House Calendar

Thursday, April 22, 2010

108th DAY OF ADJOURNED SESSION

House Convenes at 1:00 P.M.

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Favorable

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Ordered to Lie

For Informational Purposes

ORDERS OF THE DAY

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S. 287

An act relating to the licensing and regulation of loan servicers

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 (SCHIP) 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.

~~(c)~~(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.

(e)~~(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 (e) 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 subjection 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, repacking, 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)

Rep. Larson of Burlington, for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committee on **Health Care** and when further amended as follows:

First: In Sec. 40, by striking out subdivision (a)(1) and inserting a new subdivision (a)(1) to read:

(a)(1) It is the intent of the general assembly to fund the community health system pilot projects 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 $389,175.00, all of which is reallocated from existing sources.

Second: In Sec. 40, by inserting a subsection (g) to read:

(g) In fiscal year 2011, $50,000.00 of the amount appropriated in general funds in Sec. B.125 of H.789 of the Acts of the 2009 Adj. Sess. (2010) and allocated to the commission on health care reform for studies is transferred to

the joint fiscal office for hiring the consultant required in Sec. 6 of this act.

(Committee Vote: 7-3-1)

Amendment to be offered by Reps. Frank of Underhill, Andrews of Rutland City, Donahue of Northfield, Fisher of Lincoln, French of Randolph, Haas of Rochester, McFaun of Barre Town, Mrowicki of Putney, O'Donnell of Vernon, and Pugh of South Burlington to S. 88

Move that the House propose to the Senate that the bill be amended by inserting a new Sec. 40 to read:

Sec. 40. PEDIATRIC PALLIATIVE CARE

The agency of human services shall request a provision allowing Vermont to provide its Medicaid- and SCHIP-eligible children who have life-limiting illnesses with concurrent palliative services and curative care, either as part of its renewal of the state's Global Commitment for Health Medicaid Section 1115 waiver or as an amendment following renewal.

and by renumbering the remaining sections and internal references to be numerically correct

Amendment to be offered by Rep. Maier of Middlebury to S. 88

Rep. Maier of Middlebury moves that amendment offered by the Committee on Health Care be amended as follows:

First: In Sec. 1 (findings), in subdivision (2), by inserting the term "in 2010" after "$4.9 billion" and in subdivision (14), by striking the word "physician" before "best practices" and inserting in lieu thereof the words "licensed health care practitioner"

Second: In Sec. 4, 2 V.S.A. § 901, in subsection (b), by striking subdivision (2) and inserting a new subdivision (2) to read:

(2) The two nonvoting members with experience in health care shall not:

(A) be in the employ of or holding any official relation to any health care provider or insurer or be engaged in the management of a health care provider or insurer;

(B) own stock, bonds, or other securities of a health care provider or insurer, unless the stock, bond, or other security is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the member chooses the stock, bond, or security;

(C) in any manner, be connected with the operation of a health care provider or insurer; or

(D) 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.

Third: In Sec. 6, subsection (e), in subdivision (1)(C)(v)(II), by striking out the term "board" from the second sentence and inserting in lieu thereof the term "consultant"

Fourth: In Sec. 6, subsection (e), in subdivision (3)(B), by striking out the words "D & P department of health" in the second sentence and inserting in lieu thereof the words "interdepartmental diagnosis and prevention services"

Fifth: In Sec. 13, 18 V.S.A. § 701, in subdivision (4), by striking out the words "the physician and patient relationship" following "systemic supports for" and inserting in lieu thereof the words "licensed health care practitioners and their patients"

Sixth: In Sec. 13, 18 V.S.A. § 702, in subdivision (b)(1)(A), after the words "Vermont medical society;" by inserting the words "a representative from the Vermont nurse practitioners association;"

Seventh: In Sec. 14, in subdivision (a)(3)(F), by striking out the words "physician or from a mental health professional" and inserting in lieu thereof the words "licensed health care practitioner"

Eighth: In Sec. 14, in subdivision (f)(1), by striking out "2011" and inserting in lieu thereof "2012"

Ninth: In Sec. 18, by striking out subdivision (1) and inserting a new subdivision (1) to read:

(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 online of a notice that lists the rules to be adopted pursuant to this process and a seven-day public comment period following publication.

Tenth: By striking Sec. 25 in its entirety and inserting in lieu thereof a Sec. 25 to read as follows:

Sec. 25. 18 V.S.A. § 9439(f) is amended to read:

(f) ~~The commissioner shall establish, by rule, annual cycles for the review of applications for certificates under this subchapter, in addition to the review cycles for skilled nursing and intermediate care beds established under subsections (d) and (e) of this section. A review cycle may include in the same~~

~~group some or all of the types of projects subject to certificate of need review. Such rules may exempt emergency applications, pursuant to subsection 9440(d) of this title.~~ Unless an application meets the requirements of subsection 9440(e) of this title, the commissioner shall consider disapproving a certificate of need application for a hospital if a project was not identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year capital plan required under subdivision 9454(a)(6) of this title. The commissioner shall review all hospital four-year capital plans as part of the review under subdivision 9437(2)(B) of this title.

Eleventh: In Sec. 34, 8 V.S.A. § 4100i, in subdivision (a)(2), following the words "physician licensed pursuant to chapter 23 of Title 26", by inserting "or by a licensed mental health professional"

Twelfth: In Sec. 34, 8 V.S.A. § 4100i, in subsection (f), by adding a subdivision (5) to read:

(5) "Licensed mental health professional" means a licensed physician, psychologist, social worker, mental health counselor, or nurse with professional training, experience, and demonstrated competence in the treatment of mental illness.

Thirteenth: In Sec. 35, 8 V.S.A. 4100j, in subsection (a), by striking out the term "physician" after the words "prescribed by a" and inserting in lieu thereof the words "licensed health care practitioner"

Fourteenth: In Sec. 41, in subsection (a), by striking "25 (CON batching)" and inserting in lieu thereof "25 (CON prospective need)"

Amendment to be offered by Rep. Wright of Burlington to S. 88

Rep. Wright of Burlington moves that the amendment offered by the Committee on Health Care as amended be further amended by striking Sec. 33 in its entirety and inserting in lieu thereof the following:

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 provided to a health care professional for free distribution to patients;

(v) interview expenses as described in subdivision 4631a(a)(1)(G) of this title; and

(vi) 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;

(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) 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) 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) 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) After issuance of the report required by subdivision (a)(5) of this section, the office of the attorney general shall make all disclosed data used for the report publicly available and searchable through an Internet website.

(6) 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~~ 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.

Action Under Rule 52

J.R.H. 47

Joint resolution urging the United States Commodity Futures Trading Commission to limit rampant speculation in the energy futures market

(For text see House Journal 4/21/10)

H.R. 32

House resolution amending the Rules of the House of Representatives relating to the adoption of constitutional amendments

(For text see House Journal 4/21/10)

Action Postponed Until May 28, 2010
Governor's 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. 122

An act relating to recounts in elections for statewide offices

Rep. Hubert of Milton, for the Committee on Government Operations**,** 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. 17 V.S.A. § 2370 is amended to read:

§ 2370. WRITE-IN CANDIDATES

A write-in candidate shall not qualify as a primary winner unless he or she has filed a declaration of candidacy for that office with the office as set forth in section 2414 of this title and unless he or she receives at least one-half the number of votes required for ~~his~~ the office on a primary petition, except that if a write-in candidate receives more votes than a candidate whose name is printed on the ballot, he or she may qualify as a primary winner. The write-in candidate who qualifies as a primary winner under this section must still be determined a winner under section 2369 of this title before he or she becomes the party's candidate in the general election.

Sec. 2. Secs. 6, 7, and 8 of No. 73 of the Acts of 2009 Adj. Sess. (2010) are amended to read:

Sec. 6. 17 V.S.A. § 2386 is amended to read:

§ 2386. TIME FOR FILING STATEMENTS

(a) Statements pursuant to this subchapter, except for vacancies created by the death or withdrawal of a candidate after the primary ~~and statements for minor party candidates and independent candidates~~, shall be filed ~~not earlier than the second Thursday after the first Monday in June before the day of the general election and not later than 5:00 p.m. on the Tuesday following the primary election~~ as set forth in section 2356 of this title.

(b) In the case of the death or withdrawal of a candidate after the primary election, the party committee shall have seven days from the date of the withdrawal to nominate a candidate. In no event, shall a statement be filed later than 60 days prior to the election.

Sec. 7. 17 V.S.A. § 2402(d) is amended to read:

(d) A statement of nomination and a completed and signed consent form shall be filed ~~not sooner than the second Thursday after the first Monday in June and not later than the third day after the primary election~~ as set forth in

section 2356 of this title. No public official receiving nominations shall accept a petition unless a completed and signed consent form is filed at the same time.

Sec. 8. 17 V.S.A. § 2413 is amended to read:

§ 2413. NOMINATION OF JUSTICES OF THE PEACE

(a) The party members in each town, on or before the ~~fourth~~ first Tuesday of August in each even numbered year, upon the call of the town committee, may meet in caucus and nominate candidates for justice of the peace. The committee shall give notice of the caucus as provided in subsection (d) of this section and the chairman and secretary shall file the statements required in ~~sections~~ section 2385 ~~through 2387~~ of this title not later than 5:00 p.m. on the third day following the primary election.

(b) If it does not hold a caucus as provided in subsection (a) of this section, the town committee shall meet and nominate candidates for justices of the peace as provided in sections 2381 through ~~2387~~ 2385 of this title.

(c) In any town in which a political party has not formally organized, any three members of the party who are voters in the town may call a caucus to nominate candidates for justice of the peace by giving notice as required in subsection (d) of this section. Upon meeting, the caucus shall first elect a chairman and a secretary. Thereafter the caucus shall nominate its candidates for justice of the peace, and cause its chairman and secretary to file the statements required in ~~sections~~ section 2385 ~~through 2387~~ of this title not later than 5:00 p.m. on the third day following the primary election.

* * *

Sec. 3. 17 V.S.A. § 2414 is added to read:

§ 2414. WRITE-IN CANDIDATES; DECLARATION OF CANDIDACY

(a) A person who has not been nominated by any other procedure set forth in this chapter and whose name will not appear on the ballot for a particular office may be written in on a ballot for any office in a primary, general, or special election. However, a "write-in" candidate shall file a declaration of candidacy for an office with the office of the secretary of state not later than 5 p.m. on the Friday preceding the election if the candidate wishes to have the votes cast for his or her name counted by name for that office. The secretary of state shall prepare and make available a declaration of candidacy form to be completed, signed, and filed by a "write-in candidate" before the deadline.

(b) The secretary of state shall notify all town clerks of each write-in candidate who has filed a declaration of candidacy prior to the deadline. Each candidate who has filed a declaration of candidacy shall have votes cast recorded next to his or her write-in name in the vote counting process and shall

have his or her votes reported by name on the official return of votes. If a declaration of candidacy has not been filed, the name of the write-in candidate shall not be recorded, but the vote cast shall be recorded as a "scattered write-in" on all counting forms and on the official return of votes.

Sec. 4. 17 V.S.A. § 2587(e) is amended to read:

(e) In the case of "write-in" votes, the act of writing in the name of a candidate, or pasting a label containing a candidate's name upon the ballot, without other indications of the voter's intent, shall constitute a vote for that candidate, even though no cross is placed or no oval is filled in after such name. ~~The~~ If a declaration of candidacy was timely filed and the office of the secretary of state has notified the town, the election officials counting ballots and tallying results ~~must~~ shall list the name of the candidate on the tally sheet and record the number of votes received next to the candidate's name. For every other person who receives a "write-in" vote ~~and the number of votes received~~, but who did not file a declaration of candidacy, the election officials shall record the vote next to "scattered write-ins". On each tally sheet, the counters shall add together the names of candidates who have filed a declaration of candidacy that are clearly the same person, even though a nickname or only a last name is used. Names of candidates who did not file a declaration of candidacy and names of fictitious persons shall not be listed individually by name, but each vote shall be recorded and counted as a scattered write-in vote on tally sheets, summary sheets, and the official return of votes.

Sec. 5. 17 V.S.A. § 2601 is amended to read:

§ 2601. RECOUNTS

~~If~~ In an election for statewide office, county office, or state senator, if the difference between the number of votes cast for a winning candidate and the number of votes cast for a losing candidate is less than two percent of the total votes cast for all the candidates for an office, that losing candidate shall have the right to have the votes for that office recounted. In an election for all other offices, if the difference between the number of votes cast for a winning candidate and the number of votes cast for a losing candidate is less than five percent of the total votes cast for all the candidates for an office, divided by the number of persons to be elected, that losing candidate shall have the right to have the votes for that office recounted.

Sec. 6. 17 V.S.A. § 2681(f) and (g) are added to read:

(f) A person who has not been nominated by any other procedure described in this chapter and whose name will not appear on the ballot for a particular office may be written in on a ballot in any municipal election for any office.

However, a write-in candidate shall file a declaration of candidacy with the office of the town clerk not later than 5 p.m. on the Friday preceding the election if the candidate wishes to have the votes cast for his or her name counted by name for an office. The town clerk shall make available the declaration of candidacy form prepared by the secretary of state to be completed, signed, and filed by the "write-in" candidate before the deadline.

(g) The town clerk shall prepare a list of write-in candidates for each office who have filed a declaration of candidacy prior to the deadline. Each candidate who has filed a declaration of candidacy shall have votes cast recorded by his or her write-in name in the vote-counting process and reported by name on the official return of votes. If a declaration of candidacy has not been filed, the name of the write-in candidate shall not be recorded, and the vote cast shall be recorded as a "scattered write-in" on all counting forms and on the official return of votes.

Sec. 7. 17 V.S.A. § 2682(c) is amended to read:

(c) In a municipal election controlled by this subchapter, the person receiving the greatest number of votes for an office shall be declared elected to that office; a certificate of election need not be issued. However, in order to have a write-in candidate counted by name and to be elected as a write-in candidate ~~must~~, the write-in candidate shall have filed a declaration of candidacy with the town clerk as set forth in subsection 2681(f) of this title and shall receive 30 votes or the votes of one percent of the registered voters in the municipality, whichever is less.

Sec. 8. EFFECTIVE DATE

This act shall take effect upon passage.

(Committee vote: 10-0-1)

(For text see Senate Journal 4/7/ & 4/10/10)

S. 165

An act relating to eliminating the statute of limitations for felonies

Rep. Jewett of Ripton, for the Committee on Judiciary**,** recommends that the House propose to the Senate that the bill be amended as follows:

By changing the title of the bill to read: "An act relating to waiver of the statute of limitations in criminal prosecutions"

(Committee vote: 10-0-1)

(For text see Senate Journal 1/26/10)

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)

Rep. Miller of Shaftsbury, for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committee on **Human Services.**

(Committee Vote: 11-0-0)

Favorable

S. 173

An act relating to technical corrections to the trust laws

Rep. Koch of Barre Town, for the Committee on **Judiciary**, recommends that the bill ought to pass in concurrence.

(Committee Vote: 10-0-1)

(For text see Senate Journal 1/26/10-2/3/10)

Senate Proposal of Amendment

H. 759

An act relating to executive branch fees

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

First: In Sec. 2, 20 V.S.A. § 2738, in subsection (a), in subdivision (4), by striking out "and", in subdivision (5), by adding a new ;and and saving the old period for the end of a new subdivision (6) which is added to read:

(6) fees relating to licensing elevator mechanics and inspectors, and issuing permits and certificates of operation under subchapter 2A of chapter 3 of Title 21.

Second: By striking out Sec. 4 and inserting in lieu thereof a new Sec. 4 to read:

Sec. 4. 20 V.S.A. §§ 2883 and 2884 are amended to read:

§ 2883. ~~INSPECTIONS BY INSURANCE COMPANIES~~ BOILER INSPECTIONS

The commissioner has authority to obtain specific information from ~~boiler insurance companies,~~ boiler inspectors on forms ~~furnished by them,~~ which shall first be approved by the commissioner. The commissioner may authorize qualified inspectors ~~in the employ of insurance companies~~ to conduct inspections ~~under his or her control and~~ under such rules as the commissioner may prescribe. If a boiler or pressure vessel is insured, the inspection may be conducted by a qualified inspector who is employed, or contractually authorized, by the insurer. If a boiler or pressure vessel is not insured, the inspection may be conducted by any qualified inspector authorized by the commissioner. In case the inspection is made by such an inspector, no fee shall be charged by the division, except a process fee of ~~$20.00~~ $30.00 for issuance of an operating certificate. The fee for a person requesting a three-year authorization to conduct inspections shall be $150.00. A licensed boiler inspector shall carry liability insurance in an amount determined by the department.

§ 2884. QUALIFICATIONS OF INSPECTORS

All boiler inspectors~~, employed by the state and insurance companies,~~ shall have passed the examination required by the National Board of Boiler and Pressure Vessel Inspectors, and hold annual certification from such board.

Third: By inserting an internal caption and a Sec. 9a to read:

* * * Criminal conviction records * * *

Sec. 9a. 20 V.S.A. § 2056c is amended to read:

§ 2056c. DISSEMINATION OF CRIMINAL CONVICTION RECORDS TO THE PUBLIC

* * *

(c) Criminal conviction records shall be disseminated to the public by the center under the following conditions:

* * *

(10) No person entitled to receive a criminal conviction record pursuant to this section shall require an applicant to obtain, submit personally, or pay for a copy of his or her criminal conviction record, except that this subdivision shall not apply to a local governmental entity with respect to criminal conviction record checks for licenses or vendor permits required by the local governmental entity.

Fourth: By inserting an internal caption and a Sec. 9b to read:

* * * Fingerprinting fees * * *

Sec. 9b. 20 V.S.A. § 2062 is amended to read:

§ 2062. FINGERPRINTING FEES

State, county and municipal law enforcement agencies may charge a fee of not more than ~~$15.00~~ $25.00 for providing persons with a set of classifiable fingerprints. No fee shall be charged to retake fingerprints determined by the Vermont criminal information center not to be classifiable. Fees collected by the state of Vermont under this section shall be credited to the fingerprint fee special fund established and managed pursuant to ~~32 V.S.A. chapter 7,~~ subchapter 5 of chapter 7 of Title 32, and shall be available to the department of public safety to offset the costs of providing these services.

Fifth: By striking out Sec. 6 and inserting in lieu thereof a new Sec. 6 to read:

Sec. 6. 26 V.S.A. § 905 is amended to read:

§ 905. APPLICATION; EXAMINATIONS AND FEES

* * *

(d)(1) Three-year electrical license fees shall be:

For a masters license (initial and renewal) ~~$120.00~~ $150.00;

For a journeyman's license (initial and renewal) ~~$ 90.00~~ $115.00;

For a type-S journeyman's license (initial and

renewal) per field ~~$ 90.00~~ $115.00;

(2) A fee established under this subsection for a license initially obtained under section 906 of this title shall not be less than the fee charged for the same license by the reciprocal state.

(e) ~~For~~ The fee for a certificate for framing shall be $ 10.00.

~~(e)~~(f) If a license is allowed to lapse, it may be renewed within one year of its expiration date by the payment of $25.00 in addition to the renewal fee.

~~(f)~~(g) The fee for replacement of a lost or damaged license shall be $20.00.

Sixth: In Sec. 9, by adding a subsection (c) to read:

(c) 21 V.S.A. § 157 (elevator safety fund; creation) is repealed.

Seventh: By striking out Sec. 10 and inserting in lieu thereof a new Sec. 10 to read:

Sec. 10. 6 V.S.A. § 324(b) is amended to read:

(b) No person shall distribute in this state a commercial feed that has not been registered pursuant to the provisions of this chapter. Application shall be in a form and manner to be prescribed by rule of the secretary. The application for registration of a commercial feed shall be accompanied by a registration fee of ~~$70.00~~ $75.00 per product. The registration fees, along with any surcharges collected under subsection (c) of this section, shall be deposited in the special fund created by subsection 364(e) of this title. Funds deposited in this account shall be restricted to implementing and administering the provisions of this title and any other provisions of the law relating to fertilizer, lime, or seeds. If the secretary so requests, the application for registration shall be accompanied by a label or other printed matter describing the product.

Eighth: In Sec. 18, 9 V.S.A. § 2643, by striking out subsection (b) and inserting in lieu thereof a new subsection (b) to read:

(b) The secretary shall, from time to time, test the accuracy and use of laser scanning and other computer assisted check-out systems in stores. The secretary shall compare the programmed computer price with the item price of any consumer commodity offered by a store. The store shall provide access to the computer as is necessary to allow the secretary to conduct the accuracy test.

~~(b)~~ If, upon review, the programmed price of a commodity exceeds the price printed on or the advertised price of the commodity, the store may be subject to license denial, revocation, suspension or the ~~following~~ administrative penalties~~: $15.00 per violation identified in more than two percent but less than four percent of the commodities reviewed, rounded to the~~

~~nearest whole number, $20.00 per violation in the next two percent reviewed, $50.00 per violation in the next two percent and $100.00 for each additional violation. In no event, however, shall the total amount of penalty for the review exceed $1,000.00~~ allowed by 6 V.S.A. § 15 for overcharge errors identified in two percent or more of the commodities reviewed.

~~(c) If a subsequent review within 12 months reveals further violations, the total amount of penalty due may be multiplied by the number of violations discovered.~~

Ninth: By striking out Sec. 20 and inserting in lieu thereof a new Sec. 20 to read:

Sec. 20. 8 V.S.A. § 2506 is amended to read:

§ 2506. APPLICATION FOR LICENSE

* * *

(d) A nonrefundable application fee of $1,000.00 ~~and~~, a license fee of $500.00 for the applicant, and a license fee of $25.00 for each authorized delegate location shall accompany an application for a license under this subchapter. The license fee shall be refunded if the application is denied.

* * *

Tenth: By striking out Sec. 21 and inserting in lieu thereof a new Sec. 21 to read:

Sec. 21. 8 V.S.A. § 2509 is amended to read:

§ 2509. RENEWAL OF LICENSE ~~AND~~, ANNUAL REPORT, AND ANNUAL ASSESSMENT

(a) A licensee under this subchapter shall pay an annual license renewal fee of $500.00, plus an annual renewal fee of $25.00 for each authorized delegate location, provided that the total renewal fee for all authorized delegate locations shall not exceed $3,500.00, no later than December 1 for the next succeeding calendar year.

* * *

(c) On or before April 1 of each year, the licensee shall pay the department an annual assessment equal to $0.0001 per dollar volume of money services activity performed for or sold or issued to Vermont customers for the most recent year ending December 31, which assessment shall not be less than $100.00 and shall not be greater than $15,000.00.

(d) If a licensee does not file an annual report on or before April 1, pay its annual assessment on or before April 1, or pay its renewal fee by December 1,

or within any extension of time granted by the commissioner, the commissioner shall send the licensee a notice of suspension. The licensee's license shall be suspended 10 calendar days after the commissioner sends the notice of suspension. The licensee has 20 days after its license is suspended in which to file an annual report, pay its annual assessment, or pay the renewal fee, plus $100.00 for each day after suspension that the commissioner does not receive the annual report, the annual assessment, or the renewal fee. The commissioner for good cause may grant an extension of the due date of the annual report or the renewal date.

~~(d)~~(e) The commissioner may require more frequent reports from any licensee for the purpose of determining the adequacy of the licensee's security.

Eleventh: By striking out Sec. 24 and inserting in lieu thereof a new Sec. 24 to read:

Sec. 24. 8 V.S.A. § 2532a is added to read:

§ 2532a. CHANGE OF AUTHORIZED DELEGATES; CHANGE OF LOCATION

A licensee shall notify the commissioner in writing within 30 days of any change in the list of authorized delegates or locations in this state where the licensee or an authorized delegate of the licensee provides money services, including limited stations and mobile locations. Such notice shall state the name and street address of each authorized delegate or of each location removed or added to the licensee's list. Upon any such change, the licensee shall provide sufficient evidence that it is in compliance with section 2507 of this title. The licensee shall submit with the notice a nonrefundable fee of $25.00 for each new authorized delegate location and for each change in location. There is no fee to remove authorized delegates or to remove locations.

Twelfth: By inserting an internal caption and Secs. 24a, 24b, 24c, 24d, 24e, 24f, 24g, 24h, and 24i to read:

* * * Simplified licensing process for certain commercial lenders * * *

Sec. 24a. 8 V.S.A. § 2200(1) is amended to read:

(1) "Commercial loan" means any loan or extension of credit that is described in subdivision 46(1), (2), or (4) of Title 9 ~~and that is in excess of $25,000.00~~. The term does not include a loan or extension of credit ~~for the purpose of farming, as defined in subdivision 6001(22) of Title 10 and does not include a loan or extension of credit for the purpose of financing~~ secured in whole or in part by an owner occupied one- to four-unit dwelling.

Sec. 24b. 8 V.S.A. § 2202(d) is added to read:

(d) This section does not apply to a lender making only commercial loans.

Sec. 24c. 8 V.S.A. § 2202a is added to read:

§ 2202a. APPLICATION FOR COMMERCIAL LENDER LICENSE; FEES

(a) Application for a license for a lender making solely commercial loans shall be in writing, under oath, and in the form prescribed by the commissioner, and shall contain the name and address of the residence and the place of business of the applicant and, if the applicant is a partnership or association, of every member thereof, and, if a corporation, of each officer, director, and control person thereof; the county and municipality with street and number, if any, where the business is to be conducted; and such further information as the commissioner may require.

(b) At the time of making application, the applicant shall pay to the commissioner a $500.00 fee for investigating the application and a $500.00 initial license fee for a period terminating on the last day of the current calendar year.

(c) In connection with an application for a commercial lender license, the applicant and each officer, director, and control person of the applicant shall furnish to the Nationwide Mortgage Licensing System and Registry (NMLSR) information concerning the applicant's identity and the identity of each of the applicant's officers, directors, and control persons, including:

(1) Fingerprints for submission to the Federal Bureau of Investigation and for any other governmental agency or entity authorized to receive such information for a state, national, and international criminal history background check.

(2) Personal history and experience in a form prescribed by the NMLSR, including the submission of authorization for the NMLSR and the commissioner to obtain information related to any administrative, civil, or criminal findings by any governmental jurisdiction.

(3) Any other information required by the NMLSR or the commissioner.

Sec. 24d. 8 V.S.A. § 2203(f) is added to read:

(f) This section does not apply to a lender making only commercial loans.

Sec. 24e. 8 V.S.A. § 2204(d) is added to read:

(d) This section does not apply to a lender making only commercial loans.

Sec. 24f. 8 V.S.A. § 2204c is added to read:

§ 2204c. APPROVAL OF APPLICATION; ISSUANCE OF COMMERCIAL LENDER LICENSE

(a) Upon the filing of the application and payment of the required fees, the commissioner shall issue and deliver a commercial lender license to the applicant upon findings by the commissioner as follows:

(1) That the experience, character, and general fitness of the applicant are such as to command the confidence of the community and to warrant belief that the business will be operated honestly, fairly, and efficiently within the purposes of this chapter. If the applicant is a partnership or association, such findings are required with respect to each partner, member, and control person. If the applicant is a corporation, such findings are required with respect to each officer, director, and control person.

(2) That the applicant and each officer, director, and control person of the applicant has never had a lender license, mortgage broker license, mortgage loan originator license, or similar license revoked in any governmental jurisdiction, except that a subsequent formal vacation of such revocation shall not be deemed a revocation.

(3) That the applicant and each officer, director, and control person of the applicant has not been convicted of or pled guilty or nolo contendere to a felony in a domestic, foreign, or military court:

(A) During the seven-year period preceding the date of the application for licensing, except a conviction for driving under the influence or a similarly titled offense in this state or in any other jurisdiction;

(B) At any time preceding such date of application, if such felony involved an act of fraud, dishonesty, or a breach of trust, or money laundering; or

(C) Provided that any pardon of a conviction shall not be a conviction for purposes of this subsection.

(b) If the commissioner does not find as set forth in subsection (a) of this section, the commissioner shall not issue a license. Within 60 days of filing of the completed application, the commissioner shall notify the applicant of the denial, stating the reason or reasons therefor. If after the allowable period, no request for reconsideration under subsection 2205(a) of this title is received from the applicant, the commissioner shall return to the applicant the sum paid by the applicant as a license fee, retaining the investigation fee to cover the costs of investigating the application.

(c) If the commissioner makes findings as set forth in subsection (a) of this section, he or she shall issue the license within 60 days of filing the completed

application. Provided the licensee annually renews the license, the license shall be in full force and effect until surrendered by the licensee or until revocation, suspension, termination, or refusal to renew by the commissioner.

Sec. 24g. 8 V.S.A. § 2209(a)(6) is added to read:

(6) For the renewal of a lender's license for a lender making only commercial loans, $500.00.

Sec. 24h. 8 V.S.A. § 2224(b) is amended to read:

(b) Annually, within 90 days of the end of its fiscal year, each licensed lender, mortgage broker, and sales finance company shall file financial statements with the commissioner in a form and substance satisfactory to the commissioner, which financial statements must include a balance sheet and income statement. This subsection does not apply to a lender making only commercial loans.

Sec. 24i. 9 V.S.A. § 46 is amended to read:

§ 46. EXCEPTIONS

Section 43 of this title relating to deposit requirements and section 45 of this title relating to prepayment penalties shall not apply and the parties may contract for a rate of interest in excess of the rate provided in section 41a of this title in the case of:

* * *

(2) obligations incurred by any person, partnership, association or other entity to finance in whole or in part income-producing business or activity, but not including obligations incurred to finance family dwellings of ~~two~~ four units or less when used as a residence by the borrower or to finance real estate which is devoted to agricultural purposes as part of an operating farming unit when used as a residence by the borrower; or

* * *

Thirteenth: By inserting an internal caption and a Sec. 29a to read:

* * * Moose hunting permit * * *

Sec. 29a. 10 V.S.A. § 4254 is amended to read:

§ 4254. FISHING AND HUNTING LICENSES; ELIGIBILITY, DESIGN, DISTRIBUTION, SALE, AND ISSUE

* * *

(i)(1) If the board establishes a moose hunting season, up to five moose permits shall be set aside to be auctioned. The board shall adopt rules

necessary for the department to establish, implement, and run the auction process. Proceeds from the auction shall be deposited in the fish and wildlife fund and used for conservation education programs run by the department. Successful bidders must have a Vermont hunting or combination license in order to purchase a moose permit. Beginning with the 2006 hunting season, the five moose permits set aside for auction shall be in addition to the number of annual moose permits authorized by the board.

* * *

(3) If the board establishes a moose hunting season, there shall be established a program to set aside three moose permits for children with life-threatening illnesses. The department of fish and wildlife shall adopt a procedure to implement the set-aside program for children with life-threatening illnesses.

Fourteenth: In Sec. 30, 3 V.S.A. § 2822(j), in subdivision (2)(B)(i), by striking out the figure "$210,000.00" and inserting in lieu thereof the figure $60,000.00

Fifteenth: In Sec. 30, 3 V.S.A. § 2822(j), by adding an ellipsis after subdivision (7)(F)

Sixteenth: In Sec. 30, 3 V.S.A. § 2822(j), by inserting subdivision (26) and amending it to read:

(26) For individual conditional use determinations, for individual wetland permits, for general conditional use determinations issued under 10 V.S.A. § 1272, or for wetland authorizations issued under a general permit, an administrative processing fee assessed under subdivision (2) of this subsection (j) and an application fee of:

(A) ~~$0.07~~ $0.14 per square foot of proposed impact to Class I or II wetlands;

(B) ~~$0.05~~ $0.10 per square foot of proposed impact to Class I or II wetland buffers;

(C) maximum fee, for the conversion of Class II wetlands or wetland buffers to cropland use, $200.00 per application. For purposes of this subdivision, "cropland" means land that is used for the production of agricultural crops, including row crops, fibrous plants, pasture, fruit-bearing bushes, trees or vines and the production of Christmas trees;

(D) minimum fee, $50.00 per application.

* * *

Seventeenth: In Sec. 30, 3 V.S.A. § 2322(j), by adding subdivisions (29) and (30) to read:

(29) For salvage yards permitted under subchapter 10 of chapter 61 of Title 24:

(A) facilities that crush or shred junk motor vehicles.	$2,000.00 per facility.
(B) facilities that accept or dismantle junk motor vehicles.	$1,000.00 per facility.
(C) facilities that manage junk on site excluding junk motor vehicles.	$350.00 per facility.
(D) facilities, the primary activity of which is handling total-loss vehicles from insurance companies.	$300.00 per facility.

(30) For beverage redemption centers certified under chapter 53 of Title 10, an annual fee of $100.00 per certified redemption center.

* * *

Eighteenth: In Sec. 30, 3 V.S.A. § 2822(l), in subdivision (2), by striking the (A) designation, the word "or" and subdivision (B) in its entirety

Nineteenth: By striking out Sec. 31 in its entirety

Twentieth: In Sec. 33, by adding a new subsection (c) to read:

(c) 24 V.S.A. § 2263 (annual salvage yard licensing fee) is repealed.

Twenty-first: In Sec. 35, 32 V.S.A. § 605, in subsection (b), by striking out subdivision (1) and inserting in lieu thereof a new subdivision (1) to read:

(1) A report covering all fees in existence on the prior July 1 within the areas of government identified by the department of finance and management accounting system as "general government," "labor," "general education," "development and community affairs" and "transportation" shall be submitted ~~by October 1, 1996 and every three years thereafter on~~ by the third Tuesday of the legislative session ~~beginning with 2000~~ beginning in 2011 and every three years thereafter.

Twenty second: By striking Sec. 35a in its entirety

Twenty third: By inserting an internal caption and a Sec. 34a to read:

* * * Probate fees * * *

Sec. 34a. 32 V.S.A. § 1434 is amended to read:

§ 1434. PROBATE COURTS

(a) The following entry fees shall be paid to the probate court for the benefit of the state, except for subdivision (17) of this subsection which shall be for the benefit of the county in which the fee was collected:

* * *

(14) Guardianships for minors	~~$35.00~~	$85.00
(15) Guardianships for adults	~~$50.00~~	$100.00
(16) Petitions for change of name	~~$75.00~~	$125.00

* * *

(23) Petitions for partial decree	$100.00
(24) Petitions for license to sell real estate	$50.00

* * *

And by renumbering the remaining sections to be numerically correct.

(For text see House Journal 2/10/10 - 2/11/10)

H. 784

An act relating to the state's transportation program

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. TRANSPORTATION PROGRAM

(a) The state's proposed fiscal year 2011 transportation program appended to the agency of transportation's proposed fiscal year 2011 budget, as amended by this act, is adopted to the extent federal, state, and local funds are available.

(b) As used in this act, unless otherwise indicated:

(1) the term "agency" means the agency of transportation;

(2) the term "secretary" means the secretary of transportation;

(3) the table heading "As Proposed" means the transportation program referenced in subsection (a) of this section; the table heading "As Amended" means the amendments as made by this act; the table heading "Change" means the difference obtained by subtracting the "As Proposed" figure from the "As Amended" figure; and the term "change" or "changes" in the text refers to the project- and program-specific amendments, the aggregate sum of which equals the net "Change" in the applicable table heading;

(4) the term "ARRA funds" refers to federal funds allocated to the state

by the American Recovery and Reinvestment Act of 2009;

(5) the term "TIB funds" refers to monies deposited in the transportation infrastructure bond fund in accordance with 19 V.S.A. § 11f;

(6) the term "debt service reserve" refers to funds required to be segregated under the terms of a trust agreement entered into to secure transportation infrastructure bonds issued pursuant to subchapter 4 of chapter 13 of Title 32;

(7) the column heading "TIB" in the agency's proposed fiscal year 2011 transportation program refers to TIB funds and to the proceeds of transportation infrastructure bonds issued pursuant to Sec. 13 of this act; and

(8) the term "TIB bond" refers to the proceeds of transportation infrastructure bonds issued pursuant to Sec. 19 of this act.

Sec. 2. RAIL

The following modifications are made to the rail program:

(1) A new project is added for Albany, New York – Bennington, Vermont – Rutland, Vermont bi-state intercity rail corridor track 3 planning with the following spending authority:

FY11	As Proposed	As Amended	Change
Other	0	1,000,000	1,000,000
Total	0	1,000,000	1,000,000
Source of funds			
State	0	250,000	250,000
Federal	0	500,000	500,000
Local	0	250,000	250,000
Total	0	1,000,000	1,000,000

The local share indicated represents the state of New York participation in the project.

(2) A new project is added for Amtrak Vermonter – New England Central Railroad track 1 improvements with the following spending authority:

FY11	As Proposed	As Amended	Change
Construction	0	26,231,846	26,231,846
Total	0	26,231,846	26,231,846
Sources of funds			
State	0	0	0
Federal	0	0	0
ARRA	0	26,231,846	26,231,846

Local	0	0	0
Total	0	26,231,846	26,231,846

Sec. 3. DEPARTMENT OF MOTOR VEHICLES

Spending authority for the department of motor vehicles is amended to read:

FY11	As Proposed	As Amended	Change
Personal Services	15,786,441	15,786,441	0
Operating Expenses	8,377,553	8,303,553	-74,000
Grants	136,476	136,476	0
Total	24,300,470	24,226,470	-74,000
Sources of funds			
State	23,096,730	23,022,730	-74,000
Federal	1,203,740	1,203,740	0
Total	24,300,470	24,226,470	-74,000

* * * Program Development * * *

Sec. 4. PROGRAM DEVELOPMENT – ROADWAY

The following modifications are made to the program development — roadway program:

(1) Authorized spending on the Waterbury FEGC F 013-4(13) project is amended to read:

FY11	As Proposed	As Amended	Change
PE	100,000	100,000	0
Construction	0	350,000	350,000
Total	100,000	450,000	350,000
Sources of funds			
State	3,000	3,000	0
TIB fund	0	10,500	10,500
Federal	95,000	427,500	332,500
Local	2,000	9,000	7,000
Total	100,000	450,000	350,000

(2) Authorized spending on the Cabot-Danville FEGC F 028-3(26)C/1 project is amended to read:

FY11	As Proposed	As Amended	Change
PE	100,000	100,000	0
Construction	500,000	447,500	-52,500
Total	600,000	547,500	-52,500
Sources of funds			

State	5,000	5,000	0
TIB fund	25,000	14,500	-10,500
Federal	570,000	528,000	-42,000
Total	600,000	547,500	-52,500

(3) The following project has received a federal earmark and is added to program development – roadway program – roadway projects candidate list as follows:

Rutland STP 3000( ) - Rutland Center Street Marketplace Improvements - $973,834.00; 100 percent federal funds.

Sec. 5. PROGRAM DEVELOPMENT – INTERSTATE BRIDGE

The following modification is made to the program development – interstate bridge program:

Authorized spending on the Littleton, NH – Waterford, VT IM 093-1( ) project (rehabilitation of I-93 bridges over CT River connecting VT and NH) is added to read:

FY11	As Proposed	As Amended	Change
Construction	0	500,000	500,000
Total	0	500,000	500,000
Sources of funds			
State	0	0	0
TIB fund	0	50,000	50,000
Federal	0	450,000	450,000
Total	0	500,000	500,000

Sec. 6. PROGRAM DEVELOPMENT – BIKE AND PEDESTRIAN FACILITIES

The following project has received a federal earmark and is added to program development – bike and pedestrian facilities – bike and pedestrian facilities candidates list:

Thetford STP 0180( ) – Thetford Village Pedestrian Improvements – $438,225.00; 100 percent federal funds.

Sec. 7. PROGRAM DEVELOPMENT – FUNDING

Spending authority in program development is modified as follows:

(1) Among eligible projects selected in the secretary's discretion, the secretary shall replace project spending authority in the total amount of $1,949,321.00 in transportation funds with the same amount in TIB funds.

(2) Among eligible projects selected in the secretary's discretion, the

secretary shall replace project spending authority in the total amount of $130,000.00 in transportation funds with the same amount in federal funds via the use of federal toll credits.

* * * Aviation * * *

Sec. 8. AVIATION

The following modifications are made to the aviation program:

(1) Spending authority for the South Burlington – Burlington International AIP Program project is amended to read:

FY11	As Proposed	As Amended	Change
ROW	4,050,000	4,050,000	0
Construction	10,880,000	10,850,000	-30,000
Total	14,930,000	14,900,000	-30,000
Sources of funds			
State	218,200	447,000	228,800
Federal	14,183,500	14,155,000	-28,500
Local	528,300	298,000	-230,300
Total	14,930,000	14,900,000	-30,000

(2) Spending authority for the Berlin CAP HQ project is amended to read as follows. The agency is authorized to proceed with the Berlin CAP HQ project if a federal earmark can be secured for the project.

FY11	As Proposed	As Amended	Change
PE	100,000	0	-100,000
Construction	900,000	0	-900,000
Total	1,000,000	0	-1,000,000
Sources of funds			
State	100,000	0	-100,000
Federal	900,000	0	-900,000
Total	1,000,000	0	-1,000,000

(3) Spending authority for Statewide – Facility Improvements is amended to read:

FY11	As Proposed	As Amended	Change
Construction	322,000	263,600	-58,400
Total	322,000	263,600	-58,400
Sources of funds			
State	322,000	263,600	-58,400
Total	322,000	263,600	-58,400

* * * Vermont Local Roads * * *

Sec. 9. TOWN HIGHWAY – VERMONT LOCAL ROADS

Spending authority for the town highway – Vermont local roads program is amended to read:

FY11	As Proposed	As Amended	Change
Grants	375,000	390,000	15,000
Total	375,000	390,000	15,000
Sources of funds			
State	235,000	235,000	0
Federal	140,000	155,000	15,000
Total	375,000	390,000	15,000

* * * Public Transit * * *

Sec. 10. PUBLIC TRANSIT

The following modifications are made to the public transit program:

(1) Spending authority for the public transit program is increased by $30,000.00 in transportation funds. The agency shall allocate $30,000.00 in transportation funds for a grant to the Vermont Kidney Association to support the transportation costs of dialysis patients.

(2) From the funds allocated to the public transit general capital program, $100,000.00 in federal funds shall be held by the agency in reserve to cover shortfalls in the funding of the elders and persons with disabilities program (E&D) that occur as a result of unanticipated demand for non-Medicaid transportation services. Transit agencies that have grant agreements with the agency for the provision of E&D services shall be eligible to receive disbursements from the reserve. Disbursements from the reserve funds shall be limited to transit agencies that have administered appropriately constrained E&D programs.

* * * Personal Services Spending * * *

Sec. 11. AGENCY PERSONAL SERVICES SPENDING

Total spending authority for agency personal services is reduced by up to $686,400.00 in transportation funds to reflect fiscal year 2011 personnel pension benefit savings. The agency shall apportion the reduction among its programs and activities accordingly.

* * * ARRA Maintenance of Effort – Appropriation Transfers * * *

Sec. 12. AMERICAN RECOVERY AND REINVESTMENT ACT; TRANSPORTATION MAINTENANCE OF EFFORT

(a) The general assembly finds that the state should maximize the federal money available for transportation. It is the intent of this section to assist the state in complying with the maintenance of effort requirements in section 1201

of the American Recovery and Reinvestment Act of 2009 (ARRA), Public Law 111-5, which requires the state to certify and maintain planned levels of expenditure of state funds for the types of projects funded by ARRA during the period February 17, 2009 through September 30, 2010. Failure to maintain the certified level of effort will prohibit the state from receiving additional federal funds through the August 2011 redistribution of federal aid highway and safety programs.

(b) Notwithstanding 32 V.S.A. § 706 and the limits on program, project, or activity spending authority in the fiscal year 2010 and 2011 transportation programs, the secretary, with the approval of the secretary of administration and subject to the provisions of subsection (c) of this section, may transfer transportation fund or federal fund appropriations, other than appropriations for the town highway state aid, structures, and class 2 roadway programs, to redirect funding to activities eligible for inclusion in, and for the specific purpose of complying with, the maintenance of effort requirements of section 1201 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. Any appropriations so transferred shall be expended on projects or activities within the fiscal year 2010 or 2011 transportation programs.

(c) If a contemplated transfer of an appropriation would, by itself, have the effect of significantly delaying the planned work schedule of a project which formed the basis of the project's funding in the fiscal year of the contemplated transfer, the secretary shall submit the proposed transfer for approval by the house and senate committees on transportation when the general assembly is in session, and when the general assembly is not in session, by the joint transportation oversight committee. In all other cases, the secretary may execute the transfer, giving prompt notice thereof to the joint fiscal office and to the house and senate committees on transportation when the general assembly is in session, and when the general assembly is not in session, to the joint transportation oversight committee.

(d) This section shall expire on September 30, 2010.

* * * FY 2011 Transportation Infrastructure Bonds * * *

Sec. 13. AUTHORITY TO ISSUE TRANSPORTATION INFRASTRUCTURE BONDS

(a) The state treasurer is authorized to issue transportation infrastructure bonds pursuant to 32 V.S.A. § 972 for the purpose of funding the appropriations of Sec. 14 of this act and associated costs of the transportation infrastructure bonds as defined in 32 V.S.A. § 972(b) in the amount of $13,500,000.00 in fiscal year 2011.

(b) In the event the state treasurer determines that:

(1) the creation and funding of a debt service reserve is advisable to support the successful issuance of transportation infrastructure bonds, or the cost of preparing, issuing, and marketing the bonds is likely to exceed $202,500.00; and

(2) the balance of the TIB fund as of the end of fiscal year 2010 is insufficient to fund a debt service reserve and to pay associated issuance costs of the bonds, the treasurer is authorized to increase the issue of transportation infrastructure bonds authorized in subsection (a) of this section up to a total amount of $16,500,000.00.

Sec. 14. TRANSPORTATION INFRASTRUCTURE BONDS; APPROPRIATION

The amount of up to $13,500,000.00 from the issuance of transportation infrastructure bonds is appropriated in fiscal year 2011 to the agency of transportation program development appropriation (8100001100) for use on eligible projects as defined in 32 V.S.A. § 972(c) in the state's fiscal year 2011 transportation program.

* * * Transportation Infrastructure Bond Reserves * * *

Sec. 15. FISCAL YEAR END 2010 TRANSPORTATION FUND SURPLUS

Subject to the funding of the transportation fund stabilization reserve in accordance with 32 V.S.A. § 308a and notwithstanding 32 V.S.A. § 308c (transportation fund surplus reserve), any surplus in the transportation fund as of the end of fiscal year 2010 up to a maximum amount of $3,000,000.00 shall be transferred to the TIB fund.

Sec. 16. AUTHORITY TO TRANSFER FISCAL YEAR 2010 APPROPRIATIONS TO PAY FISCAL YEAR 2011 BOND OBLIGATIONS

(a) Notwithstanding 32 V.S.A. § 706 and the limits on program, project, or activity spending authority in the fiscal year 2010 transportation program, the secretary of transportation, with the approval of the secretary of administration and subject to the provisions of subsection (b) of this section, may transfer transportation fund appropriations, other than appropriations for the town highway state aid, structures, and class 2 roadway programs, or TIB fund appropriations, to the TIB fund for the specific purpose of providing the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds authorized by this act, to pay the issuance costs of such bonds, or to pay the principal and interest due on such bonds in fiscal year 2011.

(b) The secretary's authority under subsection (a) of this section to transfer appropriations is limited to appropriations, the transfer of which, by itself, will

not have the effect of significantly delaying the planned fiscal year 2010 work schedule of a project which formed the basis of the project's funding in fiscal year 2010.

(c) When any appropriation is transferred pursuant to this section, the secretary shall report the transfer to the joint fiscal office and to the house and senate committees on transportation when the general assembly is in session, and when the general assembly is not in session, to the joint transportation oversight committee.

Sec. 17. CHANGE TO CONSENSUS REVENUE FORECAST

In the event the July 2010 consensus revenue forecast of fiscal year 2011 transportation fund revenue is increased above the January 2010 forecast, the increase up to $3,000,000.00 shall be transferred to the TIB fund to provide the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds authorized by this act, to pay the issuance costs of such bonds, or to pay the principal and interest due on such bonds in fiscal year 2011 or fiscal year 2012.

Sec. 18. AUTHORITY TO TRANSFER FISCAL YEAR 2011 APPROPRIATIONS TO PAY FISCAL YEAR 2012 BOND OBLIGATIONS

(a) Notwithstanding 32 V.S.A. § 706 and the limits on program, project, or activity spending authority in the fiscal year 2011 transportation program, the secretary of transportation, with the approval of the secretary of administration and subject to the provisions of subsection (b) of this section, may transfer transportation fund appropriations, other than appropriations for the town highway state aid, structures, and class 2 roadway programs, or TIB fund appropriations, to the TIB fund for the specific purpose of providing the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds authorized by this act or to pay the principal and interest due on such bonds in fiscal year 2012.

(b) The secretary's authority under subsection (a) of this section to transfer appropriations is limited to appropriations, the transfer of which, by itself, in the context of any spending authorized for the project in the fiscal year 2012 transportation program, will not have the effect of significantly delaying the planned work schedule of the project which formed the basis of the project's funding in fiscal years 2011 and 2012.

(c) The agency shall expedite the procedures required to determine the eligibility and certification of federal toll credits with respect to potentially qualifying capital expenditures made by Vermont entities through the end of fiscal year 2010 which, subject to compliance with federal maintenance of effort requirements, would be available for use by the state in fiscal year 2012.

The fiscal year 2012 transportation program shall reserve up to $3,000,000.00 of such potentially available federal toll credits and federal formula funds and authorize the secretary to utilize the federal toll credits and federal formula funds to accomplish the objectives of this section.

(d) When any appropriation is transferred pursuant to this section, the secretary shall report the transfer to the joint fiscal office and to the house and senate committees on transportation when the general assembly is in session, and when the general assembly is not in session, to the joint transportation oversight committee.

* * * FY 2011 Contingent Transportation Bonding Authority * * *

Sec. 19. FY 2011 CONTINGENT BONDING AUTHORITY; WESTERN CORRIDOR GRANT APPLICATION

(a) Notwithstanding 32 V.S.A. § 980 (authority to issue transportation infrastructure bonds), the state treasurer is authorized to issue transportation infrastructure bonds for fiscal year 2011 of up to $15,000,000.00 more than the amounts authorized in the preceding sections of this act, provided that the agency describes the proposed use of the funding and receives approval from the general assembly, or if the general assembly is not in session, the joint transportation oversight committee, of such issue and the proposed use of the funds.

(b) The agency is authorized to apply for a Federal Railroad Administration High-Speed Intercity Passenger Rail (HSIPR) grant to cover, in whole or in part, the cost of upgrading the state's western rail corridor for intercity passenger rail service. In applying for a grant, the agency is authorized to identify the bonds authorized by this section as a possible source of nonfederal match dollars which could be included in and would thereby strengthen the application.

(c) In the event transportation infrastructure bonds are issued pursuant to subsection (a) of this section for purposes other than the funding of the potential Federal Railroad Administration HSIPR grant referenced in subsection (b) of this section, the proposed spending of bond proceeds approved by the general assembly or by the joint transportation oversight committee is authorized, and the amount of the approved spending is appropriated to the programs as identified by the agency.

(d) In the event the state is awarded a Federal Railroad Administration HSIPR grant for infrastructure improvements to upgrade the state's western rail corridor for intercity passenger rail service as referenced in subsection (b) of this section:

(1) a project for the improvements covered by the grant is added to the

state's transportation program;

(2) authority to spend the federal grant funds is added as follows and the specified amount of federal funds is appropriated to the rail program; and

(3) to the extent that other state funds are not available and transportation infrastructure bonds are issued pursuant to subsection (a) of this section to fund the project, authority to spend the bond proceeds on the project is added as follows and the specified amount of transportation infrastructure bond proceeds is appropriated to the rail program:

FY11	As Proposed	As Amended	Change
Other	0	7,500,000	7,500,000
Total	0	7,500,000	7,500,000
Sources of funds			
TIB bond	0	1,500,000	1,500,000
Federal	0	6,000,000	6,000,000
Total	0	7,500,000	7,500,000

* * * Central Garage * * *

Sec. 20. TRANSFER TO CENTRAL GARAGE FUND

Notwithstanding 19 V.S.A. § 13(c), in fiscal year 2011, the amount of $1,120,000.00 is transferred from the transportation fund to the central garage fund created in 19 V.S.A. § 13.

Sec. 21. REPEAL

19 V.S.A § 13(g) (report on central garage activity, equipment rental, and fleet condition) is repealed.

* * * Notification of Emergency and Safety Projects; Reporting of Expenditures and Carry Forwards * * *

Sec. 22. 19 V.S.A. § 10g is amended to read:

§ 10g. ANNUAL REPORT; TRANSPORTATION PROGRAM; ADVANCEMENTS, CANCELLATIONS, AND DELAYS

(a) The agency of transportation shall annually present to the general assembly a multiyear transportation program covering the same number of years as the statewide transportation improvement plan (STIP), consisting of the recommended budget for all agency activities for the ensuing fiscal year and projected spending levels for all agency activities for the following fiscal years. The program shall include a description and year-by-year breakdown of recommended and projected funding of all projects proposed to be funded within the time period of the STIP and, in addition, a description of all projects which are not recommended for funding in the first fiscal year of the proposed

program but which are ~~projected to be ready~~ scheduled for construction ~~at that time (shelf projects)~~ during the time period covered by the STIP. The program shall be consistent with the planning process established by No. 200 of the Acts of the 1987 Adj. Sess. (1988), as codified in ~~3 V.S.A.~~ chapter 67 of Title 3 and ~~24 V.S.A.~~ chapter 117 of Title 24, the statements of policy set forth in sections 10b-10f of this title, and the long-range systems plan, corridor studies, and project priorities developed through the capital planning process under section 10i of this title.

* * *

(e)(1) The agency's annual transportation program shall include a separate report summarizing with respect to the most recently ended fiscal year:

(A) all expenditures of funds by source; and

(B) all unexpended appropriations of transportation funds and TIB funds that have been carried forward from the previous fiscal year to the ensuing fiscal year.

(2) The summary shall identify expenditures and carry forwards for each program category included in the proposed annual transportation program as adopted for the closed fiscal year in question and such other information as the agency deems appropriate.

* * *

(g) The agency's annual transportation program shall include a separate report referencing this section describing all proposed projects in the program which would be new to the state transportation program if adopted.

(h) Should capital projects in the transportation program be delayed because of unanticipated problems with permitting, right-of-way acquisition, construction, local concern, or availability of federal or state funds, the secretary is authorized to advance projects in the approved transportation program~~, giving priority to shelf projects~~. The secretary is further authorized to undertake projects to resolve emergency or safety issues. Upon authorizing a project to resolve an emergency or safety issue, the secretary shall give prompt notice of the decision and action taken to the joint fiscal office and to the house and senate committees on transportation when the general assembly is in session, and when the general assembly is not in session, to the joint transportation oversight committee. Should an approved project in the current transportation program require additional funding to maintain the approved schedule, the agency is authorized to allocate the necessary resources. However, the secretary shall not delay or suspend work on approved projects to reallocate funding for other projects except when other funding options are

not available. In such case, the secretary shall notify the members of the joint transportation oversight committee and the joint fiscal office. With respect to projects in the approved transportation program, the secretary shall notify, in the district affected, the regional planning commission, the municipality, legislators, ~~and~~ members of the senate and house committees on transportation, and the joint fiscal office of any significant change in design, change in construction cost estimates requiring referral to the transportation board under ~~19 V.S.A. §~~ section 10h of this title, or any change which likely will affect the fiscal year in which the project is planned to go to construction. No project shall be cancelled without the approval of the general assembly.

* * * Joint Transportation Oversight Committee; Meetings * * *

Sec. 23. 19 V.S.A. § 12b is amended to read:

§ 12b. JOINT TRANSPORTATION OVERSIGHT COMMITTEE

(a) There is created a joint transportation oversight committee composed of the chairs of the house and senate committees on appropriations, the house and senate committees on transportation, the house committee on ways and means, and the senate committee on finance. The committee shall be chaired alternately by the chairs of the house and senate committees on transportation, and the ~~two-year~~ two-year term shall run concurrently with the biennial session of the legislature. The chair of the senate committee on transportation shall chair the committee during the 2009–2010 legislative session.

(b) The committee shall meet during adjournment for official duties. Meetings shall be convened by the chair and when practicable shall be coordinated with the regular meetings of the joint fiscal committee. Members shall be entitled to compensation and reimbursement pursuant to 2 V.S.A. § 406. The committee shall have the assistance of the staff of the ~~legislative council and the joint fiscal office~~ agency of transportation.

(c) The committee shall provide legislative overview of the transportation fund revenues collection and the operation and administration of the agency of transportation construction, paving and rehabilitation programs. The secretary of transportation shall report to the oversight committee upon request.

(d)(1) In coordination with the regular meetings of the joint fiscal committee~~, the joint transportation oversight committee shall meet~~ in mid-July, mid-September, and mid-November~~. At these meetings~~, the secretary shall prepare a report on the status of the state's transportation finances and transportation programs~~, including~~. If a meeting of the committee is not convened on the scheduled dates of the joint fiscal committee meetings, the secretary in advance shall transmit the report electronically to the joint fiscal office for distribution to committee members. The report shall include a report

on contract bid awards versus project estimates and a detailed report on all known or projected cost overruns, project savings and funding availability from delayed projects; and the agency's actions taken or planned to cover the cost overruns and to reallocate the project savings and delayed project funds with respect to:

(A) all paving projects other than statewide maintenance programs; and

(B) all projects in the roadway, state bridge, interstate bridge, or town bridge programs with authorized spending in the fiscal year of $500,000.00 or more with a cost overrun equal to 20 percent or more of the authorized spending or generating project savings or delayed project available funding equal to 20 percent or more of the authorized spending.

(2) In addition, ~~at~~ with respect to the July meeting of the joint ~~transportation oversight~~ fiscal committee, the ~~secretarys shall~~ secretary's report ~~to the committee on~~ shall discuss the agency's plans to adjust spending to any changes in the consensus forecast for transportation fund revenues.

* * * Vermont Bridge Maintenance Program * * *

Sec. 24. REPEAL

The following are repealed:

(1) 19 V.S.A. § 40 (Vermont bridge maintenance program).

(2) Sec. 56 of No. 80 of the Acts of 2005 (allocation of vehicle inspection change revenue).

Sec. 25. 23 V.S.A. § 1230 is amended to read:

§ 1230. CHARGE

For each inspection certificate issued by the department of motor vehicles, the commissioner shall be paid $4.00 provided that state and municipal inspection stations that inspect only state or municipally owned and registered vehicles shall not be required to pay a fee. All vehicle inspection certificate charge revenue shall be allocated to the transportation fund with one-half reserved for bridge maintenance activities.

Sec. 26. CARRY-FORWARD AUTHORITY – BRIDGE MAINTENANCE

Notwithstanding any other provisions of law and subject to the approval of the secretary of administration, transportation fund appropriations remaining unexpended on June 30, 2010, in the transportation – bridge maintenance appropriation (8100005400) shall be carried forward, shall be designated for expenditure in the transportation – program development appropriation

(8100001100), and shall be used for the purpose of bridge maintenance.

* * * Transportation Projects; Construction Claims * * *

Sec. 27. 19 V.S.A. § 5(d) is amended to read:

(d) The board shall:

* * *

(4) provide appellate review, when requested in writing, regarding legal disputes in the execution of contracts awarded by the agency or by municipalities cooperating with the agency to advance projects in the state's transportation program;

* * *

* * * Transportation Contracts; Procurement Standards * * *

Sec. 28. 19 V.S.A. § 10 is amended to read:

§ 10. DUTIES

The agency shall, except where otherwise specifically provided by law:

(1) Award contracts on terms as it deems to be in the best interest of the state, for the construction, repair, or maintenance of transportation related facilities; for the use of any machinery or equipment either with or without operators or drivers; for the operation, repair, maintenance, or storage of any state-owned machinery or equipment; for professional engineering services, inspection of work or materials, diving services, mapping services, photographic services, including aerial photography or surveys, and any other services, with or without equipment, in connection with the planning, construction, and maintenance of transportation facilities. Persons rendering these services shall not be within the classified service, and the services shall not entitle the provider to rights under any state retirement system. Notwithstanding ~~3 V.S.A.~~ chapter 13 of Title 3, the agency may contract for services also provided by persons in the classified service, either at present or at some time in the past. ~~Any contract of more than $50,000.00 shall be advertised and awarded to the lowest qualified bidder unless determined otherwise by the board.~~ The solicitation and award of contracts by the agency shall follow procurement standards approved by the secretary of administration as well as applicable federal laws and regulations.

* * *

* * * Cancellation of Locally Managed Projects * * *

Sec. 29. 19 V.S.A. § 5(d) is amended to read:

(d) The board shall:

* * *

(12) maintain the accounting functions for the duties imposed by ~~9 V.S.A.~~ chapter 108 of Title 9 separately from the accounting functions relating to its other duties;

(13) hear and determine disputes involving a determination of the agency under section 309c of this title that the municipality is responsible for repayment of federal funds required by the Federal Highway Administration.

Sec. 30. 19 V.S.A. § 309c is added to read:

§ 309c. CANCELLATION OF LOCALLY MANAGED PROJECTS

(a) Notwithstanding section 309a of this title, a municipality or other local sponsor responsible for a locally managed project through a grant agreement with the agency shall be responsible for the repayment, in whole or in part, of federal funds required by the Federal Highway Administration or other federal agency because of cancellation of the project by the municipality or other local sponsor due to circumstances or events wholly or partly within the municipality's or other local sponsor's control. Prior to any such determination that cancellation of a project was due to circumstances or events wholly or partly within a municipality's or other local sponsor's control, the agency shall consult with the municipality or other local sponsor to attempt to reach an agreement to determine the scope of the municipality's or other local sponsor's repayment obligation.

(b) Within 15 days of an agency determination under subsection (a) of this section, a municipality may petition the board for a hearing to determine if cancellation of the project was due to circumstances or events in whole or in part outside the municipality's control. The board shall hold a hearing on the petition within 30 days of its receipt and shall issue an appropriate order within 30 days thereafter. If the board determines that cancellation of the project was due in whole or in part to circumstances or events outside the municipality's control, it shall order that the municipality's repayment obligation be reduced proportionally, in whole or in part. The municipality shall have no obligation to make a repayment under this section until the board issues its order.

* * * Filing of Transportation Deeds and Leases * * *

Sec. 31. 3 V.S.A. § 103 is amended to read:

§ 103. DOCUMENTS REQUIRED TO BE FILED

(a) All deeds, contracts of sale, leases, and other documents or copies of same conveying land or an interest therein to the state, except for ~~highway~~

~~rights-of-way~~ transportation rights-of-way, leases, and conveyances, shall be filed in the office of the secretary of state.

(b) All deeds, contracts of sale, leases, and other documents conveying land or an interest in land from the state as grantor, except for transportation rights-of-way, leases, and conveyances, shall be made out in duplicate by the authorized agent of the state. The original shall be delivered to the grantee and the duplicate copy, so marked, shall be filed in the office of the secretary of state.

(c) The secretary of state shall also record the state treasurer's bonds and other documents required to be recorded in ~~his~~ the secretary of state's office and give copies of the same upon tender of ~~his~~ the secretary of state's legal fees.

* * * Transportation Board; Town Reports * * *

Sec. 32. 24 V.S.A. § 1173 is amended to read:

§ 1173. TOWN OR VILLAGE REPORTS

The clerk of a municipality shall supply annually each library in such municipality with two copies of the municipal report, upon its publication. The clerk shall also mail to the state library two copies thereof, and one copy each to the secretary of state, commissioner of taxes, ~~transportation board,~~ state board of health, commissioner for children and families, director of the office of Vermont health access, auditor of accounts, and board of education. Officers making these reports shall supply the clerk of the municipality with the printed copies necessary for him or her to comply with the provisions of this section and section 1174 of this title.

* * *

* * * Signs and Other Traffic Control Devices * * *

Sec. 33. 23 V.S.A. § 1025 is amended to read:

§ 1025. STANDARDS

(a) The United States Department of Transportation Federal Highway Administration's Manual on Uniform Traffic Control Devices (MUTCD) for streets and highways as amended shall be the standards for all traffic control signs, signals, and markings within the state. The latest revision of the MUTCD shall be adopted upon its effective date except in the case of projects beyond a preliminary state of design that are anticipated to be constructed within two years of the otherwise applicable effective date; such projects may be constructed according to the MUTCD standards applicable at the design stage. Existing signs, signals, and markings shall be valid until such time as

they are replaced or reconstructed. When new traffic control devices are erected or placed or existing traffic control devices are replaced or repaired the equipment, design, method of installation, placement or repair shall conform with ~~such standards~~ the MUTCD.

(b) ~~These~~ The standards of the MUTCD shall apply for both state and local authorities as to traffic control devices under their respective jurisdiction.

* * *

* * * School Zone Warning Signs * * *

Sec. 34. 19 V.S.A. § 921 is amended to read:

§ 921. SCHOOL ZONES

(a) Municipalities shall erect or cause to be erected on all public highways near a school warning signs ~~bearing the legend "school zone." The signs shall conform~~ conforming to the standards of the manual on uniform traffic control devices as provided in 23 V.S.A. § 1025.

(b) For the purposes of this section and 23 V.S.A. § 1025, the term "school" shall include school district-operated prekindergarten program facilities owned or leased by a school district.

* * * State Airports * * *

Sec. 35. WILLIAM H. MORSE STATE AIRPORT (BENNINGTON); AUTHORIZATION TO ACCEPT DONATION OF HANGAR

(a) The secretary of transportation, as agent for the state of Vermont, is authorized to accept donation of an existing hangar building at the William H. Morse State Airport in the town of Bennington from Business Air, Inc., d/b/a Air Now. Notwithstanding 19 V.S.A. § 26a, the secretary is further authorized to enter into an amendment of Air Now's existing lease to allow Air Now to use the hangar building rent free, subject to Air Now's continuing to do business at the airport and maintaining the building at no expense to the state. In the event that Air Now ceases to do business at the airport or requests to assign its leasehold to some other person, the requirement to pay fair market value rent pursuant to 19 V.S.A. § 26a shall resume.

(b) Upon accepting conveyance of the hangar building under subsection (a) of this section, the secretary of transportation shall notify the secretary of administration so the hangar building can be added to the inventory of state-owned buildings maintained for purposes of 32 V.S.A. §§ 3701–3707.

* * * State-owned Railroad Property * * *

Sec. 36. 5 V.S.A. § 3406(b) is amended to read:

(b) The secretary shall have authority, with the approval of the governor, to sell ~~to any person or legal entity part or all of any parcel of~~ state-owned railroad property ~~or rights therein, provided that the terms of the sale are approved by the legislature or, in the event that the general assembly is not in session, by the joint fiscal committee~~ subject to the following conditions:

(1) the property is located more than 33 feet from the centerline of main line track (or former main line track), and the secretary determines that the property no longer is needed for railroad operating purposes or for railbanking under section 3408 of this title; and

(2)(A) if the appraised value of the property is $100,000.00 or above, with the prior approval of the general assembly of the sale and its terms, or, in the event that the general assembly is not in session, with the prior approval of the joint transportation oversight committee; or

(B) if the appraised value of the property is below $100,000.00, without further approval.

Sec. 37. 5 V.S.A. § 3408 is amended to read:

§ 3408. RAILBANKING; NOTIFICATION

(a) If the secretary finds that the continued operation of any state-owned railroad property is not economically feasible under present conditions, he or she may place the line in railbanked status after giving advance notice of such planned railbanking to the house and senate committees on transportation when the general assembly is in session, and when the general assembly is not in session, to the joint transportation oversight committee. The agency, on behalf of the state, shall continue to hold the right-of-way of a railbanked line for reactivation of railroad service or for other public purposes not inconsistent with future reactivation of railroad service. Such railbanking shall not be treated, for purposes of any law or rule of law, as an abandonment of the use of the rights-of-way for railroad purposes.

* * *

Sec. 38. APPROVAL OF TRANSACTIONS REGARDING STATE-OWNED RAILROAD PROPERTY

(a) The secretary of transportation, as agent for the state of Vermont, is authorized to sell to New England Central Railroad, Inc., for fair market value, a segment of the so-called Fonda Branch of the former Central Vermont Railway, Inc. in the town of Swanton, beginning at approximate mile post 137.86 and extending northerly a distance of approximately 1.26 miles to approximate mile post 139.12, which is the northerly abutment of the railroad bridge over the Missisquoi River.

(b) The secretary, as agent for the state of Vermont, is authorized to sell to Shelburne Limestone Corporation, for fair market value, a segment of the so-called Fonda Branch of the former Central Vermont Railway, Inc. in the town of Swanton, beginning at approximate mile post 139.12, which is the northerly abutment of the railroad bridge over the Missisquoi River, and extending northerly a distance of approximately 0.58 miles to approximate mile post 139.70, which is the southwesterly line of U.S. Route 7.

(c) In aid of the descriptions contained in this section, reference may be had to valuation plans V8/138-140 for the former Central Vermont Railway Company (dated June 30, 1917); the October 17, 1973 quit-claim deed of Central Vermont Railway, Inc. to the St. Johnsbury & Lamoille County Railroad, which is recorded at book 81, page 278 of the Swanton land records; and the December 7, 1973 quit-claim deed of the St. Johnsbury & Lamoille County Railroad to the Vermont Transportation Authority, which is recorded at book 81, page 368 of the Swanton land records.

* * * Authorized Enforcement and Emergency Vehicles * * *

Sec. 39. AUTHORITY OF LAW ENFORCEMENT AND RESCUE PERSONNEL TO ENGAGE IN NEGLIGENT OR RECKLESS CONDUCT IN EMERGENCY AND NON-EMERGENCY SITUATIONS; STUDY

The commissioner of public safety, a designee of the Professional Firefighters of Vermont, the Vermont Bar Association, the Vermont Fire Chiefs Association, the Vermont Troopers Association and the Vermont Association for Justice shall study the need to revisit the standard of care required under § 1015(c) of Title 23, and whether the provisions of § 1015(c) of Title 23 should be extended to on-duty officers in non-emergency situations. The Committee shall report its findings and recommendations to the Senate and House committees on Judiciary on or before April 1, 2011.

Sec. 40. [DELETED]

* * * Out-of-State First Responder Vehicles * * *

Sec. 41. 23 V.S.A. § 1251 is amended to read:

§ 1251. SIRENS AND COLORED SIGNAL LAMPS; OUT OF STATE EMERGENCY AND RESCUE VEHICLES

(a) No motor vehicle shall be operated upon a highway of this state equipped with a siren or signal lamp colored other than amber unless a permit authorizing such equipment, issued by the commissioner of motor vehicles, is carried in the vehicle. The commissioner may adopt additional rules as may be required to govern the acquisition of permits and the use pertaining to sirens and colored signal lamps.

(b) Notwithstanding the provisions of subsection (a) of this section, when responding to emergencies, law enforcement vehicles, ambulances, fire vehicles, or vehicles owned or leased by, or provided to, volunteer firefighters or rescue squad members, which are registered or licensed by another state or province, may use sirens and signal lamps in Vermont, and a permit shall not be required for such use, as long as the vehicle is properly permitted in its home state or province.

* * * Establishing Speed Limits * * *

Sec. 42. 23 V.S.A. § 1003(a) is amended to read:

(a) When the traffic committee constituted under 19 V.S.A. § 1(24) determines, on the basis of an engineering and traffic investigation that shall take into account, if applicable, safe speeds within school zones (or safe speeds within 200 feet of school district-operated prekindergarten program facilities owned or leased by a school district) when children are traveling to or from such schools or facilities, that a maximum speed limit established by this chapter is greater or less than is reasonable or safe under conditions found to exist at any place or upon any part of a state highway, ~~except~~ including the Dwight D. Eisenhower national system of interstate and defense highways, it may determine and declare a reasonable and safe limit which is effective when appropriate signs stating the limit are erected. This limit may be declared to be effective at all times or at times indicated upon the signs; and differing limits may be established for different times of day, different types of vehicles, varying weather conditions, or based on other factors, bearing on safe speeds which are effective when posted upon appropriate fixed or alterable signs.

Sec. 43. 23 V.S.A. § 1004(a) is amended to read:

(a) The traffic committee has exclusive authority to make and publish, and from time to time may alter, amend, or repeal, rules pertaining to vehicular, pedestrian, and animal traffic, ~~speed limits,~~ and the public safety on the Dwight D. Eisenhower national system of interstate and defense highways and other limited access and controlled access highways within this state. The rules and any amendments or revisions may be made by the committee only in accordance with chapter 25 of Title 3. The rules shall be consistent with accepted motor vehicle codes or standards, shall be consistent with law, and shall not be unreasonable or discriminatory in respect to persons engaged in like, similar, or competitive activities. The rules are applicable only to the extent that they are not in conflict with regulations or orders issued by any agency of the United States having jurisdiction and shall be drawn with due consideration for the desirability of uniformity of law of the several states of the United States.

* * * Special Occasions * * *

Sec. 44. 23 V.S.A. § 1010 is amended to read:

§ 1010. SPECIAL OCCASIONS; TOWN HIGHWAY MAINTENANCE

(a) When it appears that traffic will be congested by reason of a public occasion or when a town highway is being reconstructed or maintained or where utilities are being installed, relocated, or maintained, the legislative body of a municipality may make special regulations as to the speed of motor vehicles, may exclude motor vehicles from ~~certain public~~ town highways and may make such traffic rules and regulations as the public good requires. However, signs indicating the special regulations must be conspicuously posted in and near all affected areas, giving as much notice as possible to the public so that alternative routes of travel could be considered.

* * *

* * * Replacement of Gasoline Dispensers * * *

Sec. 45. 10 V.S.A. § 583 is amended to read:

§ 583. REPEAL OF STAGE II VAPOR RECOVERY REQUIREMENTS

(a) Effective January 1, 2013, all rules of the secretary pertaining to stage II vapor recovery controls at gasoline dispensing facilities are repealed. The secretary may not issue further rules requiring such controls. For purposes of this section, "stage II vapor recovery" means a system for gasoline vapor recovery of emissions from the fueling of motor vehicles as described in 42 U.S.C. § 7511a(b)(3).

(b) Prior to January 1, 2013, stage II vapor recovery rules shall not apply to:

* * *

(4) Any existing gasoline dispensing facility that, after May 1, 2009, replaces all of its existing gasoline dispensers with ~~new~~ gasoline dispensers that support triple data encryption standard (TDES) usage or replaces one or more of its gasoline dispensers pursuant to a plan to achieve full TDES compliance, upon verification and approval by the secretary.

* * *

* * * Relinquishment of State Highway Segments to Municipalities * * *

Sec. 46. RELINQUISHMENT OF FORMER VERMONT ROUTE 109 TO TOWN OF BELVIDERE

(a) Under the authority of 19 V.S.A. § 15(2), approval is granted for the

secretary to enter into an agreement with the town of Belvidere to relinquish to the town's jurisdiction a segment of former VT Route 109 beginning at a point in the northerly right-of-way boundary of the present VT Route 109, said point also being the northerly right-of-way boundary of the former VT Route 109, being 35 feet distant northerly radially from station 73+00 of the established centerline of Highway Project Belvidere S 0282(1); thence 155 feet, more or less, southeasterly, crossing the former VT Route 109, to a point in the northerly right-of-way boundary of the present VT Route 109, said point also being in the southerly right-of-way boundary of the former VT Route 109, being 45 feet distant northerly radially from station 74+55 of the centerline; thence northeasterly, easterly, and southeasterly along the southerly right-of-way boundary of the former VT Route 109 to a point in the northerly right-of-way boundary of the present VT Route 109, being 70 feet distant northerly at right angle from station 82+15 of the centerline; thence 79 feet, more or less, northeasterly crossing the former VT Route 109 to a point in the northerly right-of-way boundary of present VT Route 109, being 92 feet distant northerly at right angle from station 82+90 of the centerline; thence northwesterly, westerly, and southwesterly along the northerly right-of-way boundary of the former VT Route 109 to the point and place of beginning.

(b) The relinquishment shall include a three-rod (49.5 feet) right-of-way and slope rights within the area and is subject to the rights of utility companies under chapter 71 of Title 30 and other statutes of similar effect.

Sec. 47. RELINQUISHMENT OF STATE HIGHWAY SEGMENTS TO THE TOWN OF NORWICH

(a) Pursuant to 19 V.S.A. § 15(2), approval is granted for the secretary of transportation to enter into an agreement with the town of Norwich to relinquish to the town's jurisdiction a segment of the state highway known as VT Route 10A in the town of Norwich, beginning at the low-water mark of the Connecticut River at a point in the center of VT Route 10A and continuing 2,756 feet (approximately 0.52 miles) westerly to mile marker 1.218 where VT Route 10A intersects with U.S. Route 5 (this point also is station 78+00 on the U.S. Route 5 centerline of Highway Project Hartford-Norwich I 91-2(5)).

(b) Pursuant to 19 V.S.A. § 15(2), approval is granted for the secretary of transportation to enter into an agreement with the town of Norwich to relinquish to the town's jurisdiction a segment of the state highway known as U.S. Route 5 (Church Street) in the town of Norwich, beginning at its intersection with VT Route 10A approximately at mile marker 1.218. This point is also station 78+00 on the U.S. Route 5 centerline of Highway Project Hartford Norwich I 91-2(5). The relinquishment shall continue 6,496 feet (approximately 1.230 miles) northerly and easterly along the center of U.S.

Route 5 to its intersection with the Norwich State Highway approximately at U.S. Route 5 mile marker 2.448.

(c) Pursuant to 19 V.S.A. § 15(2), approval is granted for the secretary of transportation to enter into an agreement with the town of Norwich to relinquish to the town's jurisdiction a segment of the state highway known as Norwich State Highway, beginning at the intersection of the Norwich State Highway with VT Route 10A. The relinquishment shall continue 6,071 feet (approximately 1.15 miles) northerly along the center of the Norwich State Highway to its intersection with U.S. Route 5 approximately at Norwich State Highway mile marker 1.150.

(d) Control of the highways but not ownership of the lands or easements within the highway right-of-way shall be relinquished to the town of Norwich. The town of Norwich shall not sell or abandon any portion of the relinquishment areas or allow any encroachments within the relinquishment areas without written permission of the agency of transportation.

* * * Town of Bennington; Adjustments to State Highway System * * *

Sec. 48. TOWN OF BENNINGTON; ADJUSTMENTS TO STATE HIGHWAY SYSTEM

(a) Under the authority of 19 V.S.A. § 15(2), the general assembly authorizes the secretary to enter into an agreement with the town of Bennington to relinquish to the town's jurisdiction approximately 1.07 miles of U.S. Route 7 (South Street) between mile marker 1.088 (near Carpenter Hill Road [TH #48]) and mile marker 2.156 (near the entrance to the Park Lawn Cemetery) to become a class 1 town highway.

(b) Under the authority of 19 V.S.A. § 15(2), the general assembly authorizes the secretary to enter into an agreement with the town of Bennington to accept as part of the state highway system approximately 1,300 feet of VT Route 9 (Main Street [TH #2]) between mile marker 5.655, near the location of a crosswalk to be constructed under the transportation project Bennington NH 019-1(51), and mile marker 5.901, which is the existing jurisdictional boundary between the state highway and the class 1 town highway. The agreement shall provide for the town of Bennington to be responsible for maintenance of sidewalks within the subject area.

* * * Short-Range Public Transit Plan * * *

Sec. 49. REPEAL

The following are repealed:

(1) 24 V.S.A. § 5088(7) (definition of "short-range public transit plan").

(2) 24 V.S.A. § 5091(f) (requirement that grantees shall be eligible for funding only if a short-range public transit plan has been completed).

* * * Modal Councils * * *

Sec. 50. VERMONT RAIL, AVIATION, AND PUBLIC TRANSIT ADVISORY COUNCILS

The agency of transportation shall examine the current functions of the Vermont Rail Advisory Council, the Vermont Aviation Advisory Council, and the Vermont Public Transit Advisory Council. The agency shall consider the structure, composition, and format of each council and shall report back to the senate and house committees on transportation with any recommendations for modifications to improve the efficiency and effectiveness of each council by January 15, 2011.

* * * Scenery Preservation Council * * *

Sec. 51. 10 V.S.A. § 425 is amended to read:

§ 425. SCENERY PRESERVATION COUNCIL

(a) The scenery preservation council shall:

(1) upon request, advise and consult with organizations, municipal planning commissions or legislative bodies, or regional planning commissions concerning byway program grants and in the designation of municipal scenic roads or byways;

(2) recommend for designation state scenic roads or byways after holding a public meeting to determine local support for designation; and

(3) encourage and assist in fostering public awareness, understanding, and participation in the objectives and functions of scenery preservation and in stimulating public participation and interest.

(b) ~~There is created within the state planning office a scenery preservation council to advise and assist the state planning director in the performance of his duties with respect to this chapter.~~ The scenery preservation council shall consist of ~~ten~~ seven members ~~including:~~ the secretary ~~of the agency~~ of natural resources~~,~~ or his or her designee; the secretary ~~of the agency~~ of transportation ~~and the director of the state planning office~~ or ~~their designees. The governor shall appoint~~ his or her designee; and five members appointed by the governor. ~~The speaker of the house shall appoint one member of the house as member and the committee on committees of the senate shall appoint one senator as member.~~ The terms of the members appointed by the governor shall be for three years, except that he or she shall appoint the first members so that the terms of the members end in one year, two years, and three years. ~~The terms~~

~~of the members appointed by the speaker of the house and the committee on committees of the senate shall end on January 15 in every odd-numbered year and their successors shall be appointed at that time.~~ The governor shall designate an appointed member to serve as chairman at the governor's pleasure. Except as provided in this section, no state employee or member of any state commission ~~nor~~ or any federal employee or member of any federal commission shall be eligible for membership on the scenery preservation council. Members of the council who are not full-time state employees~~,~~ ~~including members of the general assembly when the general assembly is not in session,~~ shall be entitled to a per diem ~~of $30.00~~ as provided in 32 V.S.A. § 1010(b) and their actual necessary expenses. Only the secretary of transportation or his or her designee may call meetings of the council, and meetings shall be called only as necessary for the council to perform the functions set forth in subsection (a) of this section.

~~(b) The scenery preservation council shall:~~

~~(1) upon request, advise and consult with municipal planning commissions or legislative bodies and regional planning commissions in the designation of municipal scenic roads;~~

~~(2) recommend for designation state scenic roads, after consultation with regional planning commissions, pursuant to the provisions of chapter 25 of Title 19;~~

~~(3) encourage and assist in fostering public awareness, understanding and participation in the objectives and functions of scenery preservation and in stimulating public participation and interest;~~

~~(4) report biennially to the governor and the general assembly upon the effectiveness of this chapter and make continuing recommendations regarding scenic corridors, scenic areas and scenic sites. The reports shall indicate the status of all state and town designated scenic roads;~~

~~(5) prepare and recommend to the transportation board prior to January 1, 1978 aesthetic criteria to carry out the purposes of this chapter.~~

* * *

* * * Highway Condemnation Orders * * *

Sec. 52. 19 V.S.A. § 512 is amended to read:

§ 512. ORDER FIXING COMPENSATION; INVERSE CONDEMNATION; RELOCATION ASSISTANCE

(a) Within ~~45~~ 30 days after the compensation hearing, the ~~transportation~~ board shall by its order fix the compensation to be paid to each person from

whom land or rights are taken~~, and~~. Within 30 days of the board's order, the agency ~~of transportation~~ shall file and record the order in the office of the clerk of the town where the land is situated, ~~and shall~~ deliver to each person ~~or persons~~ a copy of that portion of the order directly affecting the person ~~or persons,~~ and ~~shall~~ pay or tender the award to each person entitled ~~which~~. A person to whom a compensation award is paid or tendered under this subsection may ~~be accepted, retained and disposed~~ accept, retain, and dispose of the award to his or her own use without prejudice to the person's right of appeal, as provided in section 513 of this title. Upon the payment or tender of the award as above provided, the agency ~~of transportation~~ may proceed with the work for which the land is taken.

* * *

* * * Traveler Information Services * * *

Sec. 53. INTERSTATE 91 TRAVELER INFORMATION SERVICES FACILITY

(a) Pursuant to Sec. 109(b) of No. 50 of the Acts of 2009, the commissioner of buildings and general services (BGS) is authorized to negotiate and contract with businesses interested in providing travel information services near Exit 7 of Interstate 91 for the purpose of establishing a privately operated travel information center near this exit.

(b) The agency of transportation shall work with BGS and the Federal Highway Administration to implement a signage strategy to clearly direct travelers to businesses providing travel information services at any travel information center established pursuant to subsection (a) of this section.

Sec. 54. INFORMATION CENTERS; CROSS-BORDER OPPORTUNITIES

The commissioner of buildings and general services may evaluate opportunities to reach agreement with neighboring states and provinces concerning advertising at information centers or the joint operation of information centers. The commissioner shall report findings and recommendations related to any evaluation conducted pursuant to this section to the senate and house committees on transportation by January 15, 2011.

* * * Lake Champlain Bridge Facilities * * *

Sec. 55. LAKE CHAMPLAIN BRIDGE FACILITIES

(a) The secretary of transportation and the commissioner of fish and wildlife shall work together in consultation with the Division of Historic Preservation to develop plans regarding the repair and expansion of existing fishing access facilities at the Lake Champlain bridge at Crown Point.

(b) The secretary of transportation and the commissioner of buildings and general services shall work together in consultation with the Division of Historic Preservation in seeking federal funds for renovations to Chimney Point State Historic Site facilities and the repair and expansion of existing fishing access facilities in connection with construction of the Lake Champlain bridge at Crown Point.

* * * Official Business Directional Sign Fees * * *

Sec. 56. 10 V.S.A. § 501 is amended to read:

§ 501. FEES

Subject to the provisions of subsection 486(c) of this title, an applicant for an official business directional sign or an information plaza plaque shall pay to the travel information council an initial license fee and an annual renewal fee as established by this section.

* * *

(2) Annual renewal fees shall be as follows:

(A) for full and half-sized official business directional signs, ~~$125.00~~ $100.00 per sign;

(B) information plaza plaques, $25.00 per plaque.

* * * Rest Area Advisory Committee * * *

Sec. 57. REPEAL

19 V.S.A. § 12c (rest area advisory committee) is repealed.

* * * Low-Bed Trailer Permits * * *

Sec. 58. 23 V.S.A. § 1402(e) is amended to read:

(e) ~~Pilot project allowing annual permits for low-bed trailers.~~

(1) The commissioner may issue an annual permit to allow the transportation of a so-called "low-bed" trailer. A "low-bed" trailer is defined as a trailer manufactured for the primary purpose of carrying heavy equipment on a flat-surfaced deck, which deck is at a height equal to or lower than the top of the rear axle group.

(2) A blanket permit may be obtained for an annual fee of $275.00 per unit, provided the total vehicle length does not exceed 75 feet, does not exceed a loaded width of 12'6", does not exceed a total weight of 108,000 lbs., and has a height not exceeding 14 feet.

(3) Warning signs and flags shall be required if the vehicle exceeds 75

feet in length, or exceeds 8'6" in width.

(4) ~~This subsection shall expire on June 30, 2010. No later than January 15, 2010, the department of motor vehicles, after consultation with the agency of transportation, Vermont League of Cities and Towns, and Vermont Truck and Bus Association, shall report to the house and senate committees on transportation on the results of this two year pilot project. The report shall include recommendations on extending this provision on low bed trailers, as well as other recommendations relating to longer vehicle lengths.~~ [Repealed.]

Sec. 58a. LEGISLATIVE INTENT

It is the intent of the general assembly to require the commissioner of motor vehicles to conduct an in-depth study of the most effective and efficient mechanisms for promoting the use of ignition interlock devices or other devices that prevent impaired driving and implementing legislation related to such devices in Vermont. The commissioner also is directed to formulate recommended legislation by January 15, 2011, to advance the general assembly's goal to pass ignition interlock legislation.

Sec. 58b. LEGISLATIVE FINDINGS

The general assembly finds that:

(1) In 2008, nearly 12,000 people were killed in crashes attributed to alcohol-impaired driving, which accounted for 32 percent of all traffic fatalities in the United States. Impaired driving is a significant public safety concern.

(2) As a tool to combat impaired driving, 47 states have laws concerning the use of ignition interlock devices. Ignition interlock devices are installed in motor vehicles to prevent them from being started unless the operator blows into the device and the device detects that the operator's alcohol concentration is below a preset limit. Devices may be programmed to require periodic retesting while the car is running. About 146,000 ignition interlock devices currently are in use in the United States.

(3) Vermont is one of just three states that have not enacted ignition interlock legislation.

(4) Research shows that ignition interlock devices reduce subsequent arrest rates among both first-time and repeat DUI offenders by 50 to 90 percent while such devices are installed.

(5) Research estimating the costs versus the benefits of ignition interlock programs suggests a $3.00 benefit for each $1.00 in program costs for first-time DUI offenders and a $4.00 to $7.00 benefit for each $1.00 in program costs for other DUI offenders.

Sec. 58c. IGNITION INTERLOCK DEVICE STUDY

(a) The commissioner of motor vehicles, in consultation with the commissioner of corrections, the court administrator, the department of public safety, state's attorneys and sheriffs, the defender general, the attorney general, the Vermont bar association, and any other organizations or entities the commissioner deems appropriate, shall study and formulate recommended legislation authorizing use of ignition interlock devices or other devices that prevent impaired driving in Vermont. In carrying out this directive, the commissioner shall:

(1) Review current laws, rules and regulations, and practices regarding use of ignition interlock devices in other states and attempt to ascertain the factors that contribute to the varying success of states in promoting use of ignition interlock devices.

(2) Consider whether legislation should:

(A) require installation of ignition interlock devices by some or all DUI offenders as a condition of license reinstatement;

(B) for some or all DUI offenders, authorize operation of a motor vehicle during a suspension period under specified conditions if an ignition interlock device is installed;

(C) require, or authorize upon request, some or all DUI offenders to install ignition interlock devices in exchange for a reduced period of license suspension;

(D) authorize or require judges to order installation of ignition interlock devices as a condition of probation for some or all DUI offenders;

(E) authorize or require judges to provide incentives (such as reduced fines) to some or all DUI offenders to encourage installation of such devices;

(F) require devices to be installed for a period in excess of usual suspension periods for some or all offenders;

(G) supplement, or operate as an alternative to, the state's abstinence program for persons whose license has been suspended for life;

(H) apply to all impaired driving offenders (i.e., include those whose violations involve operating under the influence of drugs) or only to those whose offense involved operating under the influence of intoxicating liquor;

(I) limit eligibility to certain classes of DUI offenders (i.e., those whose offense did not result in death of another); or

(J) authorize or require installation of ignition interlock devices under any other circumstances.

(3) Consider how any recommended use of ignition interlock devices should be coordinated with the use of electronic monitoring equipment such as global position monitoring equipment, automated voice recognition telephone equipment, and transdermal alcohol monitoring equipment.

(4) Study the costs of ignition interlock devices, including installation, monthly lease charges, periodic recalibration, and data downloads and the relative merits of having such costs borne entirely by DUI offenders or partially borne by the state.

(5) Study whether conditions or restrictions (such as hours of operation or limitation to travel to or from work, school, or a treatment program) should be imposed on some or all DUI offenders operating subject to an ignition interlock device requirement.

(6) Study the administrative tasks that must be performed to implement and carry out ignition interlock legislation; the costs associated with these tasks; which agency or agencies are best suited to perform them; and what additional authority or resources an agency or agencies would need to perform them.

(7) Consider appropriate penalties for DUI offenders required to operate vehicles equipped with ignition interlock devices who tamper with or otherwise circumvent such devices, or who operate a vehicle not equipped with such a device, or whose attempt to operate a vehicle is prevented through the functioning of such device, and consider the due process to which DUI offenders cited for such activities shall be entitled.

(8) Consider appropriate penalties for third parties who tamper with or otherwise circumvent ignition interlock devices, or who knowingly provide vehicles not equipped with such devices for DUI offenders required to operate vehicles equipped with such devices, and consider the due process to which persons cited for such activities shall be entitled.

(9) Consider the degree to which the state should monitor, utilize, and impose sanctions based on data obtained from ignition interlock devices.

(10) Consider and study any other issues deemed relevant to ignition interlock device policy and legislation.

(b) The commissioner shall report his or her findings and recommended legislation to the senate and house committees on transportation, the senate and house committees on judiciary, and the joint corrections oversight committee no later than January 15, 2011.

* * * Effective Dates * * *

Sec. 59. EFFECTIVE DATES

(a) This section and the following sections of this act shall take effect on passage:

(1) Sec. 12 (ARRA maintenance of effort – appropriation transfers).

(2) Sec. 13 (FY11 transportation infrastructure bonds).

(3) Sec. 15 (end FY10 transportation fund surplus).

(4) Sec. 16 (authority to transfer FY10 appropriations).

(5) Sec. 42 (speed limits).

(6) Sec. 43 (traffic committee rulemaking).

(7) Sec. 45 (replacement of gasoline dispensers). Notwithstanding 1 V.S.A. § 214, Sec. 45 shall apply retroactively to gasoline dispensers installed at an existing gasoline dispensing facility after May 1, 2009.

(8) Sec. 58 (low-bed trailer permits).

(9) Secs. 58a–58c (study and recommendation of ignition interlock device legislation).

(b) All other sections of this act not specifically enumerated in subsection (a) of this section shall take effect on July 1, 2010.

(For text see House Journal 3/25/10 - 3/26/10)

S. 264

An act relating to stop and hauling charges

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

By striking out Sec. 5 in its entirety and inserting in lieu thereof a new Sec. 5 to read as follows:

Sec. 5. EFFECTIVE DATE

This act shall take effect upon passage, except that Sec. 2 (amendment to 6 V.S.A. § 2676, mandating that the cost of hauling shall be paid by the buyer) shall take effect when New York requires, by legislative or administrative enactment of statewide applicability and enforcement, that dairy hauling costs shall be paid by the purchaser of the cows' milk rather than by the producer of the cows' milk.

(For House Proposal of Amendment see House Journal 4/9/10 Page 819)

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?

For Informational Purposes

H. 782

An act relating to a voluntary school district merger incentive program, supervisory union duties, and other education issues

Rep. Peltz of Woodbury, for the Committee on **Education,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 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. 2. SCHOOL DISTRICT MERGER INCENTIVE PROGRAM

(a) Program created. There is created a school district merger incentive program under which the incentives outlined in Sec. 4 of this act shall be available to each new unified union school district, as defined in 16 V.S.A. § 722 or as provided in Sec. 3(b) of this act, created on or before July 1, 2016 by the voluntary merger of existing school districts pursuant to Sec. 3 of this act.

(b) Board discussion. On or before November 1, 2010, the board of every school district in the state shall discuss whether it wishes to explore merger within its supervisory union or with one or more contiguous districts outside its supervisory union, which for the purposes of this act includes supervisory districts, or both under the terms of this act.

(c) Board vote. 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.

Sec. 3. INCENTIVE PROGRAM REQUIREMENTS RELATING TO DISTRICT STRUCTURE

(a) Size and schools. Contiguous school districts, which may include one or more union school districts, may merge to form a unified union school district ("UUSD") pursuant to chapter 11 of Title 16 that, except as provided in subsection (k) of this section, shall have an average daily membership of at least 1,250 or result from the merger of at least five districts, or both.

(b) Elementary and secondary education. A UUSD shall operate one or more approved public schools offering elementary and secondary education as required by 16 V.S.A. § 722; provided, however:

(1) A proposed UUSD shall be deemed to operate grades 9 through 12 as required by 16 V.S.A. § 722 if it will designate, pursuant to the provisions of 16 V.S.A. § 827, either a Vermont public school outside the district or a Vermont approved independent school located inside or outside the district as the sole public high school of the UUSD.

(2) Two or more contiguous schools districts that, when merged, would operate one or more approved schools offering kindergarten through grade 8 and would provide for the education of resident pupils in grades 9 through 12 by paying tuition pursuant to 16 V.S.A. § 824, are eligible for the incentives outlined in Sec. 4 of this act and for purposes of this act shall be considered a UUSD if:

(A) the districts, when merged, will neither operate a school offering grades 9 through 12 nor designate a school pursuant to 16 V.S.A. § 827 that offers those grades;

(B) for at least two fiscal years prior to merger, none of the merging districts operated a school offering grades 9 through 12;

(C) on the day on which the merger takes effect and the new merged district comes into existence, none of the merging districts is a member of a union school district that operates a school offering grades 9 through 12; and

(D) the merging districts and the new, merged district comply with all other provisions of this act, or otherwise in law, that apply to a UUSD formed under the school district merger incentive program created by this act, including the provision in subdivision (d)(2) of this section that the new merged district is a distinct supervisory district and shall not be assigned to be a member of a supervisory union.

(c) Existing union school districts. Pursuant to 16 V.S.A. § 701b(b), if an existing union school district is among the districts merging to form a UUSD, a successful vote to form the UUSD dissolves the existing union district.

(d) Supervisory unions and supervisory districts.

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

(2) For purposes of this act, 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), and shall not be assigned to a supervisory union pursuant to 16 V.S.A. § 706h.

(3) If a UUSD includes all school districts within one or more existing supervisory unions, then a successful vote to form the UUSD dissolves the school districts, the supervisory union or unions, and all related elected boards on the day the new UUSD becomes operative.

(4) 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.

(e) 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.

(f) Local participation. Because the UUSD shall be governed by one board, the plan for merger presented to the electorate for approval under chapter 11 of Title 16 shall include structures and processes that provide opportunities for local participation in the creation of UUSD policy and budget development.

(g) Enrollment options. The plan for merger presented to the electorate for approval shall include 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 operates, provided:

(1) the UUSD shall comply with the regional high school choice provisions of 16 V.S.A. § 1622;

(2) the UUSD shall provide, or provide access to, secondary technical education for students residing within its boundaries; and

(3) if the proposed enrollment plan would provide fewer options to the students in one or more of the districts interested in merger than they have prior to merger, then the plan shall require the UUSD to pay tuition to a school pursuant to the provisions of chapter 21 of Title 16 for any student who resides within the UUSD if that 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's approved merger plan has determined that the school is not otherwise a school to which it will pay tuition.

(h) 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 eligible students residing within its boundaries.

(i) 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. UUSDs are encouraged to increase opportunities for students through distance learning, dual enrollment, internships, and other programs.

(j) 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 applicable to school districts and supervisory unions, including chapter 57 of Title 16 and chapter 22 of Title 21.

(k) Waiver. School districts interested in merger may request the state board of education to grant them a waiver from the requirements of subsection (a) of this section, 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.

(l) Qualification. No individual entitlement or private right of action is created by Secs. 2 through 8 of this act.

Sec. 4. VOLUNTARY MERGER PROGRAM INCENTIVES

(a) Multiyear 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. 2 and 3 of this act shall also have the option to propose one or both of the following:

(A) A multiyear 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 multiyear 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 multiyear 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 annually shall reimburse from the education fund the amount of interest paid in the prior year by a UUSD to its lender on borrowing in anticipation of any state school construction aid that was owed to a merging member of the UUSD as of the effective date of this act and has not been paid to the UUSD by the state as of July 1, 2016.

(d) Sale of school buildings. Subject to the provisions of Sec. 3(e) of this act:

(1) if a UUSD closes a school building before the earlier of its fifth fiscal year or fiscal year 2018 and sells the school building, or an energy saving measure as contemplated in 16 V.S.A. § 3448f(g), 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) Merger 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, then the UUSD shall be eligible to receive a merger 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 merger 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.

(f) Recent merger. If the Addison Northwest Unified Union School District becomes a body corporate and politic on or before July 1, 2010, then the merged district shall be entitled to receive any of the benefits set forth in subsections (b)–(e) of this section that it elects and is otherwise eligible to receive by notifying the commissioner of its election on or before July 1, 2011.

Sec. 5. TRANSITION

The UUSD merger plan presented to the electorate for approval pursuant to this act shall provide for any transition of employment of staff by member districts to employment by the UUSD by:

(1) providing 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;

(2) providing 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;

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

(4) containing 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.

Sec. 6. REPORTS; RECOMMENDATIONS

(a) On or before December 31, 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. 7. 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 subchapter 4, article 4 of chapter 11 of Title 16 and request the state board to make the adjustment.

Sec. 8. MERGER TEMPLATE

The department of education shall develop a merger template to assist subcommittees formed pursuant to Sec. 5(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.

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

Sec. 9. 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. 10. 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 U.S. Department of Education or is approved in Vermont pursuant to subdivision 166(b)(6) of this title.

* * * Duties of Supervisory Unions and Superintendents; Special Education; Class Size; Delayed Effective Dates * * *

Sec. 11. 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 in any districts 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. 12. 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. 13. 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. 14. REPEAL

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

Sec. 15. 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. 16. 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. 17. MINIMUM AND OPTIMAL CLASS SIZE POLICIES

(a) On or before July 1, 2012, the policy required by Sec. 12 of this act, 16 V.S.A. § 242(5), 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. 18. SPECIAL EDUCATORS; 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. 11 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.

* * * Small Schools * * *

Sec. 19. 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.

* * *Statutory Revision; Effective Dates * * *

Sec. 20. 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. 21. EFFECTIVE DATES

(a) Secs 11–14 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.