University Cadets championship  
NCAA Division III men's ice hockey team ..... 1469

<b>H.C.R. 324</b> Recognizing Vermont students' excellent performance on the national reading examination .....	1469
<b>H.C.R. 325</b> Congratulating Philip Swanson on the 25th anniversary of his exemplary public service as Woodstock's town and village manager .....	1469
<b>H.C.R. 326</b> Commemorating the World War II friendship and military service of Raymond Sanville and Bill Spriggs .....	1469
<b>H.C.R. 327</b> In memory of the Rev. Michael A. DeMasi .....	1469
<b>H.C.R. 328</b> Congratulating Andrea Rogers on 30 years of extraordinary leadership and commitment to artistic excellence and community involvement .....	1469
<b>H.C.R. 329</b> In memory of Mark Richard Skakel .....	1469
<b>H.C.R. 330</b> Congratulating Charles Hunter on being named the Great Falls Regional Chamber of Commerce Person of the Year .....	1470
<b>H.C.R. 331</b> Recognizing American Craft Beer Week in Vermont.....	1470
<b>H.C.R. 332</b> Designating the Deerfield Valley as the Blueberry Capital of Vermont.....	1470

---

---

**ORDERS OF THE DAY**

---

---

**ACTION CALENDAR**

**Third Reading**

**H. 770**

An act relating to approval of amendments to the charter of the city of Barre

**H. 781**

An act relating to renewable energy

**H. 792**

An act relating to implementation of challenges for change

**Amendment to be offered by Rep. Browning of Arlington to H. 792**

Rep. Browning of Arlington moves that the bill be amended following Sec. 67, by inserting a new Sec. 68 to read:

**Sec. 68. STATE TREASURER; BONDING AUTHORITY**

(a) The state treasurer is authorized to issue \$10 million in short-term general obligation bonds for the purpose of funding this act. The state treasurer, with the approval of the governor, shall determine the appropriate form and maturity of the bonds authorized by this section consistent with the underlying nature of the project to be funded.

(b) Proceeds from bonds issued under this section are appropriated as follows:

(1) to the commissioner of corrections for the purpose of investing in programs and services which will reduce incarceration and recidivism:

\$3,164,000

(2) to the secretary of administration to implement Sec. 2 of this act, and to finance other investments in information technology, productive assets, programs, or operations authorized in this act that will ensure lower costs and better outcomes for state agencies in the future:

\$6,836,000

and by renumbering the existing Sec. 68 to be Sec. 69

**Amendment to be offered by Rep. Lippert of Hinesburg to H. 792**

Rep. Lippert of Hinesburg moves that the bill be amended as follows:

First: By adding a Sec. 24a to read as follows:

\* \* \* Home Detention\* \* \*

Sec. 24a. 13 V.S.A. § 7554b is added to read:

§ 7554b. HOME DETENTION PROGRAM FOR DETAINEES

(a) As used in this section, “home detention” means a program of confinement and supervision that restricts a defendant to a preapproved residence continuously, except for authorized absences, and is enforced by appropriate means of surveillance and electronic monitoring by the department of corrections. The court may authorize scheduled absences such as work, school, or treatment. Any changes in the schedule shall be solely at the discretion of the department of corrections. A defendant who is on home detention shall remain in the custody of the commissioner of the department of corrections with conditions set by the court.

(b) Procedure. The status of a defendant who is detained pretrial for more than seven days in a correctional facility for lack of bail may be reviewed by the court to determine whether the defendant is appropriate for home detention. The request for review may be made by either the department of corrections or the defendant. After a hearing, the court may order that the defendant be released to the home detention program, providing that the court finds placing the defendant on home detention will reasonably assure his or her appearance in court when required and the proposed residence is appropriate for home detention. In making such a determination, the court shall consider:

(1) the nature of the offense with which the defendant is charged;

(2) the defendant’s prior convictions, history of violence, medical and mental health needs, history of supervision, and risk of flight; and

(3) any risk or undue burden to other persons who reside at the proposed residence, or risk to third parties or to public safety, that may result from such placement.

(c) Failure to comply. The department of corrections may revoke a defendant’s home detention status for an unauthorized absence or failure to comply with any other condition of the program and shall return the defendant to a correctional facility.

(d) Sentence computation. Upon conviction and at the time of sentencing, the defendant shall be given credit for any day spent in the home detention program as though it had been spent in a correctional facility.

Second: By adding Secs. 25a and 25b to read:

\* \* \* Expand Diversion\* \* \*

Sec. 25a. 3 V.S.A. § 164 is amended to read:

§ 164. ADULT COURT DIVERSION PROJECT

(a) The attorney general shall develop and administer an adult court diversion project in all counties. The project shall be operated through the juvenile diversion project and shall be designed to assist ~~adult first time offenders~~ adults who have been charged with a first or second misdemeanor or a first felony. The attorney general shall adopt only such rules as are necessary to establish an adult court diversion project for adults, in compliance with this section.

\* \* \*

(c) All adult court diversion projects receiving financial assistance from the attorney general shall adhere to the following provisions:

\* \* \*

(4) Each state's attorney, in cooperation with the adult court diversion project, shall develop clear criteria for deciding what types of offenses and offenders will be eligible for diversion; however, the state's attorney shall retain final discretion over the referral of each case for diversion.

\* \* \*

#### Sec. 25b. COURT DIVERSION PROJECT

The Vermont association of court diversion programs, the department of state's attorneys and sheriffs and the Vermont network against domestic and sexual violence shall jointly develop referral criteria to appropriately screen charges for the purpose of identifying those that have elements of underlying domestic violence, sexual violence, or stalking.

Third: By adding a Sec. 26a to read as follows:

\* \* \*Permit the Office of Child Support to Prosecute Nonsupport\* \* \*

Sec. 26a. 15 V.S.A. § 202 is amended to read:

#### § 202. PENALTY FOR DESERTION OR NONSUPPORT

A married person who, without just cause, shall desert or wilfully neglect or refuse to provide for the support and maintenance of his or her spouse and children, leaving them in destitute or necessitous circumstances or a parent who, without lawful excuse, shall desert or wilfully neglect or refuse to provide for the support and maintenance of his child or an adult child possessed of sufficient pecuniary or physical ability to support his parents, who unreasonably neglects or refuses to provide such support when the parent is destitute, unable to support himself and resident in this state, shall be imprisoned not more than two years or fined not more than \$300.00, or both. Should a fine be imposed, the court may order the same to be paid in whole or in part to the needy spouse, parent or to the guardian, custodian or trustee of

the child. The office of child support attorneys, in addition to any other duly authorized person, may prosecute cases under this section in Vermont district court.

**Amendment to be offered by Rep. Zuckerman of Burlington to H. 792**

Rep. Zuckerman of Burlington moves that the bill be amended by inserting a new Sec. 5 to read:

**Sec. 5. TWO-YEAR SURTAX ON TOP FOUR INCOME TAX BRACKETS**

For taxable years beginning on or after January 1, 2010, and before January 1, 2013, there is imposed a surtax on the tax imposed pursuant to 32 V.S.A. § 5822 equal to four and one-half percent of Vermont personal income tax liability if the last dollar of taxable income is subject to one of the following marginal tax rates: 7%, 8.25%, 8.9%, and 9.4%.

and by renumbering the remaining sections and all cross-references in the bill to be numerically correct and internally consistent

**Amendment to be offered by Rep. Sweaney of Windsor to H. 792**

Rep. Sweaney of Windsor moves that the bill be amended as follows:

First: In Sec. 65, 2 V.S.A. § 970(a), by striking subdivision (6) in its entirety and inserting in lieu thereof a new subdivision (6) to read:

(6) Review the fiscal condition of the state on a two-year and five-year basis, including relevant data such as comparisons of budgeted amounts to actual expenditures, comparison of current and projected expenditures to current and projected revenues, and capital investments funded by bonding.

Second: In Sec. 65, 2 V.S.A. § 970(a)(7), by striking “Create and implement” and inserting in lieu thereof “Recommend”

Third: In Sec. 65, 2 V.S.A. § 970, by striking subsection (b) in its entirety and inserting in lieu thereof a new subsection (b) to read:

(b) The membership of the committee shall be appointed each biennial session of the general assembly. The committee shall be comprised of eight members: four members of the house of representatives who shall not all be from the same party: one from the committee on government operations, one from the committee on appropriations, one from the committee on ways and means, and one from the committee on corrections and institutions, appointed by the speaker of the house; and four members of the senate who shall not all be from the same party: one from the committee on government operations, one from the committee on appropriations, one from the committee on finance, and one from the committee on institutions, appointed by the committee on

committees. The governor shall appoint one person to serve as a nonvoting liaison to the committee.

**Amendment to be offered by Rep. Martin of Wolcott to H. 792**

Rep. Martin of Wolcott moves that the bill be amended as follows:

First: In Sec. 1, by adding subsection (d) to read:

(d) It is the intent of the legislature that all branches, elected offices and units of government participate in the performance contracting and grant making challenge, as defined in Sec. 3 of No. 68 of the Acts of the 2009 Adj. Sess. (2010), and notwithstanding any other provision of law, memorandums of understanding be executed between the administration and the aforementioned government units to achieve the desired outcomes and implementation of this initiative.

Second: By adding a Sec. 2a to read:

Sec. 2a. SECRETARY OF ADMINISTRATION; EXCESS SAVINGS AND REVENUES

Notwithstanding any other provisions of law to the contrary, for a period of two years after the effective date of this section the secretary of administration may grant to a designated charter unit the ability to retain and reinvest savings or revenues if the combined savings of the charter unit is in excess of the two million dollar savings or revenue target and may transfer appropriations or funds as deemed necessary to accomplish the results specified for the charter unit challenge and consistent with plans to improve business processes presented to the secretary.

Third: By striking Sec. 36 in its entirety and inserting in lieu thereof a new Sec. 36 to read:

Sec. 36. SECRETARY OF STATE; PUBLICATION OF PROPOSED RULES

(a) The secretary of state shall arrange for one formal publication, in a consolidated advertisement in newspapers having general circulation in different parts of the state as newspapers of record approved by the secretary of state, of information relating to all proposed rules that includes the following information:

(1) the name of the agency and its Internet address;

(2) the title or subject of the rule;

(3) the name, telephone number, and address of an agency official able to answer questions and receive comments on the proposal; and



(4) a statement that as of January 1, 2011, notice of proposed rules will no longer be published in newspapers.

(b) The secretary of state shall be reimbursed by agencies making publication so that all costs are prorated among agencies publishing at the same time.

**Amendment to be offered by Rep. Kilmartin of Newport City to H. 792**

Rep. Kilmartin of Newport City moves that the bill be amended after Sec. 33 and before the internal caption “\* \* \* Environmental and Energy Regulation \* \* \*” by inserting 23 new sections to be Secs. 33a – 33w to read:  
Sec. 33a. INTENT

It is the intent of the general assembly:

(1) to ensure that any change to the governance structure of the Vermont educational system will create better opportunities for students, reasonably increase economies of scale, preserve a sense of community, and provide incentives for cost efficiencies available in personnel assignment and the management of resources;

(2) to provide technical assistance, incentives, and statutory changes to encourage voluntary merger of school districts;

(3) to assist schools and education governing units to use meaningful, standardized metrics for evaluating programs, comparing local, national, and international student data, and assessing and identifying system improvements;

(4) to ensure that there are meaningful methods to analyze the costs and benefits of resource allocations;

(5) to make effective use of technology to expand educational opportunities for all students; and

(6) to ensure that voters have opportunities to make local decisions regarding school choice and other enrollment options, in Vermont public schools and in approved independent schools, that are appropriate for their communities.

\* \* \* School District Merger Incentive Program \* \* \*

**Sec. 33b. SCHOOL DISTRICT MERGER INCENTIVE PROGRAM**

There is created a school district merger incentive program to be in effect through fiscal year 2017 under which each new unified union school district created by the voluntary merger of existing school districts pursuant to Secs. 33c and 33e of this act shall receive the incentives outlined in Sec. 33d of this act.

Sec. 33c. INCENTIVE PROGRAM REQUIREMENTS RELATING TO DISTRICT STRUCTURE

(a) Size and Schools. Two or more contiguous school districts, which may include one or more union school districts, may merge to form a unified union school district (“UUSD”) that (except as provided in Sec. 33f of this act) shall:

(1) have an average daily membership of at least 1,250 or result from the merger of at least five districts, or both; and

(2) maintain one or more approved public schools offering elementary and secondary education. Notwithstanding any other provision of law to the contrary:

(A) and for purposes of this subdivision, a UUSD shall be deemed to maintain a public high school if it has designated a public school outside the district or an approved independent school as its public high school pursuant to the provisions of 16 V.S.A. § 827 and if a UUSD designates a school to satisfy the requirement of this subdivision, the act of designation will not limit the enrollment options available to the UUSD under the proposal approved by the electorate in Sec. 33e(b)(2)(B)(ii) of this act, including tuitioning students to public schools or approved independent schools inside or outside the UUSD; and

(B) the fact that an existing union high school district is among the districts merging to form a UUSD shall not limit the enrollment options available to the UUSD under the proposal approved by the electorate in Sec. 33e(b)(2)(B)(ii) of this act, including tuitioning students to public schools or approved independent schools inside or outside the UUSD.

(b) Supervisory unions.

(1) School districts that merge to form a UUSD do not need to be from the same supervisory union.

(2) If a UUSD includes all school districts within one or more supervisory unions, then the UUSD shall replace the school districts, the supervisory union or unions, and all related elected boards.

(3) If a UUSD forms and does not include all school districts within one or more supervisory unions, then:

(A) the UUSD is an independent entity distinct from the remaining school districts and the supervisory union or unions; and

(B) any school district that is a member of the same supervisory union as one or more of the merging districts and that does not merge to form the UUSD shall maintain its existing governance structure; provided, however,

that upon vote of the electorate, the school district may notify the state board of education of its intent to operate as a supervisory district as defined in 16 V.S.A. § 11(24) or may request the state board to assign it to an existing supervisory union pursuant to 16 V.S.A. § 261.

(c) Organization. A UUSD is a supervisory district consisting of a single unified union school district, as explicitly contemplated by 16 V.S.A. § 11(a)(24). Subject to the provisions of this act, a UUSD is a unified union school district as defined by 16 V.S.A. § 722 that is not assigned to a supervisory union pursuant to 16 V.S.A. § 706 and operates pursuant to chapter 11 of Title 16.

(d) Operation of schools. A UUSD shall not close any school within its boundaries during the first four years of merger or prior to fiscal year 2018, whichever is earlier, unless the electorate of the municipality in which the school is located consents to closure.

(e) UUSD board.

(1) Membership. The UUSD shall be governed by one board. Members of the board shall be elected pursuant to 16 V.S.A. §§ 706e and 706k and any other related provisions of chapter 11 of Title 16.

(2) Duties. The UUSD board shall:

(A) develop, approve, and ensure implementation of educational and other policies for schools within the UUSD, which shall include those required by 16 V.S.A. §§ 563 and 261a;

(B) adopt a proposed budget;

(C) hire no more than one superintendent; and

(D) perform other duties for which school district and supervisory union boards are legally responsible, as applicable.

(f) Local participation. The plan for merger presented to the electorate for approval under Sec. 33e of this act shall include structures and processes that provide opportunities for local participation in the creation of UUSD policy and budget development.

(g) Enrollment options.

(1) As part of the merger process, each UUSD shall implement the student enrollment options proposed by the subcommittee under Sec. 33e(b)(2)(B)(ii) of this act and approved by the electorate.

(2) Notwithstanding the authority to establish enrollment options pursuant to subdivision (1) of this subsection, the UUSD shall comply with the regional high school choice provisions of 16 V.S.A. § 1622.

(h) Educational requirements.

(1) Technical education. The UUSD shall provide access to secondary technical education for students pursuant to 16 V.S.A. § 1541a and shall permit any qualified student in grades 9–12 residing within its boundaries to enroll, as capacity permits, in appropriate classes and programs offered by the technical center or centers.

(2) Special education; local education agency. The UUSD shall be the local education agency for purposes of both 20 U.S.C. §§ 1400–1485 (Individuals with Disabilities Education Act) and 20 U.S.C. §§ 6311–6318 (the Elementary and Secondary Education Act of 1965 and the No Child Left Behind Act of 2001) and their implementing regulations, as amended from time to time. The UUSD shall provide special education services and shall be responsible for developing the individualized education plans for students residing within its boundaries.

(3) Curriculum. The UUSD shall have a UUSD-wide curriculum that meets the standards adopted pursuant to 16 V.S.A. § 165(a)(3) and that is approved by the UUSD board and fully implemented no later than the sixth year of the UUSD’s existence.

(4) Higher education. Prior to the beginning of the third year of merger, the UUSD shall provide opportunities for students to enroll in postsecondary classes for secondary credit and to enroll in postsecondary classes for both secondary and postsecondary credit.

(5) Distance learning. To the extent there is sufficient bandwidth capacity, the UUSD shall provide opportunities for students attending a school operated by the UUSD to enroll in distance learning programs pursuant to 16 V.S.A. § 563(32).

(6) Connections to the workforce. The UUSD shall offer opportunities for students to participate in internships or other work experiences with area businesses, artisans, and organizations.

(7) Graduation. The UUSD shall provide opportunities for students who have completed all graduation requirements to graduate from secondary school prior to the student’s expected year of graduation.

(i) Daily schedule. Secondary schools within the UUSD and the affiliated technical center or centers shall develop daily schedules that support opportunities for students to participate in available educational opportunities.

(j) Transportation. The UUSD board shall decide to what extent the UUSD will offer transportation to students.

(k) Employment and labor relations. The UUSD, upon assuming operating responsibility on the first day of its existence, shall:

(1) assume the obligations of individual employment contracts between the participating districts and their bargaining unit employees;

(2) assume the collective bargaining agreements between the participating districts and their respective representative organizations, including any provisions that address the transition to the UUSD, until such time as it reaches its own agreement with teachers and administrators under 16 V.S.A. § 2005, and with respect to other employees under 21 V.S.A. § 1725(a); and

(3) otherwise comply with all laws regarding labor relations, including chapter 57 of Title 16 and chapter 22 of Title 21.

#### Sec. 33d. UUSD PROGRAM INCENTIVES

(a) Multi-year budgets.

(1) In addition to the option of proposing a single-year budget on an annual basis pursuant to the provisions of chapter 11 of Title 16 and notwithstanding any other provision of law, a UUSD formed pursuant to Secs. 33c and 33e of this act shall also have the option to propose one or both of the following:

(A) A multi-year budget for the first two fiscal years of its existence, provided the years are prior to fiscal year 2018, that will be included as part of the plan that must be approved by the electorate in order to create the UUSD.

(B) A multi-year budget for the third and fourth fiscal years of its existence, provided the years are prior to fiscal year 2018, that is presented to the electorate for approval at the UUSD's annual meeting convened in its second fiscal year.

(2) The plan presented to the electorate to authorize creation of the UUSD may contain a provision authorizing the UUSD, beginning in the earlier of the fifth fiscal year of its existence or fiscal year 2018, to present multi-year proposed budgets to the electorate once in every two or three years.

(3) A UUSD that spends less than the budgeted amount prior to fiscal year 2018 shall be entitled to retain the budget surplus to lower its tax rate in fiscal year 2018 or after, or for another purpose approved by the electorate.

(b) Tax rates.

(1) Subject to the provisions of subdivision (3) of this subsection and notwithstanding any other provision of law, for no more than four consecutive years prior to fiscal year 2018:

(A) if the UUSD's approved annual education spending in one fiscal year is less than its education spending in the prior fiscal year, then for purposes of calculating the UUSD's homestead property tax rate for the year, the UUSD's education spending per equalized pupil shall be decreased by \$875.00;

(B) if the UUSD's approved annual education spending in one fiscal year is equal to its education spending in the prior fiscal year, then for purposes of calculating the UUSD's homestead property tax rate for the year, the UUSD's education spending per equalized pupil shall be decreased by \$750.00;

(C) if the UUSD's approved annual education spending in one fiscal year is greater than its education spending in the prior fiscal year by one percent or less, then for purposes of calculating the UUSD's homestead property tax rate for the year, the UUSD's education spending per equalized pupil shall be decreased by \$600.00;

(D) if the UUSD's approved annual education spending in one fiscal year is greater than its education spending in the prior fiscal year by more than one percent but not by more than two percent, then for purposes of calculating the UUSD's homestead property tax rate for the year, the UUSD's education spending per equalized pupil shall be decreased by \$400.00; and

(E) if the UUSD's approved annual education spending in one fiscal year is greater than its education spending in the prior fiscal year by more than two percent but not by more than four percent, then for purposes of calculating the UUSD's homestead property tax rate for the year, the UUSD's education spending per equalized pupil shall be decreased by \$200.00.

(2) For purposes of determining the UUSD's homestead property tax rate under this subsection for the first fiscal year of merger, the UUSD's education spending in the first fiscal year of merger shall be compared to the combined education spending of the merging districts from the fiscal year two years prior to the first fiscal year of merger increased by the percentage change in the New England Economic Partnership Cumulative Price Index for state and local government purchases of goods and services between the fiscal year two years prior to the first year of UUSD operation and the fiscal year one year prior to the first year of operation, as of November 15 prior to the first year of operation.

(3) During the years in which a UUSD's homestead property tax rate is calculated pursuant to this subsection, the equalized homestead property tax rate for each municipality within the UUSD shall not increase or decrease by more than five percent in a single year.

(c) Capital debt service. Beginning in fiscal year 2018, and notwithstanding any other provision of law, the commissioner shall pay from the education fund the interest owed by a UUSD on that portion of capital debt incurred prior to fiscal year 2012 that has been determined to be eligible for state construction aid but is subject to the suspension imposed by Sec. 45 of No. 200 of the Acts of the 2007 Adj. Sess. (2008), as amended by Sec. 22 of No. 54 of the Acts of 2009.

(d) Sale of school buildings. Subject to the provisions of Sec. 33c(d) of this act:

(1) if a UUSD closes a school building before the earlier of its fifth fiscal year or 2018 and sells the school building or energy saving measure associated with the building, then neither the UUSD nor any other entity shall be required to refund a percentage of the sale price to the state pursuant to chapter 123 of Title 16; and

(2) if a participating district retains ownership of and closes a school building as part of the electorate-approved plan for merger and the participating district sells the school building or energy saving measure associated with the building, then neither the district nor any other entity shall be required to refund a percentage of the sale price to the state pursuant to chapter 123 of Title 16.

(e) Consolidation support grant. If the merging districts of a UUSD included at least one "eligible school district," as defined in 16 V.S.A. § 4015, that had received a small school support grant under section 4015 in the fiscal year two years prior to the first fiscal year of merger shall, then the UUSD shall be eligible to receive a consolidation support grant in each of its first five fiscal years in an amount equal to the small school support grant received by the eligible school district in the fiscal year two years prior to the first fiscal year of merger. If more than one merging district was an eligible school district, then the consolidation support grant shall be in an amount equal to the total combined small school support grants they received in the fiscal year two years prior to the first fiscal year of merger.

#### Sec. 33e. UUSD FORMATION

(a) Vote to explore merger. On or before November 1, 2010, the board of every school district in the state shall discuss whether it wishes to explore merger within the supervisory union or with one or more contiguous districts

outside the supervisory union or both under the terms of this act. On or before December 1, 2010, each school district board shall vote whether to work with other boards to perform a more comprehensive analysis of potential merger, and shall report the results of its vote to the commissioner of education and the voters of the district.

(b) Subcommittee.

(1) If the boards of two or more contiguous districts vote in favor of considering merger, then the districts shall form a subcommittee, in which the vote of each district shall be weighted equally, to explore the possibility of merger, analyze its implications, and, if it concludes it is advisable, develop a merger proposal pursuant to 16 V.S.A. §§ 706, 706a, and 706b to the extent they are not contrary to specific provisions of this act.

(2) With assistance, as requested, from the department of education, the superintendent of each supervisory union of which the participating districts are members, and the UUSD merger template required by Sec. 33h of this act:

(A) the subcommittee shall analyze the advisability of merger;

(B) if the subcommittee determines that merger is advisable, then it shall prepare a proposal in the form of an agreement pursuant to 16 V.S.A. § 706b to be entered into by the districts upon affirmative vote of the electorate in each participating district determined to be “necessary” under subdivision 706b(b)(1) that, in addition to the items required by subsection 706b(b), specifies:

(i) the structures and processes that will provide opportunities for local participation, including the precise nature and authority of local participation;

(ii) whether and to what extent the voters of the participating districts wish to allow the elementary and secondary students residing within the UUSD to enroll in any school the UUSD maintains and in other schools, and whether and in what manner approved independent schools and designated schools will be included; provided, however:

(I) that the determinations shall be made in a manner that allows all students substantially equal access to educational programs and services available to students in the UUSD; and

(II) that if the proposed merger plans would provide fewer options to the students in one or more of the districts interested in merger, then the plan shall include a process by which the UUSD will pay tuition to a school pursuant to the provisions of chapter 21 of Title 16 for any student who resides within the UUSD if the student resided in one of the participating districts prior



to merger and as a result of that residency was enrolled in the school at public expense at the time of merger, even if the UUSD has determined that the school is not otherwise a school to which it would pay tuition.

(iii) the proposed UUSD budget for the first fiscal year or the first and second fiscal years of its operation, together with an explanation that if the merger proposal is approved and the proposed budget is for more than one year, then the electorate would not vote on a school budget until it voted whether to approve the proposed budget for the third fiscal year or the third and fourth fiscal years of operation;

(iv) at the subcommittee's option, a provision authorizing the UUSD, beginning in fiscal year 2018, to present multi-year proposed budgets to the electorate once in every two or three years; and

(v) a plan that addresses transitional matters related to employees of the member districts and the proposed UUSD and that:

(I) provides for the UUSD to assume all contractual obligations of the member districts under each existing collective bargaining agreement or other employment contract until the agreement's or contract's expiration, subject to employee compliance with performance standards and any lawful reduction in force, layoff, nonrenewal, or dismissal;

(II) provides for the immediate and voluntary recognition by the UUSD of the recognized representatives of the employees of the member districts as the recognized representatives of the employees of the UUSD;

(III) ensures that no nonprobationary employee of a member district shall be considered a probationary employee upon the transition to the UUSD; and

(IV) contains an agreement with the recognized representatives of the employees of the member districts, which is effective on the date on which the UUSD comes into existence, regarding how the UUSD, prior to reaching its first collective bargaining agreement with its employees, will address issues of seniority, reduction in force, layoff, and recall;

(vi) the date on which the new UUSD and its board of directors shall come into existence, which shall also be the date on which:

(I) all component districts and supervisory unions and their respective elected boards cease to exist;

(II) the members of the UUSD board, who shall be provisionally elected on the day the electorate of each potential member district votes whether to approve merger and creation of the UUSD, shall begin their respective terms; and

(III) the incentives created in Sec. 33d of this act shall begin to apply to the UUSD.

(c) Approval of merger, designation as a new unified union school district, and operation. Except as specifically provided in this act, the subcommittee shall obtain state board of education approval of the merger proposal prepared pursuant to this section, the electorate of each participating district shall vote whether to approve the proposed merger, the new UUSD shall be designated a new unified union school district, and the UUSD shall operate pursuant to the provisions of chapter 11 of Title 16.

#### Sec. 33f. ALTERNATIVE PATHS TO MERGER

Two or more school districts interested in merger may request the state board of education to consider granting them a waiver from the requirements of Sec. 33c(a) of this act, which shall be granted if the districts can demonstrate that for them the requirements of that subsection would not be cost-effective, would decrease educational opportunities, or would diminish student achievement, or any combination of these.

Sec. 33g. 16 V.S.A. § 261(e) is added to read:

(e) Notwithstanding subsections (a)–(c) of this section, the state board shall not adjust the boundaries of a supervisory district consisting of one unified union school district unless the municipalities within the district approve the adjustment pursuant to chapter 11, subchapter 4, article 4 of Title 16 and request the state board to make the adjustment.

#### Sec. 33h. MERGER TEMPLATE

The department of education shall develop a merger template to assist subcommittees formed pursuant to Sec. 33e(b) of this act or 16 V.S.A. § 706 to consider the advisability of and prepare a proposal for merger. Among other things, the template shall provide data regarding the enrollment and finances of the participating school districts and demographic statistics regarding Vermont municipalities. It shall also outline common issues considered by districts exploring merger and provide links to related resources. The department shall publish the template on its website on or before December 15, 2010.

#### Sec. 33i. APPLICATION OF LAW

(a) All provisions of chapter 11 of Title 16 and state board rules relating to unified union school districts, including the study, formation, operation, and change in membership, shall apply to UUSDs unless the provision is inconsistent with this act.

(b) 16 V.S.A. § 706h (assignment of a union school district to a supervisory union) does not apply to UUSDs formed pursuant to this act.

(c) Districts interested in forming a UUSD under the provisions of this act may request the state board of education to grant a waiver from one or more provisions of chapter 11 of Title 16, relating to union school district formation.

\* \* \* Distance Learning; Out-of-State Programs \* \* \*

Sec. 33j. 16 V.S.A. § 166(b)(6) is amended to read:

(6) This subdivision applies to an independent school located in Vermont ~~which that~~ offers a distance learning program of elementary or secondary education through correspondence, electronic mail, satellite communication, or other means and ~~which that~~, because of its structure, does not meet some or all the rules of the state board for approved independent schools. In order to be approved under this subdivision, a school shall meet the standards adopted by rule of the state board for approved independent schools ~~which that~~ can be applied to the applicant school and any other standards or rules adopted by the state board regarding these types of schools. A school approved under this subdivision shall not be eligible to receive tuition payments from public school districts under chapter 21 of this title. ~~However, a school district may enter into a contract or contracts with a school approved under this subdivision for provisions of some education services for its students.~~

Sec. 33k. 16 V.S.A. § 563(32) is added to read:

(32) May enter into a contract or contracts with a school offering a distance learning program that is approved by one or more accrediting agencies recognized by the United States Department of Education or is approved in Vermont pursuant to subdivision 166(b)(6) of this title.

\* \* \* Supervisory Union Duties; Class Size \* \* \*

Sec. 33 l. 16 V.S.A. § 261a is amended to read:

#### § 261a. DUTIES OF SUPERVISORY UNION BOARD

The board of each supervisory union shall:

(1) ~~set policy to coordinate curriculum plans among the sending and receiving schools in that supervisory union~~ establish a supervisory union-wide curriculum, by either developing the curriculum or assisting the member districts to develop it jointly, and ensure implementation of the curriculum. The curriculum ~~plans~~ shall meet the requirements adopted by the state board under subdivision 165(a)(3)(B) of this title;

(2) ~~take reasonable steps to~~ assist each school in the supervisory union to follow ~~its respective~~ the curriculum plan as adopted under the requirements of the state board pursuant to subdivision 165(a)(3)(B) of this title;

(3) if students residing in the supervisory union receive their education outside the supervisory union, periodically review the compatibility of the supervisory union's curriculum plans with those other schools;

(4) in accordance with criteria established by the state board, establish and implement a plan for receiving and disbursing federal and state funds distributed by the department of education, including funds awarded under P.L. 89-10, the Elementary and Secondary Education Act of 1965 as amended;

~~(5) provide for the establishment of a written policy on professional development of teachers employed in the supervisory union and periodically review that policy. The policy may provide financial assistance outside the negotiated agreements for teachers' professional development activities and may require the superintendent periodically to develop and offer professional development activities within the supervisory union~~ professional development programs or arrange for or enable the provision of them, or both, for teachers, administrators, and staff within the supervisory union, which may include programs offered solely to one school or other component of the entire supervisory union to meet the specific needs or interests of that component;

~~(6) provide or, if agreed upon by unanimous vote at a supervisory union meeting, coordinate provision of the following educational services on behalf of member districts:~~

~~(A) special education;~~

~~(B) except as provided in section 144b of this title, compensatory and remedial services; and~~

~~(C) other services as directed by the state board and local boards~~ provide special education services to member districts and, except as provided in section 144b of this title, compensatory and remedial services; and provide or coordinate the provision of other educational services as directed by the state board or local boards;

(7) employ a person or persons qualified to ~~manage~~ provide financial and student data management services for the supervisory union ~~accounts;~~

(8) at the option of the supervisory union, provide the following services for the benefit of member districts according to joint agreements under section 267 of this title and in a manner that promotes the efficient use of financial and human resources:

(A) ~~centralized purchasing~~ manage a system to procure and distribute goods and operational services;

(B) ~~construction management~~ manage construction projects;

(C) budgeting, accounting and other financial management provide financial and student data management services, including grant writing and fundraising as requested;

(D) teacher negotiations negotiate with teachers and administrators, pursuant to chapter 57 of this title, and with other school personnel, pursuant to chapter 22 of Title 21, at the supervisory union level provided that contracts may vary by district;

(E) transportation provide transportation or arrange for the provision of transportation, or both, if it is offered within the supervisory union; and

(F) provide human resources management support; and

(G) provide other appropriate services;

~~(9) require that the superintendent as executive officer of the supervisory union board be responsible to the commissioner and state board for reporting on all financial transactions within the supervisory union. On or before August 15 of each year, the superintendent, using a format approved by the commissioner, shall forward to the commissioner a report describing the financial operations of the supervisory union for the preceding school year. The state board may withhold any state funds from distribution to a supervisory union until such returns are made; [Repealed.]~~

(10) submit to the town auditors of each member school district or to the person authorized to perform the duties of an auditor for the school district, on or before January 15 of each year, a summary report of financial operations of the supervisory union for the preceding school year, an estimate of its financial operations for the current school year, and a preliminary budget for the supervisory union for the ensuing school year. This requirement shall not apply to a supervisory district. For each school year, the report shall show the actual or estimated amount expended by the supervisory union for special education-related services, including:

(A) A breakdown of that figure showing the amount paid by each school district within the supervisory union;

(B) A summary of the services provided by the supervisory union's use of the expended funds;

(11) on or before June 30 of each year, adopt a budget for the ensuing school year; and

(12) adopt supervisory unionwide truancy policies consistent with the model protocols developed by the commissioner.

(13)–(17) [Repealed.]

Sec. 33m. 16 V.S.A. § 242 is amended to read:

§ 242. DUTIES OF SUPERINTENDENTS

The superintendent shall be the chief executive officer for the supervisory union board and for each school board in within the supervisory district union, and shall:

(1) carry out the policies adopted by the school ~~board~~ boards relating to the educational or business affairs of the school district or supervisory union, and develop procedures to do so;

(2) ~~identify~~ prepare, for adoption by a local school board, plans to achieve the educational goals and objectives of established by the school district and prepare plans to achieve those goals and objectives for adoption by the school board;

(3) ~~recommend that the school board employ or dismiss persons as necessary to carry out the work of the school district~~ (A) nominate a candidate for employment by the school district or supervisory union if the vacant position requires a licensed employee; provided, if the appropriate board declines to hire a candidate, then the superintendent shall nominate a new candidate;

(B) select nonlicensed employees to be employed by the district or supervisory union; and

(C) dismiss licensed and nonlicensed employees of a school district or the supervisory union as necessary, subject to all procedural and other protections provided by contract, collective bargaining agreement, or provision of state and federal law;

(4)~~(A) furnish the commissioner~~ provide data and information required by the commissioner; ~~and~~

(B) report all financial operations within the supervisory union to the commissioner and state board for the preceding school year on or before August 15 of each year, using a format approved by the commissioner;

(C) report all financial operations for each member school district to the commissioner and state board for the preceding school year on or before August 15 of each year, using a format approved by the commissioner; and

(D) prepare for each district an itemized report detailing the portion of the proposed supervisory union budget for which the district would be assessed for the subsequent school year identifying the component costs by category and explaining the method by which the district's share for each cost was calculated; and provide the report to each district at least 14 days before a

budget, including the supervisory union assessment, is voted on by the electorate of the district;

(5) work with the school boards of the member districts to develop and implement policies regarding minimum and optimal average class sizes for regular and technical education classes. The policies may be supervisory union-wide, may be course- or grade-specific, and may reflect differences among school districts due to geography or other factors; and

(6) provide for the general supervision of the public schools in the supervisory union or district.

Sec. 33n. 16 V.S.A. § 563(11)(C) is amended to read:

(C) At a school district's annual or special meeting, the electorate may vote to provide notice of availability of the school budget required by this subdivision to the electorate in lieu of distributing the budget. If the electorate of the school district votes to provide notice of availability, it must specify how notice of availability shall be given, and such notice of availability shall be provided to the electorate at least 30 days before the district's annual meeting. The proposed budget shall be prepared and distributed at least ten days before a sum of money is voted on by the electorate. Any proposed budget shall show the following information in a format prescribed by the commissioner of education:

(i) all revenues from all sources, and expenses, including as separate items any assessment for a supervisory union of which it is a member, and any tuition to be paid to a technical center; and including the report required in subdivision 242(4)(D) of this title itemizing the component costs of the supervisory union assessment;

\* \* \*

Sec. 33o. 16 V.S.A. § 1981(8) and (9) are amended to read:

(8) "School board negotiations council" means, for a supervisory district, its school board, and, for school districts within a supervisory union, the body comprising representatives designated by each school board within the supervisory union to engage in professional negotiations with a teachers' or administrators' organization.

~~(A) School districts within a supervisory union that has more than one public high school, however, may form separate negotiations councils, each consisting of representatives, as appropriate, designated by:~~

~~(i) Each school district providing kindergarten through grade 12 within the supervisory union; or~~

~~(ii) The school board for a high school within the supervisory union and the board of each elementary school, if any, that sends its students to the high school.~~

~~(B) A school district, however, may form a separate negotiations council if it:~~

~~(i) Maintains a school but does not offer grades 9 through 12;~~

~~(ii) Is not a member of a union high school district; and~~

~~(iii) Is in a supervisory union that includes a district providing kindergarten through grade 12.~~

(9) “Teachers’ organization negotiations council” or “administrators’ organization negotiations council” means the body comprising representatives designated by each teachers’ organization or administrators’ organization within a supervisory district or supervisory union to act as its representative for professional negotiations.

~~(A) Teachers’ or administrators’ organizations within a supervisory union that has more than one public high school, however, may form separate negotiations councils, each consisting of representatives designated by the teachers’ or administrators’ organization, as appropriate, of:~~

~~(i) Each school district providing kindergarten through grade 12 within the supervisory union; or~~

~~(ii) A high school within the supervisory union and of each elementary school, if any, that sends its students to the high school.~~

~~(B) A teachers’ or administrators’ organization, however, may form a separate negotiations council if it is within a school district that:~~

~~(i) Maintains a school but does not offer grades 9 through 12;~~

~~(ii) Is not a member of a union high school district; and~~

~~(iii) Is in a supervisory union that includes a district providing kindergarten through grade 12.~~

Sec. 33p. 21 V.S.A. § 1722(18) and (19) are amended to read:

(18) “School board negotiations council” means, for a supervisory district, its school board, and, for school districts within a supervisory union, the body comprising representatives designated by each school board within the supervisory union to engage in collective bargaining with their school employees’ negotiations council.



~~(A) School districts within a supervisory union that has more than one public high school, however, may form separate negotiations councils, each consisting of representatives, as appropriate, designated by:~~

~~(i) Each school district providing kindergarten through grade 12 within the supervisory union; or~~

~~(ii) The school board for a high school within the supervisory union and the board of each elementary school, if any, that sends its students to the high school.~~

~~(B) A school district, however, may form a separate negotiations council if it:~~

~~(i) Maintains a school but does not offer grades nine through 12;~~

~~(ii) Is not a member of a union high school district; and~~

~~(iii) Is in a supervisory union that includes a district providing kindergarten through grade 12.~~

(19) “School employees’ negotiations council” means the body comprising representatives designated by each exclusive bargaining agent within a supervisory district or supervisory union to engage in collective bargaining with its school board negotiations council.

~~(A) Exclusive bargaining agents within a supervisory union that has more than one public high school, however, may form separate negotiations councils, each consisting of representatives designated by the exclusive bargaining agent, as appropriate, of:~~

~~(i) Each school district providing kindergarten through grade 12 within the supervisory union; or~~

~~(ii) A high school within the supervisory union and of each elementary school, if any, that sends its students to the high school.~~

~~(B) An exclusive bargaining agent, however, may form a separate negotiations council if it is within a school district that:~~

~~(i) Maintains a school but does not offer grades nine through 12;~~

~~(ii) Is not a member of a union high school district; and~~

~~(iii) Is in a supervisory union that includes a district providing kindergarten through grade 12.~~

Sec. 33q. MINIMUM AND OPTIMAL CLASS SIZE POLICIES

(a) On or before December 31, 2010, the policy required by Sec. 33m, 16 V.S.A. § 242(5), of this act regarding minimum and optimal average class size shall be:

- (1) adopted by each supervisory union board and member district board;
- (2) posted on the website maintained by the supervisory union; and
- (3) forwarded to the commissioner of education.

(b) On or before August 31, 2010, the commissioner of education shall develop two or more model policies regarding minimum and optimal class size and shall post them on the department's website.

Sec. 33r. REPEAL

16 V.S.A. § 563(13) (duty of school district board to report financial information to the commissioner) is repealed.

\* \* \* Reports; Effective Dates; Transitional Issues \* \* \*

Sec. 33s. REPORTS; EFFECTS OF MERGER; RECOMMENDATIONS

(a) On or before December 1, 2010, the commissioner of education shall report to the house and senate committees on education regarding the school boards that have voted to consider merger.

(b) On or before March 15, 2011, and in every January thereafter through 2017, the commissioner shall report to the house and senate committees on education regarding the status of merger discussions and votes.

(c) The James M. Jeffords Center of the University of the Vermont, the department of education, and school districts participating in the voluntary merger process authorized by this act shall collaborate to study:

(1) data and comments from school districts and supervisory unions statewide that are discussing voluntary merger;

(2) the results of local district elections to approve voluntary merger under the provisions of this act; and

(3) in connection with UUSDs that are formed under the provisions of this act:

(A) real dollar efficiencies realized;

(B) operational efficiencies realized;

(C) changes in student learning opportunities; and

(D) changes in student outcomes.

(d) On or before January 15, 2018, the James M. Jeffords Center and the department of education shall present a final report concerning the study required in subsection (c) of this section, including recommendations to the house and senate committees on education regarding what further actions, if any, should be pursued to encourage or require merger by nonparticipating school districts, and shall provide interim reports in each January until that date.

#### Sec. 33t. RECOMMENDATIONS; SMALL SCHOOLS

On or before January 15, 2011, the commissioner of education shall develop and present to the general assembly a detailed proposal to:

(1) identify annually the school districts that are “eligible school districts” pursuant to 16 V.S.A. § 4015 due to geographic necessity, including the criteria that indicate geographic necessity;

(2) calculate and adjust the level of additional financial support necessary for the districts identified in subdivision (1) of this section to provide an education to resident students in compliance with state education quality standards and other state and federal laws; and

(3) withdraw small school support gradually from districts that are “eligible school districts” pursuant to 16 V.S.A. § 4015 as currently enacted but will not be identified as “eligible school districts” pursuant to subdivision (1) of this section.

#### Sec. 33u. LEGISLATIVE COUNCIL; STATUTORY REVISION

(a) Pursuant to the statutory revision authority provided in 2 V.S.A. § 424, the legislative council shall make technical amendments to the Vermont Statutes Annotated that are necessary to effect the intent of this act.

(b) On or before January 1, 2011, the legislative council shall prepare a draft bill and provide it to the house and senate committees on education that proposes statutory changes necessary to effect the intent of this act.

#### Sec. 33v. TRANSITION

Each supervisory union shall provide for any transition of employment of special education staff by member districts to employment by the supervisory union, pursuant to Sec. 33 l of this act, 16 V.S.A. § 261a(6), by:

(1) providing that the supervisory union assumes all obligations of each existing collective bargaining agreement in effect between the member districts and their special education employees until the agreement’s expiration, subject to employee compliance with performance standards and any lawful reduction in force, layoff, nonrenewal, or dismissal;

(2) providing, in the absence of an existing recognized representative of its employees, for the immediate and voluntary recognition by the supervisory union of the recognized representatives of the employees of the member districts as the recognized representatives of the employees of the supervisory union;

(3) ensuring that no nonprobationary employee of a member district shall be considered a probationary employee upon transition to the supervisory union; and

(4) containing an agreement with the recognized representatives of the employees of the member districts that is effective on the day the supervisory union assumes obligations of existing agreements regarding how the supervisory union, prior to reaching its first collective bargaining agreement with its special education employees, will address issues of seniority, reduction in force, layoff, and recall.

#### Sec. 33w. EFFECTIVE DATES

(a) Secs 33 l through 33p of this act shall take effect on July 1, 2012.

(b) This section and all other sections of this act shall take effect on passage, subject to the provisions of existing contracts.

#### **Amendment to be offered by Rep. Marcotte of Coventry to H. 792**

Rep. Marcotte of Coventry moves that the bill be amended after Sec. 33 and before the internal caption “\* \* \* Environmental and Energy Regulation \* \* \*” by inserting a new section to be Sec. 33a to read:

#### Sec. 33a. COLLECTIVE BARGAINING; REDUCTIONS IN FORCE

Each collective bargaining agreement or other employment contract executed on or after this act’s date of passage between a supervisory union or school district and its employees for fiscal years 2011 through 2014 shall require that when making decisions related to reductions in force, the employer’s considerations shall include each licensed educator’s competency in one or more endorsement areas, competency in teaching the grade or grades or the subject or subjects for which a position is available, and seniority; provided, however, that seniority shall not be the conclusive or determinative factor.

#### **Amendment to be offered by Rep. Higley of Lowell to H. 792**

Rep. Higley of Lowell moves that the bill be amended after Sec. 33 and before the internal caption “\* \* \* Environmental and Energy Regulation \* \* \*” by inserting a new section to be Sec. 33a to read:

#### Sec. 33a. ONE-YEAR CONTRACTS; SCHOOL EMPLOYEES

No collective bargaining agreement or other employment contract executed on or after this act's date of passage between a supervisory union or school district and its employees for fiscal years 2011 through 2014 shall contain any provision that shall be in effect for more than one year.

**Amendment to be offered by Rep. Kilmartin of Newport City to H. 792**

Rep. Kilmartin of Newport City moves that the bill be amended after Sec. 33 and before the internal caption “\* \* \* Environmental and Energy Regulation \* \* \*” by inserting a new section to be Sec. 33a to read:

Sec. 33a. OPEN MEETINGS; SCHOOL EMPLOYEES; FACT FINDING; ARBITRATION

Notwithstanding 1 V.S.A. § 313, 16 V.S.A. § 2007, 16 V.S.A. § 2022, and any other provision of law to the contrary, for negotiations related to collective bargaining agreements for fiscal years 2011 through 2014:

(1) post impasse proceedings shall be open and available to the public, including all hearings, testimony, written evidence, records, papers, and information provided in connection with fact-finding pursuant to 16 V.S.A. § 2007 and arbitration pursuant to 16 V.S.A. chapter 57, subchapter 4;

(2) the fact-finding committee shall make public the report required under 16 V.S.A. § 2007 contemporaneously with its delivery to the parties;

(3) the arbitrator shall make the decision under 16 V.S.A. § 2022 shall be made public contemporaneously with its delivery to the parties.

**Favorable with amendment**

**S. 239**

An act relating to retiring outdoor wood-fired boilers that do not meet the 2008 emission standard for particulate matter

**Rep. Weston of Burlington**, for the Committee on Natural Resources and Energy, recommends that the House propose to the Senate that the bill be amended as follows:

First: In Sec. 2, 10 V.S.A. § 584, in subdivision (e)(1), after “another” by striking “type of”

Second: In Sec. 2, 10 V.S.A. § 584, in subsection (g), after “health” by adding “care” and in the phrase “and has resulted or results” by striking “and” and inserting in lieu thereof “or”

Third: In Sec. 2, 10 V.S.A. § 584, in subsection (i), in the first sentence, in the phrase “closer than 100 feet” by striking “100 feet” and inserting in lieu thereof “the setback distance”

**(Committee vote: 11-0-0 )**

**(For text see Senate Journal 3/24/10 )**

**Rep. Winters of Williamstown**, for the Committee on **Appropriations**, recommends the bill ought to pass when amended as recommended by the Committee on **Natural Resources and Energy** and when further amended as follows:

By adding a new Sec. 3 to read:

**Sec. 3. USE OF FUNDS**

The agency of natural resources is authorized to use funds from the American Electric Power Service Corporation Settlement Funds described in 10 V.S.A. § 584(b), for the purposes of this act, as follows:

(1) In fiscal year 2011, the agency is authorized to use \$360,000.00 of these funds, which amount is included in the sum appropriated in Sec. B.710 of H. 789 of the 2009 adjourned session, as enacted; and

(2) In fiscal year 2012, it is the intent of the general assembly that the agency be authorized to use at least \$140,000.00 from that same Settlement Fund source.

and by renumbering the existing Sec. 3 as Sec. 4

**( Committee Vote: 11-0-0)**

**S. 268**

An act relating to the building bright futures council

**Rep. Frank of Underhill**, for the Committee on Human Services, recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

**Sec. 1. FINDINGS**

The general assembly finds that:

(1) While Vermont has a wide range of high-quality programs for families and young children, a report issued by the Smart Start National Technical Assistance Center states, “Vermont’s early childhood system might be best described as many diverse patches, or pieces, ready to be linked and sewn together into a New England patchwork quilt.”

(2) In order to address issues of overlap and fragmentation, program accountability, and equitable access to services across the state, engaged community members, policy-makers, early childhood service providers, and advocates agree that there is a need for a comprehensive and integrated system for all children below the age of six and their families in Vermont who are in need of and desiring such services.

(3) Research shows that a child’s “environment of relationships” has a critical impact on developing brain architecture during the first months and years of life.

(4) There are approximately 39,000 children under the age of six in Vermont, including over 5,500 in poverty, 11,000 living in single-parent households, 20,489 living in two-parent households with both parents in the labor force, and approximately 1,300 young children with developmental delays.

(5) An estimated 23,000 children under the age of six are enrolled full- or part-time in over 1,900 registered or licensed child care programs funded by a combination of parent fees and public dollars such as the Child Care Financial Assistance Program and the Education Fund. Programs that receive no public funds generally have little to no formal connection to an overall early childhood system with established goals and policies for addressing the needs of young children.

(6) In addition to the care by their parents and families, thousands of Vermont children from a range of socioeconomic backgrounds receive services, support, or both from state, federal, and private programs. Many children are served by multiple programs with no mechanism in place to ensure a holistic, family-centered approach to service delivery. Early childhood services are important to the economic well-being of families throughout the state. They have a positive impact on the state’s labor supply and influence the overall economic competitiveness of the state.

(7) Section 642B of the federal Improving Head Start for School Readiness Act of 2007 mandates that the governor “designate or establish a council to serve as the State Advisory Council on Early Childhood Education and Care for children from birth to school entry, and the Governor may designate an existing entity in the State to serve as the State Advisory Council.” The governor has designated the building bright futures state council as Vermont’s entity.

(8) In November 2009, the building bright futures state council adopted a conceptual framework based on the work of Dr. Jack Shonkoff, a Harvard

University professor and one of the nation's foremost experts on early childhood learning.

Sec. 2. 33 V.S.A. chapter 46 is added to read:

CHAPTER 46. BUILDING BRIGHT FUTURES COUNCIL

§ 4601. DEFINITIONS

As used in this chapter:

(1) "Early care, health, and education" means all services provided to families expecting a child and to children up to the age of six, including child care, family support, early education, mental and physical health services, nutrition services, and disability services.

(2) "Regional council" means a regional entity linked to the state building bright futures council to support the creation of an integrated system of early care, health, and education at the local level.

§ 4602. BUILDING BRIGHT FUTURES COUNCIL

(a) The building bright futures program shall be governed by a statewide council comprising no more than 23 members. The building bright futures council's membership shall be as follows:

(1) the secretary of human services or designee;

(2) the secretary of commerce and community development or designee;

(3) the commissioner of education;

(4) the commissioner for children and families;

(5) the commissioner of health;

(6) the commissioner of mental health;

(7) two members of the house of representatives, appointed by the speaker of the house;

(8) at least one but no more than two members of the senate, appointed by the senate committee on committees;

(9) the Head Start collaboration office director; and

(10) 12 at-large members selected on the basis of their commitment to early childhood well-being and representing a range of perspectives and geographic diversity. One of the at-large members shall be a representative of a local Head Start program and one shall be a member of a school board, to be chosen by the Vermont school boards association.



(b) In the event of a vacancy in one of the at-large member positions on the council, the remaining members shall endeavor to fill the vacancy with an individual representing a perspective or geographic area not currently represented on the council.

(c) Technical assistance to the council shall be provided by staff within the departments of health, of education, and for children and families.

(d) For council meetings held when the general assembly is not in session, the legislative members of the council shall be entitled to per diem compensation and reimbursement of expenses in accordance with section 406 of Title 2. Members of the council who are not state employees or whose participation is not supported through their employment or association may be entitled to compensation and reimbursement for expenses for attending meetings of the council under section 1010 of Title 32 to the extent funds are available.

(e) The council shall function as a public-private partnership with the ability to raise and disburse funds.

(f) The council shall support the establishment of, and maintenance of relationships with, regional councils providing regional capacity to further the council's goals.

#### § 4603. POWERS AND DUTIES

The council established by section 4602 of this title shall have the following powers and duties necessary and appropriate to effectuating the purposes of this chapter:

(1) Advise the administration and general assembly on the status and needs of the early care, health, and education system by conducting a review of the status of young children in Vermont and the care, health, and education services and systems that support them.

(2) Monitor overall system performance by regularly tracking and reporting system data on the well-being of young children and the performance of the system of care related to the council's commitments to children and selected indicators.

(3) Develop an early care, health, and education system plan for Vermont to serve as the basis for policy and funding recommendations.

(4) Review and formulate recommendations for amendments or revisions to policies, rules, or regulations that may impede the ability to address state and local priorities and the ability to ensure system effectiveness.

(5) Work with the secretaries of human services and of commerce and community development and the commissioner of education to ensure the coordination of existing budgets and policies that affect the care, health, and education of young children.

(6) Identify and reduce duplication of services and of administrative approval processes and improve coordination across agencies.

(7) Work with the agencies of human services and of commerce and community development, the department of education, and the regional councils to coordinate and integrate the development of an early childhood budget that reflects alignment of funding with priorities identified in the system plan.

(8) Support the regional councils in their efforts to coordinate and implement services in accordance with identified priorities in system and regional plans.

(9) Contract with state agencies and departments to deliver services as agreed upon.

(10) Pursue and accept funding from diverse sources outside of state government to sustain, expand, and enhance the early care, health, and education system according to the early care, health, and education system plan.

(11) Disburse funds raised through fund development activities in accordance with priorities defined in the system plan.

(12) Convene members of the child care community, medical community, education community, and other organizations, as well as state agencies serving young children, to ensure that families receive quality services in the most efficient and cost-effective manner.

(13) Select the key indicators to be tracked in early childhood and identify priority strategies to improve outcomes.

(14) Ensure children from birth to six years of age are included in statistical data systems developed by the department of education and other state agencies and that all such systems are interoperable.

(15) Analyze data to assess progress in achieving outcomes consistent with No. 68 of the Acts of the 2009 Adj. Sess. (2010) and make recommendations for any necessary adjustments.

(16) Report to the governor and the legislative committees of jurisdiction during the first month of each legislative biennium on the council's findings and recommendations, progress toward outcomes consistent with No.

68 of the Acts of the 2009 Adj. Sess. (2010), and recommendations for priorities for the biennium.

§ 4604. LIMITATION OF SCOPE

Nothing in this chapter shall be construed to supersede or usurp the statutory powers or authority of any state agency or department or any school district.

Sec. 2. COMPOSITION OF COUNCIL

The members of the building bright futures council serving as of the effective date of this act shall continue to serve on the council after that date and shall adopt bylaws detailing the council's governance and procedures.

Sec. 3. EFFECTIVE DATE

This act shall take effect upon passage.

**(Committee vote: 9-0-2 )**

**(For text see Senate Journal 2/25/10 )**

**Senate Proposal of Amendment**

**H. 540**

An act relating to motor vehicles passing vulnerable users on the highway and to bicycle operation

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

Sec. 1. 23 V.S.A. § 4(81) is added to read:

(81) "Vulnerable user" means a pedestrian; an operator of highway building, repair, or maintenance equipment or of agricultural equipment; a person operating a wheelchair or other personal mobility device, whether motorized or not; a person operating a bicycle or other nonmotorized means of transportation (such as, but not limited to, roller skates, rollerblades, or roller skis); or a person riding, driving, or herding an animal.

Sec. 2. 23 V.S.A. § 1033 is amended to read:

§ 1033. ~~PASSING ON THE LEFT~~ **PASSING ON THE LEFT MOTOR VEHICLES AND VULNERABLE USERS**

(a) ~~Vehicles~~ **Passing motor vehicles.** Motor vehicles proceeding in the same direction may be overtaken and passed only as follows:

(1) The driver of a motor vehicle overtaking another motor vehicle proceeding in the same direction may pass to its left at a safe distance, and

when so doing shall exercise due care, ~~may~~ shall not pass to the left of the center of the highway unless the way ahead is clear of approaching traffic, and shall not again drive to the right side of the roadway until safely clear of the overtaken vehicle.

(2) Except when overtaking and passing on the right is permitted, the driver of an overtaken motor vehicle shall give way to the right in favor of the overtaking motor vehicle on audible signal and shall not increase the speed of his or her vehicle until completely passed by the overtaking vehicle.

(b) Passing vulnerable users. The operator of a motor vehicle approaching or passing a vulnerable user as defined in subdivision 4(81) of this title shall exercise due care, which includes increasing clearance, to pass safely the vulnerable user.

Sec. 3. 23 V.S.A. § 1039 is amended to read:

§ 1039. FOLLOWING TOO CLOSELY, CROWDING, AND HARASSMENT

(a) The driver of a vehicle shall not follow another vehicle more closely than is reasonable and prudent, having due regard for the speed of the vehicles and the traffic upon, and the conditions of, the highway. The operator of a vehicle shall not, in a careless or imprudent manner, approach, pass, or maintain speed unnecessarily close to a vulnerable user as defined in subdivision 4(81) of this title, and an occupant of a vehicle shall not throw any object or substance at a vulnerable user.

\* \* \*

Sec. 4. 23 V.S.A. § 1065 is amended to read:

§ 1065. HAND SIGNALS

(a) ~~All~~ A right or left turn shall not be made without first giving a signal of intention either by hand or by signal in accordance with section 1064 of this title. Except as provided in subsection (b) of this section, all signals to indicate change of speed or direction, when given by hand, shall be given from the left side of the vehicle and in the following manner:

- (1) Left turn. – Hand and arm extended horizontally.
- (2) Right turn. – Hand and arm extended upward.
- (3) Stop or decrease speed. – Hand and arm extended downward.

(b) ~~No turn to right or left may be made without first giving a signal of an intention to do so either by hand or by signal in accordance with section 1064 of this title~~ A person operating a bicycle may give a right-turn signal by

extending the right hand and arm horizontally and to the right side of the bicycle.

Sec. 5. 23 V.S.A. § 1127 is amended to read:

§ 1127. CONTROL IN PRESENCE OF ~~HORSES AND CATTLE~~ ANIMALS

(a) Whenever upon a public highway and approaching a vehicle drawn by a ~~horse or other~~ draft animal, ~~or approaching a horse or other~~ an animal upon which a person is riding, or animals being herded, the operator of a motor vehicle shall operate the vehicle in such a manner as to exercise every reasonable precaution to prevent the frightening of ~~such horse or any~~ animal and to ~~insure~~ ensure the safety and protection of the animal and the person riding or, driving, or herding.

(b) The operator of a motor vehicle shall yield to any ~~cattle, sheep, or goats~~ which are animals being herded on or across a highway.

Sec. 6. 23 V.S.A. § 1139(a) is amended to read:

(a) A person operating a bicycle upon a roadway shall exercise due care when passing a standing vehicle or one proceeding in the same direction and generally shall ride as near to the right side of the roadway as practicable ~~exercising due care when passing a standing vehicle or one proceeding in the same direction,~~ but shall ride to the left or in a left lane when:

(1) preparing for a left turn at an intersection or into a private roadway or driveway;

(2) approaching an intersection with a right turn lane if not turning right at the intersection;

(3) overtaking another highway user; or

(4) taking reasonably necessary precautions to avoid hazards or road conditions.

Sec. 7. 23 V.S.A. § 1141(a) is amended to read:

(a) ~~No~~ A person ~~may~~ shall not operate a bicycle at nighttime from one-half hour after sunset until one-half hour before sunrise unless it is equipped with a lamp on the front, which emits a white light visible from a distance of at least 500 feet to the front, and with a lamp on the rear, which emits a flashing or steady red reflector on the rear, which light that shall be visible at least 300 feet to the rear when directly in front of lawful upper beams of head lamps on a motor vehicle. ~~Lamps emitting red lights visible to the rear may be used in addition to the red reflector.~~ In addition, bicyclists shall operate during these hours with reflective, rear-facing material on pedals, shoes, or ankle bands.

Sec. 8. REPEAL

23 V.S.A. § 1053 (passing pedestrians on a highway) is repealed.

(For text see House Journal 3/18/10 )

#### **H. 648**

An act relating to harassment and hazing policies at independent colleges

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

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

Sec. 2. REPEAL

The following sections in Title 16 are repealed:

(1) 16 V.S.A. § 2182 (harassment and hazing prevention policies; Vermont state colleges).

(2) 16 V.S.A. § 2284 (harassment and hazing prevention policies; University of Vermont).

Second: In Sec. 4, by striking the words “Independent postsecondary” and inserting in lieu thereof the word “Postsecondary”

and that after passage the title of the bill be amended to read: "An act relating to harassment and hazing policies at postsecondary schools"

(For text see House Journal 3/16/10 )

**Action Postponed Until May 28, 2010**

**Governors Veto**

#### **H. 436**

An act relating to decommissioning funds of nuclear energy generation plants.

Pending Question: Shall the House sustain the Governor's veto?

**NOTICE CALENDAR**

**Favorable with Amendment**

#### **S. 88**

An act relating to health care financing and universal access to health care in Vermont

**Rep. Maier of Middlebury**, for the Committee on **Health Care**, recommends that the House propose to the Senate that the bill be amended by

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

\* \* \* HEALTH CARE REFORM PROVISIONS \* \* \*

Sec. 1. FINDINGS

The general assembly finds that:

(1) The escalating costs of health care in the United States and in Vermont are not sustainable.

(2) The cost of health care in Vermont is estimated to increase by \$1 billion, from \$4.9 billion to \$5.9 billion, by 2012.

(3) Vermont's per-capita health care expenditures are estimated to be \$9,463.00 in 2012, compared to \$7,414.00 per capita in 2008.

(4) The average annual increase in Vermont per-capita health care expenditures from 2009 to 2012 is expected to be 6.3 percent. National per-capita health care spending is projected to grow at an average annual rate of 4.8 percent during the same period.

(5) From 2004 to 2008, Vermont's per-capita health care expenditures grew at an average annual rate of eight percent compared to five percent for the United States.

(6) At the national level, health care expenses are estimated at 18 percent of GDP and are estimated to rise to 34 percent by 2040.

(7) Vermont's health care system covers a larger percentage of the population than that of most other states, but still about seven percent of Vermonters lack health insurance coverage.

(8) Of the approximately 47,000 Vermonters who remain uninsured, more than one-half qualify for state health care programs, and nearly 40 percent of those who qualify do so at an income level which requires no premium.

(9) Many Vermonters do not access health care because of unaffordable insurance premiums, deductibles, co-payments, and coinsurance.

(10) In 2008, 15.4 percent of Vermonters with private insurance were underinsured, meaning that the out-of-pocket health insurance expenses exceeded five to 10 percent of a family's annual income depending on income level or that the annual deductible for the health insurance plan exceeded five percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums.

(11) At a time when high health care costs are negatively affecting families, employers, nonprofit organizations, and government at the local,

state, and federal levels, Vermont is making positive progress toward health care reform.

(12) An additional 30,000 Vermonters are currently covered under state health care programs than were covered in 2007, including approximately 12,000 Vermonters who receive coverage through Catamount Health.

(13) Vermont's health care reform efforts to date have included the Blueprint for Health, a vision, plan, and statewide partnership that strives to strengthen the primary care health care delivery and payment systems and create new community resources to keep Vermonters healthy. Expanding the Blueprint for Health statewide may result in a significant systemwide savings in the future.

(14) Health information technology, a system designed to promote patient education, patient privacy, and physician best practices through the shared use of electronic health information by health care facilities, health care professionals, public and private payers, and patients, has already had a positive impact on health care in this state and should continue to improve quality of care in the future.

(15) Indicators show Vermont's utilization rates and spending are significantly lower than those of the vast majority of other states. However, significant variation in both utilization and spending are observed within Vermont which provides for substantial opportunity for quality improvements and savings.

(16) Other Vermont health care reform efforts that have proven beneficial to thousands of Vermonters include Dr. Dynasaur, VHAP, Catamount Health, and the department of health's wellness and prevention initiatives.

(17) Testimony received by the senate committee on health and welfare and the house committee on health care makes it clear that the current best efforts described in subdivisions (12), (13), (14), (15), and (16) of this section will not, on their own, provide health care coverage for all Vermonters or sufficiently reduce escalating health care costs.

(18) Only continued structural reform will provide all Vermonters with access to affordable, high quality health care.

(19) Federal health care reform efforts will provide Vermont with many opportunities to grow and a framework by which to strengthen a universal and affordable health care system.

(20) To supplement federal reform and maximize opportunities for this state, Vermont must provide additional state health care reform initiatives.



\* \* \* HEALTH CARE SYSTEM DESIGN \* \* \*

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM

The general assembly adopts the following principles as a framework for reforming health care in Vermont:

(1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health services for all Vermonters. All Vermonters must have access to comprehensive, quality health care. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time.

(2) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms in the health care system.

(3) Primary care must be preserved and enhanced so that Vermonters have care available to them; preferably, within their own communities. Other aspects of Vermont's health care infrastructure must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.

(4) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be evaluated for improvement in access, quality, and reliability and for a reduction in cost.

(5) A system for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and reducing care that does not improve health outcomes, must be implemented for the health of the Vermont economy.

(6) The financing of health care in Vermont must be sufficient, fair, sustainable, and shared equitably.

(7) State government must ensure that the health care system satisfies the principles in this section.

Sec. 3. GOALS OF HEALTH CARE REFORM

Consistent with the adopted principles for reforming health care in Vermont, the general assembly adopts the following goals:

(1) The purpose of the health care system design proposals created by this act is to ensure that individual programs and initiatives can be placed into

a larger, more rational design for access to, the delivery of, and the financing of affordable health care in Vermont.

(2) Vermont's primary care providers will be adequately compensated through a payment system that reduces administrative burdens on providers.

(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems that:

(A) are coordinated;

(B) focus on meeting community health needs;

(C) match service capacity to community needs;

(D) provide information on costs, quality, outcomes, and patient satisfaction;

(E) use financial incentives and organizational structure to achieve specific objectives;

(F) improve continuously the quality of care provided; and

(G) contain costs.

(4) To ensure financial sustainability of Vermont's health care system, the state is committed to slowing the rate of growth of total health care costs, preferably to reducing health care costs below today's amounts, and to raising revenues that are sufficient to support the state's financial obligations for health care on an ongoing basis.

(5) Health care costs will be controlled or reduced using a combination of options, including:

(A) increasing the availability of primary care services throughout the state;

(B) simplifying reimbursement mechanisms throughout the health care system;

(C) reducing administrative costs associated with private and public insurance and bill collection;

(D) reducing the cost of pharmaceuticals, medical devices, and other supplies through a variety of mechanisms;

(E) aligning health care professional reimbursement with best practices and outcomes rather than utilization;

(F) efficient health facility planning, particularly with respect to technology; and

(G) increasing price and quality transparency.

(6) All Vermont residents, subject to reasonable residency requirements, will have universal access to and coverage for health services that meet defined benefits standards, regardless of their age, employment, economic status, or their town of residency, even if they require health care while outside Vermont.

(7) A system of health care will provide access to health services needed by individuals from birth to death and be responsive and seamless through employment and other life changes.

(8) A process will be developed to define packages of health services, taking into consideration scientific and research evidence, available funds, and the values and priorities of Vermonters, and analyzing required federal health benefit packages.

(9) Health care reform will ensure that Vermonters' health outcomes and key indicators of public health will show continuous improvement across all segments of the population.

(10) Health care reform will reduce the number of adverse events from medical errors.

(11) Disease and injury prevention, health promotion, and health protection will be key elements in the health care system.

Sec. 4. 2 V.S.A. § 901 is amended to read:

§ 901. CREATION OF COMMISSION

(a) There is established a commission on health care reform. The commission, under the direction of co-chairs who shall be appointed by the speaker of the house and president pro tempore of the senate, shall monitor health care reform initiatives and recommend to the general assembly actions needed to attain health care reform.

(b)(1) Members of the commission shall include four representatives appointed by the speaker of the house, four senators appointed by the committee on committees, and two nonvoting members appointed by the governor, one nonvoting member with experience in health care appointed by the speaker of the house, and one nonvoting member with experience in health care appointed by the president pro tempore of the senate.

(2) The two nonvoting members with experience in health care shall not be in the employ of or holding any official relation to any health care provider or insurer, or engaged in the management of a health care provider or insurer, or owning stock, bonds, or other securities thereof, or who is, in any manner,

connected with the operation of a health care provider or insurer. In addition, these two members shall not render professional health care services or make or perform any business contract with any health care provider or insurer if such service or contract relates to the business of the health care provider or insurer, except contracts made as an individual or family in the regular course of obtaining health care services.

\* \* \*

#### Sec. 5. APPOINTMENT; COMMISSION ON HEALTH CARE REFORM

Within 15 days of enactment, the speaker of the house and the president pro tempore of the senate shall appoint the new members of the joint legislative commission on health care reform as specified in Sec. 4 of this act. All other current members, including those appointed by the governor and the legislative members, shall continue to serve their existing terms.

#### Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1) By February 1, 2011, one or more consultants of the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general assembly and the governor at least three design options, including implementation plans, for creating a single system of health care which ensures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multipayer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act.

(2)(A)(i) One option shall design a government-administered and publicly financed "single-payer" health benefits system decoupled from employment which prohibits insurance coverage for the health services provided by this system and allows for private insurance coverage only of supplemental health services.

(ii) One option shall design a public health benefit option administered by state government, which allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans.

(iii) One option shall design a system based on Vermont's current health care reform initiatives as provided for in 3 V.S.A. § 2222a, on the provisions in this act expanding the state's health care reform initiatives, and on the new federal insurance exchange, insurance regulatory provisions, and other provisions in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, which

further the principles in Sec. 2 of this act, the goals in Sec. 3 or the parameters described in this section.

(B) Any additional options shall be designed by the consultant, in consultation with the commission, taking into consideration the principles in Sec. 2 of this act, the goals in Sec. 3 and the parameters described in this section.

(3) Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.

(4) The proposal to the general assembly and the governor shall include a recommendation for which of the design options best meets the principles and goals outlined in Secs. 2 and 3 of this act in an affordable, timely, and efficient manner.

(b) No later than 45 days after enactment, the commission shall propose to the joint fiscal committee a recommendation, including the requested amount, for one or more outside consultants who have demonstrated experience in health care systems or designing health care systems that have expanded coverage and contained costs to provide the expertise necessary to do the analysis and design required by this act. Within seven days of the commission's proposal, the joint fiscal committee shall meet and may accept, reject, or modify the commission's proposal.

(c) In creating the designs, the consultant shall review and consider the following fundamental elements:

(1) the findings and reports from previous studies of health care reform in Vermont, including the Universal Access Plan Report from the health care authority, November 1, 1993; reports from the Hogan Commission; relevant studies provided to the state of Vermont by the Lewin Group; and studies and reports provided to the commission.

(2) existing health care systems or components thereof in other states or countries as models.

(3) Vermont's current health care reform efforts as defined in 3 V.S.A. § 2222a.

(4) the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (CHIP) of the Social Security Act.

(d) Each design option shall propose a single system of health care which

maximizes the federal funds to support the system and is composed of the following components, which are described in subsection (e) of this section:

(1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;

(2) coordinated local delivery systems;

(3) health system planning, regulation, and public health;

(4) financing and proposals to maximize federal funding; and

(5) a method to address compliance of the proposed design option or options with federal law.

(e) In creating the design options, the consultant shall include the following components for each option:

(1) A payment system for health services.

(A)(i) Packages of health services. In order to allow the general assembly a choice among varied packages of health services in each design option, the consultant shall provide at least two packages of health services providing for the integration of physical and mental health as further described in subdivision (A)(ii) of this subdivision (1) as part of each design option.

(ii)(I) Each design option shall include one package of health services which includes access to and coverage for primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health services.

(II) Each design option shall include at least one additional package of health services, which includes the services described in subdivision (A)(ii)(I) of this subdivision (1) and coverage for supplemental health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services.

(iii)(I) Each proposed package of health services shall include a cost-sharing proposal that includes a waiver of any deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.

(II) Each package of health service shall include a proposal that has no cost-sharing, including the cost differential between subdivision (A)(iii)(I) of this subdivision (1) and this subdivision (II).

(B) Administration. The consultant shall include a recommendation for:

(i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination.

(ii) enrollment processes.

(iii) integration of the pharmacy best practices and cost control program established by 33 V.S.A. §§ 1996 and 1998 and other mechanisms, to promote evidence-based prescribing, clinical efficacy, and cost-containment, such as a single statewide preferred drug list, prescriber education, or utilization reviews.

(iv) appeals processes for decisions made by entities or agencies administering coverage for health services.

(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. Payment methods for mental health services shall be consistent with mental health parity. The consultant shall consider:

(i) amendments necessary to current law on the unified health care budget, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) how to align the unified health care budget with the health resource allocation plan under 18 V.S.A. § 9405; the hospital budget review process under 18 V.S.A. § 9456; and the proposed global budgets and payments, if applicable and recommended in a design option.

(iii) recommending a global budget where it is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination. Any recommendation shall include a process for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.

(iv) payment methods to be used for each health care sector which are aligned with the goals of this act and provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles. Payment methods

may include:

(I) periodic payments based on approved annual global budgets;

(II) capitated payments;

(III) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of medications;

(IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region;

(V) diagnosis-related groups;

(VI) global payments based on a global budget, including whether the global payment should be population-based, cover specific line items, provide a mixture of a lump sum payment, diagnosis-related group (DRG) payments, incentive payments for participation in the Blueprint for Health, quality improvements, or other health care reform initiatives as defined in 3 V.S.A. § 2222a; and

(VIII) fee for service.

(v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should be in an amount which provides reasonable access to health services, provides sufficient uniform payment to health care professionals, and assists to create financial stability of health care professionals. Payment amounts shall be consistent with mental health parity. The consultant shall consider the following processes:

(I) Negotiations with hospitals, health care professionals, and groups of health care professionals;

(II) Establishing a global payment for health services provided by a particular hospital, health care provider, or group of professionals and providers. In recommending a process for determining a global payment, the board shall consider the interaction with a global budget and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The recommendation may include that



the global payment be reflected as a specific line item in the annual budget.

(III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of specialized health services that are not available locally to Vermonters.

(IV) Paying the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered and received in an out-of-state hospital with which there is not an established contract;

(V) Developing a reference pricing system for nonemergency health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract.

(VI) Utilizing one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section.

(D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the option may include a fee assessed on insurers combined with a global budget to streamline administration of health services.

(2) Coordinated regional health systems. The consultant shall propose in each design a coordinated regional health system, which ensures that the delivery of health services to the citizens of Vermont is coordinated in order to improve health outcomes, improve the efficiency of the health system, and improve patients' experience of health services. The consultant shall review and analyze Vermont's existing efforts to reform the delivery of health care, including the Blueprint for Health described in chapter 13 of Title 18, and recommend how to build on or improve current reform efforts. In designing coordinated regional health systems, the consultant shall consider:

(A) how to ensure that health professionals, hospitals, health care facilities, and home- and community-based service providers offer health services in an integrated manner designed to optimize health services at a lower cost, to reduce redundancies in the health system as a whole, and to improve quality;

(B) the creation of regional mechanisms to solicit public input for the regional health system; conduct a community needs assessment for

incorporation into the health resources allocation plan; and plan for community health needs based on the community needs assessment; and

(C) the development of a regional entity to manage health services for that region's population, including by making budget recommendations and resource allocations for the region; providing oversight and evaluation regarding the delivery of care in its region; developing payment methodologies and incentive payments; and other functions necessary to manage the region's health system.

(3) Financing and estimated costs, including federal financing. The consultant shall provide:

(A) an estimate of the total costs of each design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured; any estimated costs necessary to build a new system; and any estimated savings from implementing a single system.

(B) all estimated cost savings and reductions for existing health care programs, including Medicaid or Medicaid-funded programs. Medicaid cost savings reductions shall be presented relative to actual fiscal 2009 expenditures and by the following service categories: nursing home; home- and community-based service – mental retardation; pharmacy; mental health clinic; physician; outpatient; D & P department of health; inpatient; day treatment mental health services; home- and community-based services; disproportionate hospital payments; Catamount premiums; assistive community care; personal care services; dental; physiologist; alcohol and drug abuse families in recovery; transportation; and federally qualified health care centers.

(C) financing proposals for sustainable revenue, including by maximizing federal revenues, or reductions from existing health care programs, services, state agencies, or other sources necessary for funding the cost of the new system.

(D) a proposal to the Centers on Medicare and Medicaid Services to waive provisions of Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act if necessary to align the federal programs with the proposals contained within the design options in order to maximize federal funds or to promote the simplification of administration, cost-containment, or promotion of health care reform initiatives as defined by 3 V.S.A. § 2222a.

(E) a proposal to participate in a federal insurance exchange established by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 in order to maximize federal funds and, if applicable, for a waiver from these

provisions when available.

(4) A method to address compliance of the proposed design option or options with federal law if necessary, including the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options.

(f)(1) The agency of human services and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the commission and its consultant have the information necessary to create the design options.

(2) The consultant may request legal and fiscal assistance from the office of legislative council and the joint fiscal office.

(3) The commission or its consultant may engage with interested parties, such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont.

(g)(1) By January 1, 2011, the consultant shall release a draft of the design options to the public and provide 15 days for public review and the submission of comments on the design options. The consultant shall review and consider the public comments and revise the draft design options as necessary prior to the final submission to the general assembly and the governor.

(2) In the proposal and implementation plan provided to the general assembly and the governor, the consultant shall include a recommendation for key indicators to measure and evaluate the design option chosen by the general assembly and an analysis of each design option as compared to the current state of health care in Vermont, including:

(A) the financing and cost estimates outlined in subdivision (e)(3) of this section;

(B) the impacts on the current private and public insurance system;

(C) the expected net fiscal impact, including tax implications, on individuals and on businesses from the modifications to the health care system proposed in the design;

(D) impacts on the state's economy;

(E) the pros and cons of alternative timing for the implementation of

each design, including the sequence and rationale for the phasing in of the major components; and

(F) the pros and cons of each design option and of no changes to the current system.

#### Sec. 7. GRANT FUNDING

The staff director of the joint legislative commission on health care reform shall apply for grant funding, if available, for the design and implementation analysis provided for in Sec. 6 of this act. Any amounts received in grant funds shall first be used to offset any state funds that are appropriated or allocated in this act or in other acts related to the requirements of Sec. 6. Any grant funds received in excess of the appropriated amount may be used for the analysis.

\* \* \*HEALTH CARE REFORM – MISCELLANEOUS\* \* \*

Sec. 8. 18 V.S.A. § 9401 is amended to read:

#### § 9401. POLICY

(a) It is the policy of the state of Vermont ~~to~~ that health care is a public good for all Vermonters, and that the state must ensure that all residents have access to quality health services at costs that are affordable. To achieve this policy, it is necessary that the state ensure the quality of health care services provided in Vermont and, until health care systems are successful in controlling their costs and resources, to oversee cost containment.

\* \* \*

Sec. 9. 8 V.S.A. § 4062c is amended to read:

#### § 4062c. COMPLIANCE WITH FEDERAL LAW

Except as otherwise provided in this title, health insurers, hospital or medical service corporations, and health maintenance organizations that issue, sell, renew, or offer health insurance coverage in Vermont shall comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (42 U.S.C., Chapter 6A, Subchapter XXV), and 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. The commissioner shall enforce such requirements pursuant to his or her authority under this title.

#### Sec. 10. IMPLEMENTATION OF CERTAIN FEDERAL HEALTH CARE REFORM PROVISIONS

(a) From the effective date of this act through July 1, 2011, the commissioner of health shall undertake such planning steps and other actions as are necessary to secure grants and other beneficial opportunities for Vermont provided by 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.

(b) From the effective date of this act through July 1, 2011, the commissioner of Vermont health access shall undertake such planning steps as are necessary to ensure Vermont's participation in beneficial opportunities created by 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.

\* \* \* HEALTH CARE DELIVERY SYSTEM PROVISIONS \* \* \*

#### Sec. 11. INTENT

It is the intent of the general assembly to reform the health care delivery system in order to manage total costs of the system, improve health outcomes for Vermonters, and provide a positive health care experience for patients and providers. In order to achieve this goal and to ensure the success of health care reform, it is essential to pursue innovative approaches to a single system of health care delivery that integrates health care at a community level and contains costs through community-based payment reform, such as developing a network of community health systems. It is also the intent of the general assembly to ensure sufficient state involvement and action in designing and implementing community health systems in order to comply with federal anti-trust provisions by replacing competition between payers and others with state regulation and supervision.

#### Sec. 12. BLUEPRINT FOR HEALTH; COMMITTEES

It is the intent of the general assembly to codify and recognize the existing expansion design and evaluation committee and payer implementation work group and to codify the current consensus-building process provided for by these committees in order to develop payment reform models in the Blueprint for Health. The director of the Blueprint may continue the current composition of the committees and need not reappoint members as a result of this act.

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

### CHAPTER 13. CHRONIC CARE INFRASTRUCTURE AND PREVENTION MEASURES

#### § 701. DEFINITIONS

For the purposes of this chapter:

(1) ~~“Blueprint for Health” or “Blueprint” means the state’s plan for chronic care infrastructure, prevention of chronic conditions, and chronic care management program, and includes an integrated approach to patient self-management, community development, health care system and professional practice change, and information technology initiatives program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.~~

(2) “Chronic care” means health services provided by a health care professional for an established clinical condition that is expected to last a year or more and that requires ongoing clinical management attempting to restore the individual to highest function, minimize the negative effects of the condition, prevent complications related to chronic conditions, engage in advanced care planning, and promote appropriate access to palliative care. Examples of chronic conditions include diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, spinal cord injury, hyperlipidemia, and chronic pain.

(3) “Chronic care information system” means the electronic database developed under the Blueprint for Health that shall include information on all cases of a particular disease or health condition in a defined population of individuals.

(4) “Chronic care management” means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for the physician and patient relationship, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(5) “Health care professional” means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(6) ~~“Health risk assessment” means screening by a health care professional for the purpose of assessing an individual’s health, including tests or physical examinations and a survey or other tool used to gather information about an individual’s health, medical history, and health risk factors during a health screening.~~ “Health benefit plan” shall have the same meaning as 8 V.S.A. § 4088h.

(7) “Health insurer” shall have the same meaning as in section 9402 of this title.

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

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

~~(a)(1) As used in this section, "health insurer" shall have the same meaning as in section 9402 of this title.~~

~~(b) 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 of health and the commissioner of Vermont health access, shall oversee the development and implementation of the Blueprint for Health, including the five-year a strategic plan describing the initiatives and implementation timelines and strategies. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration.

~~(e)(b)(1)(A) The secretary 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 consist of no fewer than 10 individuals, including the commissioner of health; the commissioner of mental health; a representative from the department of banking, insurance, securities, and health care administration; a representative from the office of Vermont health access; a representative from the Vermont medical society; 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 profession professions; a primary care professional serving low income or uninsured Vermonters; 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 director of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan. In addition, the director of the commission on health care reform shall be a nonvoting member of the executive committee.~~

~~(2)(B) The executive committee shall engage a broad range of health care professionals who provide health services as defined under section 8 V.S.A. § 4080f of Title 18, health insurance plans insurers, professional~~

organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local government in developing and implementing a five-year strategic plan.

(2)(A) The director shall convene an expansion design and evaluation committee, which shall meet no fewer than six times annually, to recommend a design plan, including modifications over time, for the statewide implementation of the Blueprint for Health and to recommend appropriate methods to evaluate the Blueprint. This committee shall be composed of the members of the executive committee, representatives of participating health insurers, representatives of participating medical homes and community health teams, the deputy commissioner of health care reform, a representative of the Bi-State Primary Care Association, a representative of the University of Vermont College of Medicine's Office of Primary Care, a representative of the Vermont information technology leaders, and consumer representatives. The committee shall comply with open meeting and public record requirements in chapter 5 of Title 1.

(B) The director shall also convene a payer implementation work group, which shall meet no fewer than six times annually, to design the medical home and community health team enhanced payments, including modifications over time, and to make recommendations to the expansion design and evaluation committee described in subdivision (A) of this subdivision (2). The work group shall include representatives of the participating health insurers, representatives of participating medical homes and community health teams, and the commissioner of Vermont health access or designee. The work group shall comply with open meeting and public record requirements in chapter 5 of Title 1.

~~(d)~~(c) The Blueprint shall be developed and implemented to further the following principles:

- (1) the primary care provider should serve a central role in the coordination of care and shall be compensated appropriately for this effort;
- (2) use of information technology should be maximized;
- (3) local service providers should be used and supported, whenever possible;
- (4) transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to the Blueprint model of health care delivery and payment;
- (5) implementation of the Blueprint in communities across the state should be accompanied by payment to providers sufficient to support care



management activities consistent with the Blueprint, recognizing that interim or temporary payment measures may be necessary during early and transitional phases of implementation; and

(6) interventions designed to prevent chronic disease and improve outcomes for persons with chronic disease should be maximized, should target specific chronic disease risk factors, and should address changes in individual behavior, the physical and social environment, and health care policies and systems.

(d) The Blueprint for Health shall include the following initiatives:

(1) technical assistance as provided for in section 703 of this title to implement:

(A) a patient-centered medical home;

(B) community health teams; and

(C) a model for uniform payment for health services by health insurers, Medicaid, Medicare if available, and other entities that encourage the use of the medical home and the community health teams.

(2) collaboration with Vermont information technology leaders established in section 9352 of this title to assist health care professionals and providers to create a statewide infrastructure of health information technology in order to expand the use of electronic medical records through a health information exchange and a centralized clinical registry on the Internet.

(3) in consultation with employers, consumers, health insurers, and health care providers, the development, maintenance, and promotion of evidence-based, nationally recommended guidelines for greater commonality, consistency, and coordination across health insurers in care management programs and systems.

(4) the adoption and maintenance of clinical quality and performance measures for each of the chronic conditions included in Medicaid's care management program established in 33 V.S.A. § 1903a. These conditions include asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.

(5) the adoption and maintenance of clinical quality and performance measures, aligned with but not limited to existing outcome measures within the agency of human services, to be reported by health care professionals, providers or health insurers and used to assess and evaluate the impact of the Blueprint for health and cost outcomes. In accordance with a schedule established by the Blueprint executive committee, all clinical quality and

performance measures shall be reviewed for consistency with those used by the Medicare program and updated, if appropriate.

(6) the adoption and maintenance of clinical quality and performance measures for pain management, palliative care, and hospice care.

(7) the use of surveys to measure satisfaction levels of patients, health care professionals, and health care providers participating in the Blueprint.

~~(c)(1) The strategic plan shall include:~~

~~(A) a description of the Vermont Blueprint for Health model, which includes general, standard elements established in section 1903a of Title 33, patient self management, community initiatives, and health system and information technology reform, to be used uniformly statewide by private insurers, third party administrators, and public programs;~~

~~(B) a description of prevention programs and how these programs are integrated into communities, with chronic care management, and the Blueprint for Health model;~~

~~(C) a plan to develop and implement reimbursement systems aligned with the goal of managing the care for individuals with or at risk for conditions in order to improve outcomes and the quality of care;~~

~~(D) the involvement of public and private groups, health care professionals, insurers, third party administrators, associations, and firms to facilitate and assure the sustainability of a new system of care;~~

~~(E) the involvement of community and consumer groups to facilitate and assure the sustainability of health services supporting healthy behaviors and good patient self management for the prevention and management of chronic conditions;~~

~~(F) alignment of any information technology needs with other health care information technology initiatives;~~

~~(G) the use and development of outcome measures and reporting requirements, aligned with existing outcome measures within the agency of human services, to assess and evaluate the system of chronic care;~~

~~(H) target timelines for inclusion of specific chronic conditions in the chronic care infrastructure and for statewide implementation of the Blueprint for Health;~~

~~(I) identification of resource needs for implementing and sustaining the Blueprint for Health and strategies to meet the needs; and~~

~~(J) a strategy for ensuring statewide participation no later than January 1, 2011 by health insurers, third party administrators, health care professionals, hospitals and other professionals, and consumers in the chronic care management plan, including common outcome measures, best practices and protocols, data reporting requirements, payment methodologies, and other standards. In addition, the strategy should ensure that all communities statewide will have implemented at least one component of the Blueprint by January 1, 2009.~~

~~(2) The strategic plan developed under subsection (a) of this section shall be reviewed biennially and amended as necessary to reflect changes in priorities. Amendments to the plan shall be included in the report established under subsection (i) of this section section 709 of this title.~~

~~(f) The director of the Blueprint shall facilitate timely progress in adoption and implementation of clinical quality and performance measures as indicated by the following benchmarks:~~

~~(1) by July 1, 2007, clinical quality and performance measures are adopted for each of the chronic conditions included in the Medicaid Chronic Care Management Program. These conditions include, but are not limited to, asthma, chronic obstructive pulmonary disease, congestive heart failure, diabetes, and coronary artery disease.~~

~~(2) at least one set of clinical quality and performance measures will be added each year and a uniform set of clinical quality and performance measures for all chronic conditions to be addressed by the Blueprint will be available for use by health insurers and health care providers by January 1, 2010.~~

~~(3) in accordance with a schedule established by the Blueprint executive committee, all clinical quality and performance measures shall be reviewed for consistency with those used by the Medicare program and updated, if appropriate.~~

~~(g) The director of the Blueprint shall facilitate timely progress in coordination of chronic care management as indicated by the following benchmarks:~~

~~(1) by October 1, 2007, risk stratification strategies shall be used to identify individuals with or at risk for chronic disease and to assist in the determination of the severity of the chronic disease or risk thereof, as well as the appropriate type and level of care management services needed to manage those chronic conditions.~~

~~(2) by January 1, 2009, guidelines for promoting greater commonality, consistency, and coordination across health insurers in care management programs and systems shall be developed in consultation with employers, consumers, health insurers, and health care providers.~~

~~(3) beginning July 1, 2009, and each year thereafter, health insurers, in collaboration with health care providers, shall report to the secretary on evaluation of their disease management programs and the progress made toward aligning their care management program initiatives with the Blueprint guidelines.~~

~~(h)(1) No later than January 1, 2009, the director shall, in consultation with employers, consumers, health insurers, and health care providers, complete a comprehensive analysis of sustainable payment mechanisms. No later than January 1, 2009, the director shall report to the health care reform commission and other stakeholders his or her recommendations for sustainable payment mechanisms and related changes needed to support achievement of Blueprint goals for health care improvement, including the essential elements of high quality chronic care, such as care coordination, effective use of health care information by physicians and other health care providers and patients, and patient self-management education and skill development.~~

~~(2) By January 1, 2009, and each year thereafter, health insurers will participate in a coordinated effort to determine satisfaction levels of physicians and other health care providers participating in the Blueprint care management initiatives, and will report on these satisfaction levels to the director and in the report established under subsection (i) this section.~~

~~(i) The director shall report annually, no later than January 1, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year, and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight committee, and the commission on health care reform. The report shall include the number of participating insurers, health care professionals and patients; the progress for achieving statewide participation in the chronic care management plan, including the measures established under subsection (c) of this section; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in subsections (g) and (h) of this section; and other information as requested by the committees. The surveys shall be developed in collaboration with the executive committee established under subsection (c) of this section.~~

~~(j) It is the intent of the general assembly that health insurers shall participate in the Blueprint for Health no later than January 1, 2009 and shall engage health care providers in the transition to full participation in the Blueprint.~~

§ 703. HEALTH PREVENTION; CHRONIC CARE MANAGEMENT

(a) The director shall develop a model for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management through an integrated system, including a patient-centered medical home and a community health team; and uniform payment for health services by health insurers, Medicaid, Medicare if available, and other entities that encourage the use of the medical home and the community health teams.

(b) When appropriate, the model may include the integration of social services provided by the agency of human services or may include coordination with a team at the agency of human services to ensure the individual's comprehensive care plan is consistent with the agency's case management plan for that individual or family.

(c) In order to maximize the participation of federal health care programs and to maximize federal funds available, the model for care coordination and management may meet the criteria for medical home, community health team, or other related demonstration projects established by the U.S. Department of Health and Human Services and the criteria of any other federal program providing funds for establishing medical homes, community health teams, or associated payment reform.

(d) The model for care coordination and management shall include the following components:

(1) a process for identifying individuals with or at risk for chronic disease and to assist in the determination of the risk for or severity of a chronic disease, as well as the appropriate type and level of care management services needed to manage those chronic conditions.

(2) evidence-based clinical practice guidelines, which shall be aligned with the clinical quality and performance measures provided for in section 702 of this title.

(3) models for the collaboration of health care professionals in providing care, including through a community health team.

(4) education for patients on how to manage conditions or diseases, including prevention of disease; programs to modify a patient's behavior; and a

method of ensuring compliance of the patient with the recommended behavioral change.

(5) education for patients on health care decision-making, including education related to advance directives, palliative care, and hospice care.

(6) measurement and evaluation of the process and health outcomes of patients.

(7) a method for all health care professionals treating the same patient to routinely report and share information about that patient.

(8) requirements that participating health care professionals and providers have the capacity to implement health information technology that meets the requirements of 42 U.S.C. § 300jj in order to facilitate coordination among members of the community health team, health care professionals, and primary care practices; and, where applicable, to report information on quality measures to the director of the Blueprint.

(9) a sustainable, scalable, and adaptable financial model reforming primary care payment methods through medical homes supported by community health teams that lead to a reduction in avoidable emergency room visits and hospitalizations and a shift by health insurer expenditures from disease management contracts to local community health teams in order to promote health, prevent disease, and manage care in order to increase positive health outcomes and reduce costs over time.

(e) The director of the Blueprint shall provide technical assistance and training to health care professionals, health care providers, health insurers, and others participating in the Blueprint.

#### § 704. MEDICAL HOME

Consistent with federal law to ensure federal financial participation, a health care professional providing a patient's medical home shall:

(1) provide comprehensive prevention and disease screening for his or her patients and managing his or her patients' chronic conditions by coordinating care;

(2) enable patients to have access to personal health information through a secure medium, such as through the Internet, consistent with federal health information technology standards;

(3) use a uniform assessment tool provided by the Blueprint in assessing a patient's health;

(4) collaborate with the community health teams, including by developing and implementing a comprehensive plan for participating patients;

(5) ensure access to a patient's medical records by the community health team members in a manner compliant with the Health Insurance Portability and Accountability Act, 12 V.S.A. § 1612, 18 V.S.A. §§ 1852, 7103, 9332, and 9351, and 21 V.S.A. § 516; and

(6) meet regularly with the community health team to ensure integration of a participating patient's care.

#### § 705. COMMUNITY HEALTH TEAMS

(a) Consistent with federal law to ensure federal financial participation, the community health team shall consist of health care professionals from multiple disciplines, including obstetrics and gynecology, pharmacy, nutrition and diet, social work, behavioral and mental health, chiropractic, other complementary and alternative medical practice licensed by the state, home health care, public health, and long-term care.

(b) The director shall assist communities to identify the service areas in which the teams work, which may include a hospital service area or other geographic area.

(c) Health care professionals participating in a community health team shall:

(1) collaborate with other health care professionals and with existing state agencies and community-based organizations in order to coordinate disease prevention, manage chronic disease, coordinate social services if appropriate, and provide an appropriate transition of patients between health care professionals or providers. Priority may be given to patients willing to participate in prevention activities or patients with chronic diseases or conditions identified by the director of the Blueprint.

(2) support a health care professional or practice which operates as a medical home, including by:

(A) assisting in the development and implementation of a comprehensive care plan for a patient that integrates clinical services with prevention and health promotion services available in the community and with relevant services provided by the agency of human services. Priority may be given to patients willing to participate in prevention activities or patients with chronic diseases or conditions identified by the director of the Blueprint.

(B) providing a method for health care professionals, patients, caregivers, and authorized representatives to assist in the design and oversight of the comprehensive care plan for the patient;

(C) coordinating access to high-quality, cost-effective, culturally appropriate, and patient- and family-centered health care and social services.

including preventive services, activities which promote health, appropriate specialty care, inpatient services, medication management services provided by a pharmacist, and appropriate complementary and alternative (CAM) services.

(D) providing support for treatment planning, monitoring the patient's health outcomes and resource use, sharing information, assisting patients in making treatment decisions, avoiding duplication of services, and engaging in other approaches intended to improve the quality and value of health services;

(E) assisting in the collection and reporting of data in order to evaluate the Blueprint model on patient outcomes, including collection of data on patient experience of care, and identification of areas for improvement; and

(F) providing a coordinated system of early identification and referral for children at risk for developmental or behavioral problems such as through the use of health information technology or other means as determined by the director of the Blueprint.

(3) provide care management and support when a patient moves to a new setting for care, including by:

(A) providing on-site visits from a member of the community health team, assisting with the development of discharge plans and medication reconciliation upon admission to and discharge from the hospitals, nursing homes, or other institution settings;

(B) generally assisting health care professionals, patients, caregivers, and authorized representatives in discharge planning, including by assuring that postdischarge care plans include medication management as appropriate;

(C) referring patients as appropriate for mental and behavioral health services;

(D) ensuring that when a patient becomes an adult, his or her health care needs are provided for; and

(E) serving as a liaison to community prevention and treatment programs.

#### § 706. HEALTH INSURER PARTICIPATION

(a) As provided for in 8 V.S.A. § 4088h, health insurance plans shall be consistent with the Blueprint for Health as determined by the commissioner of banking, insurance, securities, and health care administration.

(b) No later than January 1, 2011, health insurers shall participate in the Blueprint for Health as a condition of doing business in this state as provided for in this section and in 8 V.S.A. § 4088h. Under 8 V.S.A. § 4088h, the



commissioner of banking, insurance, securities, and health care administration may exclude or limit the participation in the Blueprint of Health insurers offering a stand-alone dental plan or specific disease or other limited benefit coverage. Health insurers shall be exempt from participation if the insurer only offers 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.

(c)(1) The Blueprint payment reform methodologies shall include per-person per-month payments to medical home practices by each health insurer and Medicaid for their attributed patients and for contributions to the shared costs of operating the community health teams. Per-person per-month payments to practices shall be based on the official National Committee for Quality Assurance's Physician Practice Connections – Patient Centered Medical Home (NCQA PPC-PCMH) score and shall be in addition to their normal fee-for-service or other payments.

(2) Consistent with the recommendation of the Blueprint expansion design and evaluation committee, the director of the Blueprint may implement changes to the payment amounts or to the payment reform methodologies described in subdivision (1) of this subsection, including by providing for enhanced payment to health care professional practices which operate as a medical home, payment toward the shared costs for community health teams, or other payment methodologies required by the Centers for Medicare and Medicaid Services (CMS) for participation by Medicaid or Medicare.

(3) Health insurers shall modify payment methodologies and amounts to health care professionals and providers as required for the establishment of the model described in sections 703 through 705 of this title and this section, including any requirements specified by the Centers for Medicare and Medicaid Services (CMS) in approving federal participation in the model to ensure consistency of payment methods in the model.

(4) In the event that the secretary of human services is denied permission from the Centers for Medicare and Medicaid Services (CMS) to include financial participation by Medicare, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.

(d) An insurer may appeal a decision of the director to require a particular payment methodology or payment amount to the commissioner of Vermont health access, who shall provide a hearing in accordance with chapter 25 of Title 3. An insurer aggrieved by the decision of the commissioner may appeal to the superior court for the Washington district within 30 days after the commissioner issues his or her decision.

§ 707. PARTICIPATION BY HEALTH CARE PROFESSIONALS AND  
HOSPITALS

(a) No later than July 1, 2011, hospitals shall participate in the Blueprint for Health by creating or maintaining connectivity to the state's health information exchange network as provided for in this section and in section 9456 of this title. The director of health care reform or designee and the director of the Blueprint shall establish criteria by rule for this requirement consistent with the state health information technology plan required under section 9351 of this title. The criteria shall not require a hospital to create a level of connectivity that the state's exchange is not able to support.

(b) The director of health care reform or designee shall ensure hospitals have access to state and federal resources to support connectivity to the state's health information exchange network.

(c) The director of the Blueprint shall engage health care professionals and providers to encourage participation in the Blueprint, including by providing information and assistance.

§ 708. CERTIFICATION OF HOSPITALS

(a) The director of health care reform or designee shall establish a process for annually certifying that a hospital meets the participation requirements established under section 707 of this title. Once a hospital is fully connected to the state's health information exchange, the director of health care reform or designee shall waive further certification. The director may require a hospital to resume certification if the criteria for connectivity change, if the hospital loses connectivity to the state's health information exchange, or for another reason which results in the hospital not meeting the participation requirement in section 707 of this title. The certification process, including a time for appeal, shall be completed prior to the hospital budget review required under section 9456 of this title.

(b) Once the hospital has been certified or certification has been waived, the director of health care reform or designee shall provide the hospital with documentation to include in its annual budget review as required by section 9456 of this title.

(c) A denial of certification by the director of health care reform or designee may be appealed to the commissioner of Vermont health access, who shall provide a hearing in accordance with chapter 25 of Title 3. A hospital aggrieved by the decision of the commissioner may appeal to the superior court for the district in which the hospital is located within 30 days after the commissioner issues his or her decision.

§ 709. ANNUAL REPORT

(a) The director of the Blueprint shall report annually, no later than January 15, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year, and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight committee, and the joint legislative commission on health care reform.

(b) The report shall include the number of participating insurers, health care professionals, and patients; the progress for achieving statewide participation in the chronic care management plan, including the measures established under this subchapter; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in this subchapter; and other information as requested by the committees.

Sec. 14. COMMUNITY HEALTH SYSTEMS; PILOT

(a)(1) The department of Vermont health access shall be responsible for developing pilot programs which develop community health systems as provided for under this section. The director of community health systems shall oversee the development, implementation, and evaluation of the community health system pilot projects. Whenever health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration. The terms used in this section shall have the same meanings as in chapter 13 of Title 18.

(2) The director of community health systems shall convene a broad-based group of stakeholders, including health care professionals who provide health services as defined under 8 V.S.A. § 4080f, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, and state and local government to advise the director in developing and implementing the pilot projects.

(3) Community health system pilot projects shall be developed and implemented to manage the total costs of the health care delivery system in a region, improve health outcomes for Vermonters, provide a positive health care experience for patients and providers, and further the following objectives:

(A) community health systems should be organized around primary care providers;

(B) community health systems should align with the Blueprint for Health strategic plan and the statewide health information technology plan;

(C) health care providers and professionals should integrate patient care through a local entity or organization facilitating this integration;

(D) health insurers, Medicaid, Medicare, and all other payers should reimburse the entity or organization of health care providers and professionals for integrated patient care through a single system of coordinated payments and a global budget;

(E) the design and implementation of the community health system should be aligned with the requirements of federal law to ensure the full participation of Medicare in multi-payer payment reform.

(F) the global budget should include a broad, comprehensive set of services, including prescription drugs, diagnostic services, and services received in a hospital, from a physician or from a mental health professional.

(G) after consultation with long-term care providers, the global budget may also include home health services, and long-term care services if feasible.

(H) transition plans should be developed by all involved parties to ensure a smooth and timely transition from the current model to community health systems;

(I) financial performance of an integrated community of care should be measured instead of the financial viability of a single institution.

(4) The strategic plan for the pilot projects shall include:

(A) A description of the proposed community health system pilot projects organized around primary care professionals. The population served by a community health system pilot project would be those who use the primary care professionals in the community health system.

(B) An implementation time line for pilot projects with the first project to become operational no later than January 1, 2012, and with two or more additional pilot projects to become operational no later than July 1, 2012.

(C) A description of the possible organizational model or models for health care providers or professionals to become part of a community health system pilot project, including a description of the legal or contractual mechanisms available. The models considered should include traditional physician hospital organizations, regional structures that support more than one community health system, and community health foundations that include providers but are not necessarily provider-based.

(D) A design of the financial model or models, including:

(i) gradual modification over time of existing reimbursement methods used by health insurers, Medicaid, Medicare, and other payers to pay health care providers and professionals from existing models to a global budget with a single system of payment for the community health system;

(ii) cost-containment targets to reduce health care system inflation in a particular community, which may include shared savings, risk-sharing, or other incentives for the community health system to reduce costs while maintaining or improving health outcomes and patient satisfaction;

(iii) health care outcome target to encourage both effective care and prevention programs, which may include shared savings or other incentives for the community health system;

(iv) patient satisfaction targets to ensure that individuals have positive experiences with their community health systems, which may include shared savings or other incentives for the community health system.

(v) An estimate of savings to the health care system from cost reductions due to reduced administration and from a reduction in health care inflation.

(vi) The scope of services to be included in a comprehensive global budget in order to contain costs and ensure high quality and patient satisfaction.

(vii) Ongoing program evaluation and improvement protocols.

(b) Health insurer participation.

(1)(A) Health insurers shall participate in the development of the community health system strategic plan for the pilot projects and in the implementation of community health systems pilot projects, including by providing incentives or fees, as required in this section. This requirement may be enforced by the department of banking, insurance, securities, and health care administration to the same extent as the requirement to participate in the Blueprint for Health provided for in 8 V.S.A. § 4088h.

(B) In consultation with the director of the Blueprint for Health and the director of health care reform, the commissioner of banking, insurance, securities, and health care administration may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan, specific disease, or other limited benefit coverage, or insurers with a minimal number of covered lives as defined by the commissioner. Health insurers shall be exempt from participation if the insurer only offers 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.

(C) Health insurers shall have the same appeal rights provided for in 18 V.S.A. § 706 for participation in the Blueprint for Health.

(2) 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.

(c) To the extent required to avoid federal anti-trust violations, the commissioner of banking, insurance, securities, and health care administration shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the community health system pilot projects, including creating a shared incentive pool. The department shall ensure that the process and implementation includes sufficient state supervision over these entities to comply with federal anti-trust provisions.

(d) The commissioner of Vermont health access or designee shall apply for grant funding, if available, for the design and implementation of the pilot projects described in this act. Any amounts received in grant funds shall first be used to offset any state funds that are appropriated or allocated in this act or in other acts related to the pilot projects described in this section. Any grant funds received in excess of the appropriated amount may be used for the analysis.

(e) The director shall report to the house committee on health care and senate committee on health and welfare by March 15, 2011, on the implementation of the first pilot project and present a detailed description of and a timetable for the implementation of the additional pilot projects.

(f)(1) Beginning in 2011, the director of community health systems shall report annually by January 15 on the status of implementation of the community health systems for the prior calendar year, and shall provide the report to the house committee on health care, the senate committee on health and welfare, the health access oversight committee, and the commission on health care reform.

(2) The report shall include the number of participating insurers, health care professionals, and patients; the progress for achieving statewide participation in the community health systems; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; and other information as requested by the committees.

Sec. 15. 8 V.S.A. § 4088h is amended to read:

§ 4088h. HEALTH INSURANCE AND THE BLUEPRINT FOR  
HEALTH

(a)(1) A health insurance plan shall be offered, issued, and administered consistent with the blueprint for health established in chapter 13 of Title 18, as determined by the commissioner.

~~(b)(2)~~ As used in this section, “health insurance plan” means any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined in ~~section 18 V.S.A. § 9402 of Title 18~~. The term shall include the health benefit plan offered by the state of Vermont to its employees and any health benefit plan offered by any agency or instrumentality of the state to its employees. The term shall not include benefit plans providing coverage for specific disease or other limited benefit coverage unless so directed by the commissioner.

(b) Health insurers as defined in 18 V.S.A. § 701 shall participate in the Blueprint for Health as specified in 18 V.S.A. § 706. In consultation with the director of the Blueprint for Health and the director of health care reform, the commissioner 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. Health insurers shall be exempt from participation if the insurer only offers 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.

Sec. 16. 18 V.S.A. § 9456(a) is amended to read:

(a) The commissioner 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. The commissioner 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.

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, as amended by the Health Care and Education Reconciliation Act of 2010, 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 chapter 13 of Title 18.

(2) Upon establishment by the Secretary of the U.S. Department of Health and Human Services (HHS) of a shared savings program pursuant to Sec. 3022 of H.R. 3590, the Patient Protection and Affordable Care Act, as amended by H.R. 4872, the Health Care and Education Reconciliation Act of 2010, the secretary of human services may apply to the Secretary of HHS to enable Vermont to participate in the program by establishing community health system pilot projects as provided for in Sec. 14 of this act.

(b)(1) Medicaid waivers. The intent of this section is to provide the secretary of human services with the authority to pursue Medicaid participation in the Blueprint for Health through any existing or new waiver.

(2) Upon establishment by the Secretary of the U.S. Department of Health and Human Services (HHS) of a health home demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, the secretary of human services may apply to the Secretary of HHS to include Medicaid as a participant in the Blueprint for Health as described in chapter 13 of Title 18. 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. 18. EXPEDITED RULES

Notwithstanding the provisions of chapter 25 of Title 3, the agency of human services shall specify the requirements and time frame that an insurer or health care provider must meet to be considered participating in the Blueprint for Health as required by chapter 13 of Title 18 or the community health systems as required by this act by adopting rules pursuant to the following process:

(1) The secretary shall file final proposed rules with the secretary of state and the legislative committee on administrative rules under 3 V.S.A. § 841, after publication, in three daily newspapers with the highest average circulation in the state, of a notice that lists the rules to be adopted pursuant to this process and a seven-day public comment period following publication.



(2) The secretary shall file final proposed rules with the legislative committee on administrative rules no later than 28 days after the effective date of this act.

(3) The legislative committee on administrative rules shall review, and may approve or object to, the final proposed rules under 3 V.S.A. § 842, except that its action shall be completed no later than 14 days after the final proposed rules are filed with the committee.

(4) The secretary may adopt a properly filed final proposed rule after the passage of 14 days from the date of filing final proposed rules with the legislative committee on administrative rules or after receiving notice of approval from the committee, provided the secretary:

(A) has not received a notice of objection from the legislative committee on administrative rules; or

(B) after having received a notice of objection from the committee, has responded pursuant to 3 V.S.A. § 842.

(5) Rules adopted under this section shall be effective upon being filed with the secretary of state and shall have the full force and effect of rules adopted pursuant to chapter 25 of Title 3. Rules filed by the secretary of the agency of human services with the secretary of state pursuant to this section shall be deemed to be in full compliance with 3 V.S.A. § 843, and shall be accepted by the secretary of state if filed with a certification by the secretary of the agency of human services that the rule is required to meet the purposes of this section.

#### Sec. 19. BLUEPRINT FOR HEALTH; EXPANSION

The commissioner of Vermont health access shall expand the Blueprint for Health as described in chapter 13 of Title 18 to at least two primary care practices in every hospital services area no later than July 1, 2011, and statewide to primary care practices who wish to participate no later than October 1, 2013.

\* \* \* IMMEDIATE COST-CONTAINMENT PROVISIONS \* \* \*

#### Sec. 20. HOSPITAL BUDGETS

(a)(1) The commissioner of banking, insurance, securities, and health care administration shall implement this section consistent with the goals identified in Sec. 50 of No. 61 of the Acts of 2009, 18 V.S.A. § 9456, the goals of systemic health care reform, containing costs, solvency for efficient and effective hospitals, and promoting fairness and equity in health care financing. The authority provided in this section shall be in addition to the

commissioner's authority under subchapter 7 of chapter 221 of Title 8 (hospital budget reviews).

(2) Except as provided for in subdivision (3) of this subsection, the commissioner of banking, insurance, securities, and health care administration shall target hospital budgets consistent with the following:

(A) For fiscal years 2011 and 2012, the commissioner shall aim to minimize rate increases for each hospital in an effort to balance the goals outlined in this section and shall ensure that the systemwide increase shall be lower than the prior year's increase.

(B)(i) For fiscal year 2011, the total systemwide net patient revenue increase for all hospitals reviewed by the commissioner shall not exceed 4.5 percent.

(ii) For fiscal year 2012, the total systemwide net patient revenue increase for all hospitals reviewed by the commissioner shall not exceed 4.0 percent.

(3)(A) Consistent with the goals of lowering overall cost increases in health care without compromising the quality of health care, the commissioner may restrict or disallow specific expenditures, such as new programs. In his or her own discretion, the commissioner may identify or may require hospitals to identify the specific expenditures to be restricted or disallowed.

(B) In calculating the hospital budgets as provided for in subdivision (2) of this subsection and if necessary to achieve the goals identified in this section, the commissioner may exempt hospital revenue and expenses associated with health care reform, hospital expenses related to electronic medical records or other information technology, hospital expenses related to acquiring or starting new physician practices, and other expenses, such as all or a portion of the provider tax. The expenditures shall be specifically reported, supported with sufficient documentation as required by the commissioner and may only be exempt if approved by the commissioner.

(b) Notwithstanding 18 V.S.A. § 9456(e), permitting the commissioner to waive a hospital from the budget review process, and consistent with this section and the overarching goal of containing health care and hospital costs, the commissioner may waive a hospital from the hospital budget process for more than two years consecutively. This provision does not apply to a tertiary teaching hospital.

(c) Upon a showing that a hospital's financial health or solvency will be severely compromised, the commissioner may approve or amend a hospital budget in a manner inconsistent with subsection (a) of this section.

Sec. 21. 18 V.S.A. § 9440(b)(1) is amended to read:

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

\* \* \*

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

Sec. 22. 18 V.S.A. § 9456(g) is amended to read:

(g) The commissioner may request, and a hospital shall provide, information determined by the commissioner 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 authority shall extend to an affiliated corporation or other person in the control of or controlled by the hospital, to the extent 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.

Sec. 23. 18 V.S.A. § 9456(h)(2) is amended to read:

(2)(A) After notice and an opportunity for hearing, the commissioner 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 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 (B) shall be issued after notice and an opportunity to be heard, except where the commissioner 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 may issue orders under this subdivision (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 for the hospital's request for a hearing, and a decision shall be issued within 30 days after conclusion of the hearing. The commissioner may enlarge the time to hold the hearing or 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 in the administrative proceeding and the standard of review shall be as provided in 8 V.S.A. § 16.

Sec. 24. 18 V.S.A. § 9456(b) is amended to read:

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

- (1) review utilization information;
- (2) consider the goals and recommendations of the health resource allocation plan;
- (3) consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;
- (4) consider any reports from professional review organizations;
- (5) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;
- (6) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;
- (7) give public notice of the meetings with hospitals, and invite the public to attend and to comment on the proposed budgets;
- (8) consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;
- (9) require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements,

and to any reduction in bad debt or charity care due to an increase in the number of insured individuals;

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

Sec. 25. REPEAL

18 V.S.A. § 9439(f) (annual review cycles of certificate of need applications) is repealed on July 1, 2010.

Sec. 26. INSURANCE REGULATION; INTENT

It is the intent of the general assembly that the commissioner of banking, insurance, securities, and health care administration use the insurance rate review and approval authority to control the costs of health insurance unrelated to the cost of medical care where consistent with other statutory obligations, such as ensuring solvency. Rate review and approval authority could include imposing limits on producer commissions in specified markets or limiting administrative costs as a percentage of the premium.

Sec. 27. 8 V.S.A § 4080a(h)(2)(D) is added to read:

(D) 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 be at the time of seeking a rate increase 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.

Sec. 28. 8 V.S.A § 4080b(h)(2)(D) is added to read:

(D) 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 be at the time of seeking a rate increase 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.

Sec. 29. RULEMAKING; REPORTING OF INFORMATION

The commissioner of banking, insurance, securities, and health care administration shall adopt rules pursuant to chapter 25 of Title 3 requiring each

health insurer licensed to do business in this state to report to the department of banking, insurance, securities, and health care administration, at least annually, information specific to its Vermont contracts, including enrollment data, loss ratios, and such other information as the commissioner deems appropriate.

Sec. 30. 8 V.S.A. § 4089b(g) is amended to read:

(g) On or before July 15 of each year, health insurance companies doing business in Vermont, ~~and~~ whose individual share of the commercially-insured Vermont market, as measured by covered lives, comprises at least five percent of the commercially-insured Vermont market, shall file with the commissioner, in accordance with standards, procedures, and forms approved by the commissioner:

\* \* \*

(2) The health insurance plan's revenue loss and expense ratio relating to the care and treatment of mental health conditions covered under the health insurance plan. The expense ratio report shall list amounts paid in claims for services and administrative costs separately. A managed care organization providing or administering coverage for treatment of mental health conditions on behalf of a health insurance plan shall comply with the minimum loss ratio requirements 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, applicable to the underlying health insurance plan with which the managed care organization has contracted to provide or administer such services. The health insurance plan shall also bear responsibility for ensuring the managed care organization's compliance with the minimum loss ratio requirement pursuant to this subdivision.

\* \* \* HEALTH CARE WORKFORCE PROVISIONS \* \* \*

Sec. 31. INTERIM STUDY OF VERMONT'S PRIMARY CARE  
WORKFORCE DEVELOPMENT

(a) Creation of committee. There is created a primary care workforce development committee to determine the additional capacity needed in the primary care delivery system if Vermont achieves the health care reform principles and purposes established in Secs. 1 and 2 of No. 191 of the Acts of the 2005 Adj. Sess. (2006) and to create a strategic plan for ensuring that the necessary workforce capacity is achieved in the primary care delivery system. The primary care workforce includes physicians, advanced practice nurses, and other health care professionals providing primary care as defined in section 8 V.S.A. § 4080f.

(b) Membership. The primary care workforce development committee shall be composed of 17 members as follows:

(1) the commissioner of Vermont health access;

(2) the deputy commissioner of the division of health care administration or designee;

(3) the director of the Blueprint for Health;

(4) the commissioner of health or designee;

(5) a representative of the University of Vermont College of Medicine's Area Health Education Centers (AHEC) program;

(6) a representative of the University of Vermont College of Medicine's Office of Primary Care, a representative of the University of Vermont College of Nursing and Health Sciences, a representative of nursing programs at the Vermont State Colleges, and a representative from Norwich University's nursing programs;

(7) a representative of the Vermont Association of Naturopathic Physicians;

(8) a representative of Bi-State Primary Care Association;

(9) a representative of Vermont Nurse Practitioners Association;

(10) a representative of Physician Assistant Academy of Vermont;

(11) a representative of the Vermont Medical Society;

(12) a representative from a voluntary group of organizations known as the Vermont health care workforce development partners;

(13) a mental health or substance abuse treatment professional currently in practice; and

(14) a representative of the Vermont assembly of home health agencies.

(c) Powers and duties.

(1) The committee shall study the primary care workforce development system in Vermont, including the following issues:

(A) the current capacity and capacity issues of the primary care workforce and delivery system in Vermont, including the number of primary care professionals, issues with geographic access to services, and unmet primary health care needs of Vermonters.

(B) the resources needed to ensure that the primary care workforce and the delivery system are able to provide sufficient access to services should

all or most of Vermonters become insured, to provide sufficient access to services given demographic factors in the population and in the workforce, and to fully participate in health care reform initiatives, including participation in the Blueprint for Health and transition to electronic medical records; and

(C) how state government, universities and colleges, and others may develop the resources in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes.

(2) The committee shall create a detailed and targeted five-year strategic plan with specific action steps for attaining sufficient capacity in the primary care workforce and delivery system to achieve Vermont's health care reform principles and purposes. By November 15, 2010, the department of health, in collaboration with AHEC and the department of Vermont health access, shall report to the joint legislative commission on health care reform, the house committee on health care, and the senate committee on health and welfare its findings, the strategic plan, and any recommendations for legislative action.

(3) For purposes of its study of these issues, the committee shall have administrative support from the department of health. The department of health, in collaboration with AHEC, shall call the first meeting of the committee and shall operate as co-chairs of the committee.

(d) Term of committee. The committee shall cease to exist on January 31, 2011.

\* \* \* PRESCRIPTION DRUG PROVISIONS \* \* \*

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

§ 4631a. ~~GIFTS~~ EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

(1) "Allowable expenditures" means:

(A) Payment to the sponsor of a significant educational, medical, scientific, or policy-making conference or seminar, provided:

(i) the payment is not made directly to a health care ~~provider~~ professional or pharmacist;

(ii) funding is used solely for bona fide educational purposes, except that the sponsor may, in the sponsor's discretion, apply some or all of the funding to provide meals and other food for all conference participants; and

(iii) all program content is objective, free from industry control, and does not promote specific products.



(B) Honoraria and payment of the expenses of a health care professional who serves on the faculty at a bona fide significant educational, medical, scientific, or policy-making conference or seminar, provided:

(i) there is an explicit contract with specific deliverables which are restricted to medical issues, not marketing activities; and

(ii) consistent with federal law, the content of the presentation, including slides and written materials, is determined by the health care professional.

(C) For a bona fide clinical trial:

(i) gross compensation for the Vermont location or locations involved;

(ii) direct salary support per principal investigator and other health care professionals per year; and

(iii) expenses paid on behalf of investigators or other health care professionals paid to review the clinical trial.

(D) For a research project that constitutes a systematic investigation, is designed to develop or contribute to general knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals working in the particular field of inquiry:

(i) gross compensation;

(ii) direct salary support per health care professional; and

(iii) expenses paid on behalf of each health care professional.

(E) Payment or reimbursement for the reasonable expenses, including travel and lodging-related expenses, necessary for technical training of individual health care professionals on the use of a medical device if the commitment to provide such expenses and the amounts or categories of reasonable expenses to be paid are described in a written agreement between the health care provider and the manufacturer.

(F) Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally recognized discovery for which the health care provider holds an ownership right.

(G) The payment of the reasonable expenses of an individual related to the interview of the individual by a manufacturer of prescribed products in connection with a bona fide employment opportunity.

~~(G)~~(H) Other reasonable fees, payments, subsidies, or other economic benefits provided by a manufacturer of prescribed products at fair market value.

(2) “Bona fide clinical trial” means an FDA-reviewed clinical trial that constitutes “research” as that term is defined in 45 C.F.R. § 46.102 and reasonably can be considered to be of interest to scientists or health care professionals working in the particular field of inquiry.

(3) “Clinical trial” means any study assessing the safety or efficacy of prescribed products administered alone or in combination with other prescribed products or other therapies, or assessing the relative safety or efficacy of prescribed products in comparison with other prescribed products or other therapies.

(4) “Free clinic” means a health care facility operated by a nonprofit private entity that:

(A) in providing health care, does not accept reimbursement from any third-party payor, including reimbursement from any insurance policy, health plan, or federal or state health benefits program that is individually determined;

(B) in providing health care, either:

(i) does not impose charges on patients to whom service is provided; or

(ii) imposes charges on patients according to their ability to pay;

(C) may accept patients’ voluntary donations for health care service provision; and

(D) is licensed or certified to provide health services in accordance with Vermont law.

(5) “Gift” means:

(A) Anything of value provided to a health care provider for free; or

(B) ~~Any~~ Except as otherwise provided in subdivision (a)(1)(A)(ii) of this section, any payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless:

(i) it is an allowable expenditure as defined in subdivision (a)(1) of this section; or

(ii) the health care provider reimburses the cost at fair market value.

(6) “Health benefit plan administrator” means the person or entity who sets formularies on behalf of an employer or health insurer.

~~(5)(7)~~(A) “Health care professional” means:

(i) a person who is authorized by law to prescribe or to recommend prescribed products, who regularly practices in this state, and who either is licensed by this state to provide or is otherwise lawfully providing health care in this state; or

(ii) a partnership or corporation made up of the persons described in subdivision (i) of this subdivision ~~(5)(7)~~(A); or

(iii) an officer, employee, agent, or contractor of a person described in subdivision (i) of this subdivision ~~(5)(7)~~(A) who is acting in the course and scope of employment, of an agency, or of a contract related to or supportive of the provision of health care to individuals.

(B) The term shall not include a person described in subdivision (A) of this subdivision ~~(5)(7)~~ who is employed solely by a manufacturer.

~~(6)(8)~~ “Health care provider” means a health care professional, a hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to dispense or purchase for distribution prescribed products in this state. The term does not include a hospital foundation that is organized as a nonprofit entity separate from a hospital.

~~(7)(9)~~ “Manufacturer” means a pharmaceutical, biological product, or medical device manufacturer or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repackaging, distributing, or labeling of prescribed products. The term does not include a wholesale distributor of biological products, a retailer, or a pharmacist licensed under chapter 36 of Title 26.

~~(8)(10)~~ “Marketing” shall include promotion, detailing, or any activity that is intended to be used or is used to influence sales or market share or to evaluate the effectiveness of a professional sales force.

~~(9)(11)~~ “Pharmaceutical manufacturer” means any entity which is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, whether directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, or any entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs. The term does not include a wholesale distributor of prescription drugs, a retailer, or a pharmacist licensed under chapter 36 of Title 26.

~~(10)~~(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, ~~or 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.

(13) “Sample” means a unit of a prescription drug, biological product, or medical device that is not intended to be sold and is intended to promote the sale of the drug, product, or device. The term includes starter packs and coupons or other vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price.

~~(11)~~(14) “Significant educational, scientific, or policy-making conference or seminar” means an educational, scientific, or policy-making conference or seminar that:

(A) is accredited by the Accreditation Council for Continuing Medical Education or a comparable organization, or is presented by an approved sponsor of continuing education, provided that the sponsor is not a manufacturer of prescribed products; and

(B) offers continuing ~~medical~~ education credit, features multiple presenters on scientific research, or is authorized by the ~~sponsoring association~~ sponsor to recommend or make policy.

(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.

(2) The prohibition set forth in subdivision (1) of this subsection shall not apply to any of the following:

(A) Samples of a prescribed product or reasonable quantities of an over-the-counter drug, nonprescription medical device, or item of nonprescription durable medical equipment provided to a health care provider for free distribution to patients.

(B) The loan of a medical device for a short-term trial period, not to exceed 90 days, to permit evaluation of a medical device by a health care provider or patient.

(C) The provision of reasonable quantities of medical device demonstration or evaluation units to a health care provider to assess the appropriate use and function of the product and determine whether and when to use or recommend the product in the future.

(D) The provision, distribution, dissemination, or receipt of peer-reviewed academic, scientific, or clinical articles or journals and other

items that serve a genuine educational function provided to a health care provider for the benefit of patients.

(E) Scholarship or other support for medical students, residents, and fellows to attend a significant educational, scientific, or policy-making conference or seminar of a national, regional, or specialty medical or other professional association if the recipient of the scholarship or other support is selected by the association.

(F) Rebates and discounts for prescribed products provided in the normal course of business.

(G) Labels approved by the federal Food and Drug Administration for prescribed products.

(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.

(I) The provision of free prescription drugs to or on behalf of an individual through a prescription drug manufacturer's patient assistance program.

(J) Fellowship salary support provided to fellows through grants from manufacturers of prescribed products, provided:

(i) such grants are applied for by an academic institution or hospital,

(ii) the institution or hospital selects the recipient fellows;

(iii) the manufacturer imposes no further demands or limits on the institution's, hospital's, or fellow's use of the funds; and

(iv) fellowships are not named for a manufacturer, and no individual recipient's fellowship is attributed to a particular manufacturer of prescribed products.

(K) The provision of coffee or other snacks or refreshments at a booth at a conference or seminar.

(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees and may impose on a manufacturer that violates this section a civil penalty of no more than \$10,000.00 per violation. Each unlawful gift shall constitute a separate violation.

Sec. 33. 18 V.S.A. § 4632 is amended to read:

§ 4632. DISCLOSURE OF ALLOWABLE EXPENDITURES AND GIFTS  
BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a)(1) Annually on or before October 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the fiscal year ending the previous June 30th the value, nature, purpose, and recipient information of:

(A) any allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title to any health care provider, except:

(i) royalties and licensing fees as described in subdivision 4631a(a)(1)(F) of this title;

(ii) rebates and discounts for prescribed products provided in the normal course of business as described in subdivision 4631a(b)(2)(F) of this title;

(iii) payments for clinical trials as described in subdivision 4631a(a)(1)(C) of this title, which shall be disclosed after the earlier of the date of the approval or clearance of the prescribed product by the Food and Drug Administration or two calendar years after the date the payment was made. For a clinical trial for which disclosure is delayed under this subdivision (iii), the manufacturer shall identify to the attorney general the clinical trial, the start date, and the web link to the clinical trial registration on the national clinical trials registry; ~~and~~

(iv) ~~samples of a prescription drug or biological product provided to a health care professional for free distribution to patients~~ interview expenses as described in subdivision 4631a(a)(1)(G) of this title; and

(v) coffee or other snacks or refreshments at a booth at a conference or seminar.

(B) any allowable expenditure or gift ~~permitted under subdivision 4631a(b)(2) of this title~~ to an academic institution, to a nonprofit hospital foundation, or to a professional, educational, or patient organization representing or serving health care providers or consumers, located in or providing services in Vermont, except:

(i) royalties and licensing fees as described in subdivision 4631a(a)(1)(F) of this title;

(ii) rebates and discounts for prescribed products provided in the normal course of business as described in subdivision 4631a(b)(2)(F) of this title; and

(iii) payments for clinical trials as described in subdivision 4631a(a)(1)(C) of this title, which shall be disclosed after the earlier of the date of the approval or clearance of the prescribed product by the Food and Drug Administration or two calendar years after the date the payment was made. For a clinical trial for which disclosure is delayed under this subdivision (iii), the manufacturer shall identify to the attorney general the clinical trial, the start date, and the web link to the clinical trial registration on the national clinical trials registry; and

~~(iv) samples of a prescription drug provided to a health care professional for free distribution to patients.~~

(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 October 1 of each year, each manufacturer of prescribed products shall disclose to the office of the attorney general all free samples of prescribed products, including starter packs, provided to health care providers during the fiscal year ending the previous June 30, identifying for each sample the product, recipient, number of units, and dosage.

(ii) The office of the attorney general may contract with academic researchers to release to such researchers data relating to manufacturer distribution of free samples, subject to confidentiality provisions and without including the names or license numbers of individual recipients, for analysis and aggregated public reporting.

(iii) Any public reporting of manufacturer distribution of free samples shall not include information that allows for the identification of individual recipients of samples or connects individual recipients with the monetary value of the samples provided.

(B) Subdivision (A) of this subdivision (a)(2) shall not apply to samples of prescription drugs required to be reported under Sec. 6004 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, if, as of January 1, 2011, the office of the attorney general has determined that the U.S. Department of Health and Human Services will collect and report state- and recipient-specific information regarding manufacturer distribution of free samples of such prescription drugs.

~~(2)(3)~~ Annually on July 1, each manufacturer of prescribed products also shall disclose to the office of the attorney general the name and address of the individual responsible for the manufacturer's compliance with the provisions of this section.

~~(3)~~(4) Disclosure shall be made on a form and in a manner prescribed by the office of the attorney general and shall require manufacturers of prescribed products to report each allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title including:

(A) except as otherwise provided in subdivision (a)(2) of this section, the value, nature, and purpose of each allowable expenditure, and gift permitted under subdivision 4631a(b)(2) of this title according to specific categories identified by the office of the attorney general;

(B) the name of the recipient;

(C) the recipient's address;

(D) the recipient's institutional affiliation;

(E) prescribed product or products being marketed, if any; and

(F) the recipient's state board number.

~~(4)~~(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 April 1. The report shall include:

(A) Information on allowable expenditures and gifts required to be disclosed under this section, which shall be presented in both aggregate form and by selected types of health care providers or individual health care providers, as prioritized each year by the office.

(B) Information on violations and enforcement actions brought pursuant to this section and section 4631a of this title.

~~(5)~~(6) After issuance of the report required by subdivision ~~(a)~~(5) of this ~~section~~ subsection and except as otherwise provided in subdivision (2)(A)(i) of this subsection, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

~~(6)~~(7) The office of Vermont health access shall examine the data available from the office of the attorney general for relevant expenditures and determine whether and to what extent prescribing patterns by health care providers of prescribed products reimbursed by Medicaid, VHAP, Dr. Dynasaur, VermontRx, and VPharm may reflect manufacturer influence. The office may select the data most relevant to its analysis. The office shall report its analysis annually to the general assembly and the governor on or before October 1.

(b)(1) Annually on July 1, the office of the attorney general shall collect a \$500.00 fee from each manufacturer of prescribed products filing annual



disclosures of expenditures greater than zero described in subsection (a) of this section.

(2) Fees collected under this section shall fund collection and analysis of information on activities related to the marketing of prescribed products under sections 4631a and 4632 of ~~Title 18~~ of this title. The fees shall be collected in a special fund assigned to the office.

(c) The attorney general may bring an action in Washington superior court for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer of prescribed products that fails to disclose as required by subsection (a) of this section a civil penalty of no more than \$10,000.00 per violation. Each unlawful failure to disclose shall constitute a separate violation.

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

\* \* \* HEALTH INSURANCE COVERAGE PROVISIONS \* \* \*

Sec. 34. 8 V.S.A. chapter 107, subchapter 12 is added to read:

Subchapter 12. Coverage for Dental Procedures

§ 4100i. ANESTHESIA COVERAGE FOR CERTAIN DENTAL PROCEDURES

(a) A health insurance plan shall provide coverage for the hospital or ambulatory surgical center charges and administration of general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for dental procedures performed on a covered person who is:

(1) a child seven years of age or younger who is determined by a dentist licensed pursuant to chapter 13 of Title 26 to be unable to receive needed dental treatment in an outpatient setting, where the provider treating the patient certifies that due to the patient's age and the patient's condition or problem, hospitalization or general anesthesia in a hospital or ambulatory surgical center is required in order to safely and effectively perform significantly complex dental procedures;

(2) a child 12 years of age or younger with documented phobias or a documented mental illness, as determined by a physician licensed pursuant to chapter 23 of Title 26, whose dental needs are sufficiently complex and urgent that delaying or deferring treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity; for whom a successful result cannot be expected from dental care provided under local anesthesia; and

for whom a superior result can be expected from dental care provided under general anesthesia; or

(3) a person who has exceptional medical circumstances or a developmental disability, as determined by a physician licensed pursuant to chapter 23 of Title 26, which place the person at serious risk.

(b) A health insurance plan may require prior authorization for general anesthesia and associated hospital or ambulatory surgical center charges for dental care in the same manner that prior authorization is required for these benefits in connection with other covered medical care.

(c) A health insurance plan may restrict coverage for general anesthesia and associated hospital or ambulatory surgical center charges to dental care that is provided by:

(1) a fully accredited specialist in pediatric dentistry;

(2) a fully accredited specialist in oral and maxillofacial surgery; and

(3) a dentist to whom hospital privileges have been granted.

(d) The provisions of this section shall not be construed to require a health insurance plan to provide coverage for the dental procedure or other dental care for which general anesthesia is provided.

(e) The provisions of this section shall not be construed to prevent or require reimbursement by a health insurance plan for the provision of general anesthesia and associated facility charges to a dentist holding a general anesthesia endorsement issued by the Vermont board of dental examiners if the dentist has provided services pursuant to this section on an outpatient basis in his or her own office and the dentist is in compliance with the endorsement's terms and conditions.

(f) As used in this section:

(1) "Ambulatory surgical center" shall have the same meaning as in 18 V.S.A. § 9432.

(2) "Anesthesiologist" means a person who is licensed to practice medicine or osteopathy under chapter 23 or 33 of Title 26 and who either:

(A) has completed a residency in anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology or their predecessors or successors; or

(B) is credentialed by a hospital to practice anesthesiology and engages in the practice of anesthesiology at that hospital full-time.

(3) “Certified registered nurse anesthetist” means an advanced practice registered nurse licensed by the Vermont board of nursing to practice as a certified registered nurse anesthetist.

(4) “Health insurance plan” means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, but does not include policies or plans providing coverage for a specified disease or other limited benefit coverage.

Sec. 35. 8 V.S.A. chapter 107, subchapter 13 is added to read:

Subchapter 13. Tobacco Cessation

§ 4100j. COVERAGE FOR TOBACCO CESSATION PROGRAMS

(a) A health insurance plan shall provide coverage of at least one three-month supply of tobacco cessation medication per year if prescribed by a physician for an individual insured under the plan. A health insurance plan may require the individual to pay the plan’s applicable prescription drug co-payment for the tobacco cessation medication.

(b) As used in this subchapter:

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

(2) “Tobacco cessation medication” means therapies approved by the federal Food and Drug Administration for use in tobacco cessation.

\* \* \* CATAMOUNT PROVISIONS \* \* \*

Sec. 36. 2 V.S.A. § 903(b)(2) is amended to read:

(2) If the commission determines that the market is not cost-effective, the agency of administration shall issue a request for proposals for the administration only of Catamount Health as described in section 4080f of Title 8. A contract entered into under this subsection shall not include the assumption of risk. If Catamount Health is administered under this subsection, the agency shall purchase a stop-loss policy for an aggregate claims amount for Catamount Health as a method of managing the state’s financial risk. The agency shall determine the amount of aggregate stop-loss reinsurance and may purchase additional types of reinsurance if prudent and cost-effective. ~~The~~

~~agency may include in the contract the chronic care management program established under section 1903a of Title 33.~~

Sec. 37. 8 V.S.A. § 4080f is amended to read:

§ 4080f. CATAMOUNT HEALTH

\* \* \*

(c)(1) Catamount Health shall provide coverage for primary care, preventive care, chronic care, acute episodic care, and hospital services. The benefits for Catamount Health shall be a preferred provider organization plan with:

\* \* \*

(2) Catamount Health shall provide a chronic care management program ~~that has criteria substantially similar to the chronic care management program established in section 1903a of Title 33~~ in accordance with the Blueprint for Health established under chapter 13 of Title 18 and shall share the data on enrollees, to the extent allowable under federal law, with the secretary of administration or designee in order to inform the health care reform initiatives under section 2222a of Title 3.

\* \* \*

(f)(1) Except as provided for in subdivision (2) of this subsection, the carrier shall pay a health care professional the lowest of the health care professional's contracted rate, the health care professional's billed charges, or the rate derived from the Medicare fee schedule, at an amount 10 percent greater than fee schedule amounts paid under the Medicare program in 2006. Payments based on Medicare methodologies under this subsection shall be indexed to the Medicare economic index developed annually by the Centers for Medicare and Medicaid Services. The commissioner may approve adjustments to the amounts paid under this section in accordance with a carrier's pay for performance, quality improvement program, or other payment methodologies in accordance with the ~~blueprint for health~~ Blueprint for Health established under chapter 13 of Title 18.

(2) Payments for hospital services shall be calculated using a hospital-specific cost-to-charge ratio approved by the commissioner, adjusted for each hospital to ensure payments at 110 percent of the hospital's actual cost for services. The commissioner may use individual hospital budgets established under section 9456 of Title 18 to determine approved ratios under this subdivision. Payments under this subdivision shall be indexed to changes in the Medicare payment rules, but shall not be lower than 102 percent of the hospital's actual cost for services. The commissioner may approve

adjustments to the amounts paid under this section in accordance with a carrier's pay for performance, quality improvement program, or other payment methodologies in accordance with the ~~blueprint for health~~ Blueprint for Health established under chapter 13 of Title 18.

(3) Payments for chronic care and chronic care management shall meet the requirements in section 702 of Title 18 ~~and section 1903a of Title 33.~~

\* \* \*

\* \* \* OBESITY PREVENTION \* \* \*

Sec. 38. REPORT ON OBESITY PREVENTION INITIATIVE

No later than November 15, 2010, the attorney general shall report to the house committees on health care and on human services, the senate committee on health and welfare, and the commission on health care reform regarding the results of the attorney general's initiative on the prevention of obesity. Specifically, the report shall include:

- (1) a list of the stakeholders involved in the initiative;
- (2) the actions the stakeholder group identified and developed related to obesity prevention;
- (3) the stakeholder group's recommendations; and
- (4) opportunities identified by the group to generate revenue and the group's recommendations on how such revenue should be applied.

\* \* \* MISCELLANEOUS PROVISIONS \* \* \*

Sec. 39. POSITIONS

In fiscal year 2011, the department of Vermont health access may establish one new exempt position to create a director of community health systems in the division of health care reform to fulfill the requirements in Sec. 14 of this act. This position shall be transferred and converted from existing vacant positions in the executive branch of state government.

Sec. 40. APPROPRIATIONS

(a)(1) It is the intent of the general assembly to fund the community health system pilots described in Sec. 14 of this act, including the position provided for in Sec. 39 of this act, and the health care reform design options and implementation plans in Sec. 6 of this act in a budget neutral manner. The total cost in state funds is \$339,175, all of which is reallocated from existing sources.

- (2) The community health system pilots have a total cost of \$250,000

(\$89,175 state; \$160,825 federal funds).

(3) The health care reform design options and implementation plans have a total cost of \$300,000; \$250,000 is reallocated from other sources and \$50,000 is allocated from the commission on health care reform's existing budget.

(b) In fiscal year 2011, \$527,242.00 of the amount appropriated in Catamount funds in Sec. B.312 of H.789 of the Acts of 2009 (Adj. Sess.) and allocated to the department of health for the Blueprint for Health is transferred to the agency of human services Global Commitment fund.

(c) In fiscal year 2011, \$250,000.00 of the amount appropriated in general funds in Sec. B.301 of H.789 of the Acts of 2009 (Adj. Sess.) and allocated to the agency of human services is transferred to the joint fiscal office for hiring the consultant required under Sec. 6 of this act.

(d) In fiscal year 2011, \$500,000.00 is appropriated from federal funds to the agency of human services Global Commitment fund.

(e) In fiscal year 2011, \$250,000.00 is appropriated from the Global Commitment fund to the department of Vermont health access to fill the position described in Sec. 39 and to implement the community health systems pilot projects described in Sec. 14 of this act.

(f) In fiscal year 2011, \$527,242.00 is appropriated from the Global Commitment fund to the department of health for the Blueprint for Health.

#### Sec. 41. EFFECTIVE DATES

(a) This section, Secs. 1 (findings), 2 (principles), 3 (goals), 4 (health care reform commission membership), 5 (appointments), 6 (design options), 7 (grants), 8 (public good), 9 (federal health care reform; BISHCA), 10 (federal health care reform; AHS), 11 (intent), 17 (demonstration waivers), 18 (expedited rules), 20 through 24 (hospital budgets), 25 (CON batching), 29 (rules; insurers), 31 (primary care study), 32 and 33 (pharmaceutical expenditures), and 38 (obesity report) of this act shall take effect upon passage.

(b) Secs. 12 and 13 (Blueprint for Health), 14 (community health systems), 15 (8 V.S.A. § 4088h), 16 (hospital certification), 19 (Blueprint Expansion), 26 through 28 (insurer rate review), 36 and 37 (citation corrections), 39 (position), and 40 (appropriations) of this act shall take effect on July 1, 2010.

(c) Sec. 30 (8 V.S.A. § 4089b; loss ratio) shall take effect on January 1, 2011 and shall apply to all health insurance plans on and after January 1, 2011, on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than January 1, 2012.

(d) Secs. 34 and 35 of this act shall take effect on October 1, 2010, and shall apply to all health insurance plans on and after October 1, 2010, on such date as a health insurer offers, issues, or renews the health insurance plan, but in no event later than October 1, 2011.

**(Committee vote: 9-2-0 )**

**(For text see Senate Journal 4/7/10 - 4/8/10 )**

**S. 237**

An act relating to operational standards for salvage yards

**Rep. McCullough of Williston**, for the Committee on **Fish, Wildlife & Water Resources**, recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 24 V.S.A. §§ 2248 and 2249 are added to read:

§ 2248. SALVAGE YARD OPERATIONAL STANDARDS

(a) Beginning July 1, 2010, a salvage yard shall meet the following operational standards:

(1) The salvage yard shall comply with the screening and fencing requirements of section 2257 of this title.

(2) Motor vehicles shall be drained of all fluids prior to crushing and within 365 days of receipt by the salvage yard, except that a vehicle with visible signs of leaking fluids shall be drained immediately. Fluids shall be drained, collected, and stored according to standards established by the secretary in order to prevent release to the environment. The fluids that shall be drained, collected, and stored under this subdivision include antifreeze, oil, brake fluid, fuel, refrigerants, and transmission fluid.

(3) Vehicles shall be drained and crushed:

(A) on or over a surface that is designed to retain seepage or draining fluids and that is designed to prevent releases to groundwater, discharges to surface waters, or other releases to the environment; or

(B) by a crusher with an onboard fluid-recovery and storage system that prevents releases to groundwater, discharges to surface waters, or other releases to the environment.

(4) A salvage yard issued a certificate of registration under section 2242 of this title after July 1, 2010, shall not be sited or operated within 100 feet of a Class I or Class II wetland as those terms are defined in 10 V.S.A. § 902. This

subdivision shall not apply to the renewal of a valid certificate of registration under this subchapter.

(5)(A) A salvage yard issued a certificate of registration under section 2242 of this title after July 1, 2010, shall not be sited or operated within 300 feet of a potable water supply, as that term is defined in 10 V.S.A. § 1972, unless:

(i) the water supply provides water to the salvage yard; or

(ii) the agency of natural resources approves management practices or remedial measures to prevent contamination of the potable water supply.

(B) This subdivision shall not apply to the renewal of a valid certificate of registration under this subchapter.

(b) On or before March 31, 2011, the secretary shall adopt by rule requirements for the siting, operation, and closure of salvage yards. The rules shall establish requirements for:

(1) the siting of salvage yards, including setbacks from surface waters, wetlands, and potable water supplies. Siting requirements under this subdivision may include site-specific conditions for salvage yards operating under a valid certificate of registration under section 2242 of this title, provided that such site-specific conditions are designed to prevent releases to groundwater, discharges to surface waters, or other risks to public health and the environment. A site-specific condition under this subdivision may include the requirement that the owner or operator of a salvage yard obtain an individual certificate of registration under section 2242 of this title instead of operating under a general permit adopted by the secretary under subsection (c) of this section;

(2) exemptions from the requirement to obtain a certificate of registration under section 2242 of this title;

(3) when an instrument of financial responsibility may be required by the secretary in amounts necessary to:

(A) remediate potential or existing environmental contamination caused by the salvage yard; or

(B) assure proper management of salvage materials upon closure of the salvage yard;

(4) removal of solid waste or tires from the salvage yard for proper disposal;



(5) establishment and maintenance of screening or fencing of salvage yards from public view;

(6) assuring proper closure of a salvage yard facility;

(7) postclosure environmental monitoring of a salvage yard;

(8) classes or categories of salvage yards, including those handling total loss vehicles from insurance; and

(9) additional measures that the secretary determines necessary for the protection of public health, safety, and the environment.

(c)(1) The secretary may issue a general permit for a certificate of registration issued to salvage yards under section 2242 of this title. The general permit may include a provision allowing a holder of a valid certificate of registration issued under this subchapter to self-certify compliance with the applicable standards of this subchapter and rules adopted under this subchapter. A general permit issued under this section shall be adopted by rule and may be incorporated into the rule required under subsection (b) of this section.

(2) If the secretary adopts a general permit for the regulation of salvage yards under subdivision (1) of this subsection, the secretary may require an owner or operator of a salvage yard that is operating under the general permit or that is applying for coverage under the general permit to obtain an individual certificate of registration under section 2242 of this title if any one of the following applies:

(A) the salvage yard does not qualify for the general permit;

(B) a salvage yard operating under the general permit is in violation of the terms and conditions of the general permit;

(C) the size, scope, or nature of the activity of the salvage yard exceeds the parameters of the general permit;

(D) the owner or operator of the salvage yard has a history of noncompliance; or

(E) the salvage yard presents a potential risk to public health or the environment.

(d) No person may deliver salvage vehicles to or operate a mobile salvage vehicle crusher at a salvage yard that does not hold a certificate of registration under this subchapter. A salvage yard holding a certificate of registration under this subchapter shall post a copy of its current certificate in a clearly visible location in the proximity of each entrance to the salvage yard.

(e) The requirement under subdivision (a)(2) of this section or rules adopted under this section to drain a vehicle within 365 days of receipt shall not apply to a salvage yard holding a certificate of registration under this subchapter that, as of January 1, 2010, is conducting business, the primary activity of which is the handling of total loss vehicles from insurance companies.

#### § 2249. SALVAGE YARD OPERATOR TRAINING

At least annually, the owner or operator of a salvage yard shall attend a training workshop conducted by the agency of natural resources regarding the requirements of this subchapter, best management practices, existing and proposed environmental standards, and other applicable federal, state, or municipal requirements.

Sec. 2. 24 V.S.A. § 2241 is amended to read:

#### § 2241. DEFINITIONS

For the purposes of this subchapter:

- (1) “Abandoned” means a motor vehicle as defined in 23 V.S.A. § 2151.
- (2) “Board” means the state transportation board, or its duly delegated representative.
- (3) “Highway” means any highway as defined in ~~section 19 V.S.A. § 1 of Title 19.~~
- (4) “Interstate or primary highway” means any highway, including access roads, ramps and connecting links, which have been designated by the state with the approval of the Federal Highway Administration, Department of Transportation, as part of the National System of Interstate and Defense Highways, or as a part of the national system of primary highways.
- (5) “Junk” means old or scrap copper, brass, iron, steel, and other old or scrap or nonferrous material, including but not limited to rope, rags, batteries, glass, rubber debris, waste, trash, or any discarded, dismantled, wrecked, scrapped, or ruined motor vehicles or parts thereof.
- (6) “Junk motor vehicle” means a discarded, dismantled, wrecked, scrapped, or ruined motor vehicle or parts thereof, ~~or one a motor vehicle,~~ other than an on-premise utility vehicle, which is allowed to remain unregistered or uninspected for a period of ~~ninety~~ 90 days from the date of discovery.
- (7) “Salvage yard” means any place of outdoor storage or deposit for storing, keeping, processing, buying, or selling junk or as a scrap metal processing facility. “Salvage yard” also means any ~~place of outdoor storage or~~

~~deposit, not in connection with a business which is maintained or used for storing or keeping four or more junk motor vehicles which are visible from any portion of a public highway or navigable water, as that term is defined in section 1422 of Title 10 outdoor area used for operation of an automobile graveyard.~~ It does not mean a garage where wrecked or disabled motor vehicles are stored for less than 90 days for inspection or repairs.

(8) “Legislative body” means the city council of a city, the board of selectmen of a town, or the board of trustees of a village.

(9) “Main traveled way” means the portion of a highway designed for the movement of motor vehicles, shoulders, auxiliary lanes, and roadside picnic, parking, rest, and observation areas and other areas immediately adjacent and contiguous to the traveled portion of the highway and designated by the transportation board as a roadside area for the use of highway users and generally but not necessarily located within the highway right-of-way.

(10) “Motor vehicle” means any vehicle propelled or drawn by power other than muscular power, including trailers.

(11) “Notice” means by certified mail with return receipt requested.

(12) “Scrap metal processing facility” means a manufacturing business which purchases sundry types of scrap metal from various sources including the following: industrial plants, fabricators, manufacturing companies, railroads, junkyards, auto wreckers, salvage dealers, building wreckers, and plant dismantlers and sells the scrap metal in wholesale shipments directly to foundries, ductile foundries, and steel foundries where the scrap metal is melted down and utilized in their manufacturing process.

(13) “Secretary” means the secretary of natural resources or the secretary’s designee.

(14) “Automobile hobbyist” means a person who is not primarily engaged in the business of:

(A) selling motor vehicles or motor vehicle parts; or

(B) accepting, storing, or dismantling junk motor vehicles.

(15) “Automobile graveyard” means a yard, field, or other outdoor area on a property owned or controlled by a person and used or maintained for storing or depositing four or more junk motor vehicles. “Automobile graveyard” does not include:

(A) an area used by an automobile hobbyist to store, organize, restore, or display motor vehicles or parts of such vehicles, provided that the

hobbyist's activities comply with all applicable federal, state, and municipal law;

(B) an area used for the storage of motor vehicles exempt from registration under chapter 7 of Title 23;

(C) an area owned or used by a dealer registered under 23 V.S.A. § 453 for the storage of motor vehicles; or

(D) an area used or maintained for the parking or storage of operational commercial motor vehicles, as that term is defined in 23 V.S.A. § 4103(4), that are temporarily out of service and unregistered but are expected to be used in the future by the vehicle operator or owner.

Sec. 3. 24 V.S.A. § 2242 is amended to read:

§ 2242. REQUIREMENT FOR OPERATION OR MAINTENANCE

(a) A person shall not operate, establish, or maintain a salvage yard unless he or she:

(1) Holds a certificate of approval for the location of the salvage yard; and

(2) Holds a certificate of registration issued by the secretary to operate, establish, or maintain a salvage yard.

(b) The issuance of a certificate of registration under subsection (a) of this section shall not relieve a salvage yard from the obligation to comply with existing state and federal environmental laws and to obtain all permits required under state or federal environmental law.

(c) The secretary may require a person to obtain a salvage yard certificate of registration under this section upon a determination, based on available information, that the person has taken action to circumvent the requirements of this subchapter.

Sec. 3. 24 V.S.A. § 4454(a) is amended to read:

(a) An action, injunction, or other enforcement proceeding relating to the failure to obtain or comply with the terms and conditions of any required municipal land use permit may be instituted under ~~sections~~ section 1974a, 4451, or 4452 of this title against the alleged offender if the action, injunction, or other enforcement proceeding is instituted within 15 years from the date the alleged violation first occurred and not thereafter, except that the 15-year limitation for instituting an action, injunction, or enforcement proceeding shall not apply to any action, injunction, or enforcement proceeding instituted for a violation of subchapter 10 of chapter 61 of this title. The burden of proving

the date the alleged violation first occurred shall be on the person against whom the enforcement action is instituted.

Sec. 4. 27 V.S.A. § 612(a) is amended to read:

(a) Notwithstanding the majority decision in *Bianchi v. Lorenz* (1997), for land development, as defined in 24 V.S.A. § 4303~~(3)~~(10), no encumbrance on record title to real estate or effect on marketability shall be created by the failure to obtain or comply with the terms or conditions of any required municipal land use permit as defined in 24 V.S.A. § 4303~~(24)~~(11).

Sec. 5. 24 V.S.A. § 4303(11) is amended to read:

(11) “Municipal land use permit” means any of the following whenever issued:

(A) A zoning, subdivision, site plan, or building permit or approval, any of which relate to “land development” as defined in this section, that has received final approval from the applicable board, commission, or officer of the municipality.

(B) A wastewater system permit issued under any municipal ordinance adopted pursuant to chapter 102 of this title.

(C) Final official minutes of a meeting that relate to a permit or approval described in subdivision (11)(A) or (B) of this section that serve as the sole evidence of that permit or approval.

(D) A certificate of occupancy, certificate of compliance, or similar certificate that relates to the permits or approvals described in subdivision (11)(A) or (B) of this section, if the bylaws so require.

(E) An amendment of any of the documents listed in subdivisions (11)(A) through (D) and (F) of this section.

(F) A certificate of approved location for a salvage yard issued under subchapter 10 of chapter 61 of this title.

Sec. 6. REPEAL

24 V.S.A. § 2248(a) (statutory operational standards for salvage yards) is repealed March 31, 2011.

Sec. 7. EFFECTIVE DATE

This act shall take effect July 1, 2010.

**(Committee vote: 9-0-0 )**

**(For text see Senate Journal 3/19/10 - 3/24/10 )**

**S. 287**

An act relating to the licensing and regulation of loan servicers

**Rep. Clerkin of Hartford**, for the **Committee on Commerce and Economic Development**, recommends that the House propose to the Senate that the bill be amended as follows:

§ 2900. DEFINITIONS

As used in this chapter:

(1) “Commercial loan” means any loan or extension of credit that is described in 9 V.S.A. § 46(1), (2), or (4). The term does not include a loan or extension of credit that is secured by an owner occupied one- to four-unit dwelling.

(2) “Commissioner” means the commissioner of banking, insurance, securities, and health care administration.

(3) “Control” means the possession, direct or indirect, of the power to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities or other interest of any other person.

(4) “Depository institution” has the same meaning as in Section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813(c), which includes any bank and any savings association as defined in Section 3 of the Federal Deposit Insurance Act. For purposes of this chapter, “depository institution” also includes any credit union organized and regulated as such under the laws of the United States or any state or territory of the United States.

(5) “Dwelling” has the same meaning as in subsection 103(v) of the Truth in Lending Act, 15 U.S.C. § 1602(v).

(6) “Individual” means a natural person.

(7) “Loan” means a residential mortgage loan.

(8) “Nationwide Mortgage Licensing System and Registry” means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators, or any successor to the Nationwide Mortgage Licensing System and Registry.

(9) “Person” shall have the meaning set forth in 1 V.S.A. § 128 and includes a natural person, corporation, company, limited liability company, partnership, or association.

(10) “Residential mortgage loan” means any loan primarily for personal, family, or household use that is secured by a mortgage, deed of trust, or other equivalent consensual security interest on either a dwelling or residential real estate, upon which is constructed or intended to be constructed a dwelling.

(11) “Residential real estate” means any real property located in Vermont, upon which is constructed or intended to be constructed a dwelling.

(12) “Servicing” means receiving a scheduled periodic payment from a borrower pursuant to the terms of a loan, including amounts for escrow accounts, and making the payments to the owner of the loan or other third party of principal and interest and other payments with respect to the amounts received from the borrower as may be required pursuant to the terms of the servicing loan document or servicing contract. In the case of a home equity conversion mortgage or a reverse mortgage, servicing includes making payment to the borrower.

(13) “Third party loan servicer” means a person who engages in the business of servicing a loan, directly or indirectly, owed or due or asserted to be owed or due another.

**(Committee vote: 11-0-0 )**

**(For text see Senate Journal 2/16/10 )**

### **J.R.S. 50**

Joint resolution urging expedited federal initiation of the National Environmental Policy Act process relating to the proposed federal acquisition of Eagle Point Farm in Derby, Vermont.

**Rep. Lewis of Derby**, for the Committee on **Fish, Wildlife & Water Resources**, recommends the House propose to the Senate to amend the resolution by striking all after the title and inserting in lieu thereof the following:

*Whereas*, the late Michael Dunn, the owner of the 800-acre Eagle Point Farm (approximately one-half of which is located in Derby, Vermont, and the balance in Quebec), conditionally donated through his trust the Vermont portion of this exceptional parcel as a gift to the United States of America for purposes of permanent preservation and public enjoyment, and

*Whereas*, Eagle Point Farm's Vermont acreage includes diverse freshwater wetland, woodland, and riparian habitats, rich agricultural land, and more than a mile of frontage on 27-mile-long Lake Memphremagog, and

*Whereas*, this impressive acreage provides land for high quality breeding, migratory, and wintering habitats for priority waterfowl and grassland bird species, and

*Whereas*, many rare plants and unique natural communities are also located at Eagle Point Farm, and

*Whereas*, for many decades, through the generosity of the Dunn family, many Vermonters have enjoyed Eagle Point Farm for walking, fishing, hunting, trapping, wildlife observation, and access to Lake Memphremagog, and

*Whereas*, because Eagle Point Farm is waterfront land, it is valuable monetarily and is at high risk of being developed should the United States not ultimately accept Michael Dunn's generous gift, and

*Whereas*, not only is this land attractive to developers, but also, in accordance with the terms of Michael Dunn's conditional donation, should the federal government not acquire the Vermont portion of Eagle Point Farm by September 1, 2010, then the trustee must dispose of the property in a manner that would maximize its cash value for the benefit of a secondary institutional beneficiary, and

*Whereas*, the northeastern office of the United States Fish and Wildlife Service (USFWS), in close collaboration with the state of Vermont, has assessed the conservation value of the Vermont portion of Eagle Point Farm, and

*Whereas*, there is mutual agreement among federal and state authorities that the optimal disposition of the Vermont portion of Eagle Point Farm is to proceed with a proposal that the Vermont Land Trust has put forward – to wit: that the USFWS should acquire title to the land and that the Vermont Agency of Natural Resources should then administer Eagle Point Farm in Derby as a coordination area for recreational use in accordance with the Wildlife Management Area (WMA) guidelines of the Vermont Department of Fish and Wildlife and a jointly entered memorandum of understanding, and

*Whereas*, the Province of Quebec is simultaneously working toward accepting a gift of that portion of Michael Dunn's property located in the province, and such an acquisition would provide opportunities for cross-border collaboration, and



*Whereas*, the Vermont Fish and Wildlife Conservation Group, located in nearby East Charleston, has written to the Vermont congressional delegation, offering its full support for both the federal acquisition and subsequent state management of Eagle Point Farm, and

*Whereas*, the Memphremagog Watershed Association (MWA) in Derby, whose mission is “the preservation of the environment and natural beauty of the Memphremagog watershed,” has written to public officials that it “cannot overstate the importance of and their support for keeping Michael Dunn’s property in the public trust and for public use,” and

*Whereas*, the MWA has worked collaboratively with Memphremagog Conservation, Inc. for the preservation of Eagle Point Farm on both sides of the border, and it has reminded public officials that preservation of the property is “consistent with the efforts and goals of the Quebec/Vermont Steering Committee which is charged with the restoration and protection of the international waters of Lake Memphremagog,” and

*Whereas*, the northeastern office of the USFWS has submitted a proposal to its national office in Washington, D.C., to move forward immediately with the scientific assessment and public comment requirements of the National Environmental Policy Act (NEPA) in order that the acquisition process can occur prior to the September 1, 2010, deadline, and

*Whereas*, the NEPA process will provide the opportunity for the general public to offer its comments on the proposed federal acquisition and state management of Eagle Point Farm in Derby to help determine the best long-term outcome for this special piece of Vermont, *now therefore be it*

***Resolved by the Senate and House of Representatives:***

That the General Assembly urges the United States Fish and Wildlife Service to expedite the National Environmental Policy Act process relating to the proposed federal acquisition of Eagle Point Farm in Derby, Vermont, *and be it further*

***Resolved:*** That the Secretary of State be directed to send a copy of this resolution to the United States Secretary of the Interior, the United States Fish and Wildlife Service Commissioner, the United States Fish and Wildlife Service Northeast Regional Director, the Vermont Congressional Delegation, and the Vermont Secretary of Natural Resources.

**(Committee Vote: 9-0-0)**

**(For Text see House Journal 2/26/10)**

## Senate Proposal of Amendment

### H. 408

An act relating to improving nutrition programs

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

First: By inserting a new Sec. 4a to read:

Sec. 4a. SUMMER EDUCATIONAL PROGRAMS; CAMPS

On or before October 1, 2010, the department of education shall report to the house committee on human services, the senate committee on health and welfare, and the house and senate committees on appropriations and on education regarding the number of school districts that operated or funded summer educational or recreational programs or camps.

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

Sec. 5. DIRECT CERTIFICATION FOR SCHOOL MEALS PROGRAMS

The department for children and families and the department of education shall continue to improve the monthly direct certification process through the use of automated data matches in order to certify children receiving 3SquaresVT or other programs or benefits deemed by federal law to make those children eligible for school breakfast, lunch, and summer meals programs.

(For text see House Journal 3/16/10 )

### Ordered to Lie

#### H.R. 19

House resolution urging the agency of natural resources to retain delegated authority to administer the federal Clean Water Act in Vermont.

Pending Question: Shall the House adopt the resolution?

### Consent Calendar

#### Concurrent Resolutions

The following concurrent resolutions have been introduced for approval by the Senate and House and will be adopted automatically unless a Senator or Representative requests floor consideration before the end of the session of the next legislative day. Requests for floor consideration in either chamber should be communicated to the Secretary's office and/or the House Clerk's office, respectively. For text of resolutions, see Addendum to House Calendar and Senate Calendar.

**H.C.R. 317**

House concurrent resolution honoring Carl Johnson for his outstanding half century of public service as a law enforcement officer and for his dedicated work as a Franklin County historian

**H.C.R. 318**

House concurrent resolution congratulating the 2010 Windsor High School Yellow Jackets Division III girls' basketball championship team

**H.C.R. 319**

House concurrent resolution designating April 28, 2010, as National Walk@Lunch Day in Vermont

**H.C.R. 320**

House concurrent resolution honoring Meredith Sumner for her dedicated public service as a legislative council attorney

**H.C.R. 321**

House concurrent resolution honoring E. Anne Winchester's extraordinary public service as a legislative council drafter and policy analyst

**H.C.R. 322**

House concurrent resolution honoring Stanley Michael Slater on the conclusion of his outstanding legislative council career

**H.C.R. 323**

House concurrent resolution congratulating the 2010 Norwich University Cadets championship NCAA Division III men's ice hockey team

**H.C.R. 324**

House concurrent resolution recognizing Vermont students' excellent performance on the national reading examination

**H.C.R. 325**

House concurrent resolution congratulating Philip Swanson on the 25th anniversary of his exemplary public service as Woodstock's town and village manager

**H.C.R. 326**

House concurrent resolution commemorating the World War II friendship and military service of Raymond Sanville and Bill Spriggs

**H.C.R. 327**

House concurrent resolution in memory of the Rev. Michael A. DeMasi

**H.C.R. 328**

House concurrent resolution congratulating Andrea Rogers on 30 years of extraordinary leadership and commitment to artistic excellence and community involvement

**H.C.R. 329**

House concurrent resolution in memory of Mark Richard Skakel

**H.C.R. 330**

House concurrent resolution congratulating Charles Hunter on being named the Great Falls Regional Chamber of Commerce Person of the Year

**H.C.R. 331**

House concurrent resolution recognizing American Craft Beer Week in Vermont

**H.C.R. 332**

House concurrent resolution designating the Deerfield Valley as the Blueberry Capital of Vermont

**Information Notice**

**House Appropriations Committee**

**Members' amendments to H. 792**

**Challenges for Change**

The House Appropriations Committee invites all members of the House who intend to introduce amendments to H. 792 (Challenges for Change) to meet with the committee on Wednesday, April 14, at 9:00 a.m., OR for third reading, Thursday, April 15, 2010, at 8:30 a.m., in Room 42. If possible, please talk to Theresa Utton-Jerman in Room 40 (ext. 5767) to schedule a time.