Senate Calendar

WEDNESDAY, APRIL 28, 2010

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H. 562.

An act relating to the regulation of professions and occupations.

AMENDMENT TO SENATE PROPOSAL OF AMENDMENT TO H. 562 TO BE OFFERED BY SENATOR ILLUZZI BEFORE THIRD READING

Senator Illuzzi moves to amend the Senate proposal of amendment by adding a new section to be numbered Sec. 3a to read as follows:

Sec. 3a. 16 V.S.A. § 2831 is amended to read:

§ 2831. MEMBERSHIP; VACANCIES

The corporation shall be governed and all of its powers exercised by a board of directors consisting of ~~11~~ nine members. The governor shall appoint five members as follows: one person to be the financial aid officer of an institution of postsecondary education in the state of Vermont; one person to be a guidance counselor from a Vermont secondary school, and three members representing the general public. In making the appointments of the members representing the general public, the governor shall give due consideration to the board's needs for expertise and experience in the management of a financial institution. The state treasurer shall be a member. ~~The speaker of the Vermont house of representatives and the committee on committees of the Vermont senate shall each appoint one member from their respective legislative bodies to serve on the board.~~ The board shall elect three additional members. All members shall be of full age, citizens of the United States and residents of Vermont. All appointments shall be for terms of six years ~~with the exception of legislative members whose terms shall expire at the end of six years or when their service in the Vermont legislature is completed, whichever shall first occur~~. The date of the expiration of the term of appointment in each case shall be June 30. Vacancies which may occur by reason of death or resignation shall be filled in the same manner as original appointments.

AMENDMENT TO SENATE PROPOSAL OF AMENDMENT TO H. 562 TO BE OFFERED BY SENATOR ILLUZZI BEFORE THIRD READING

Senator Illuzzi moves to amend the Senate proposal of amendment by striking out the *seventh* and *ninth* proposals of amendment.

H. 578.

An act relating to requiring all state law enforcement officers to serve under the direction and control of the commissioner of public safety.

AMENDMENT TO SENATE PROPOSAL OF AMENDMENT TO H. 578 TO BE OFFERED BY SENATOR ILLUZZI BEFORE THIRD READING

Senator Illuzzi moves to amend the Senate proposal of amendment by adding a two new sections to be numbered Sec. 3 and Sec. 4 to read as follows:

Sec. 3. CERTIFICATION OF LAW ENFORCMENT OFFICERS

(a) The General Assembly finds that because the Vermont Police Academy requires candidates for certification as a full-time law enforcement officer to undergo 16 weeks of extensive physical training in addition to meeting academic requirements, older individuals or individuals with minor physical disabilities who are otherwise exceptionally qualified to discharge law enforcement duties are precluded from obtaining full-time certification and thus full-time employment as a law enforcement officer. While other states and jurisdictions have left physical training requirements to the hiring law enforcement agencies, the Vermont Criminal Justice Training Council has continued the physical training requirements, extending the cost and length of the basic training program, even though the hiring law enforcement agency already has selected and employed the candidates who seek full-time certification.

(b) The executive director of the Vermont Criminal Justice Training Council, the attorney general or designee, a designee of the Department of Sheriffs and State's Attorneys who does not serve on the Vermont Criminal Justice Training Council, the defender general or designee, the executive director of the Human Rights Commission or designee, and a Vermont constable selected by the chair of the trustees of the Vermont League of Cities and Towns shall make recommendations regarding the advisability of granting full-time certification to law enforcement officers who have been certified as part-time officers for at least the past ten years and who have been employed a total of at least 8,000 hours as an officer discharging law enforcement duties during that period. The chair of the committee shall be the attorney general or his or her designee. The committee shall report its findings and recommendations to the House and Senate Government Operations and Judiciary Committees no later than January 15, 2011.

Sec. 4. VERMONT CRIMINAL JUSTICE TRAINING COUNCIL; RULES; LAW ENFORCMENT CERTIFICATION

(a) A full-time certified law enforcement officer shall meet the fiftieth percentile physical assessment minimum training standards used by the Vermont criminal justice training council every three years beginning on July 1, 2010.

(b) If an officer is unable to meet those standards by the deadline set by rule by VCJTC, then that officer's full-time certification shall be converted to a part-time certification until the officer is able to meet the applicable standards.

(c) The Vermont criminal justice training council shall adopt rules by February 1, 2011 to implement this section.

and by renumbering the remaining section to be Sec. 5

Second Reading

Favorable with Proposal of Amendment

H. 213.

An act to provide fairness to tenants in cases of contested housing security deposit withholding.

Reported favorably by Senator McCormack for the Committee on Finance.

(Committee Vote: 6-0-1)

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

The Committee recommends that the Senate propose to the House to amend the bill by adding a new section to be Sec. 2 to read as follows:

Sec. 2. 9 V.S.A. § 4467 is amended to read:

§ 4467. TERMINATION OF TENANCY; NOTICE

(a) Termination for nonpayment of rent. The landlord may terminate a tenancy for nonpayment of rent by providing actual notice to the tenant of the date on which the tenancy will terminate which shall be at least 14 days after the date of the actual notice. The rental agreement shall not terminate if the tenant pays or tenders rent due through the end of the rental period in which payment is made or tendered. Acceptance of partial payment of rent shall not constitute a waiver of the landlord's remedies for nonpayment of rent or an accord and satisfaction for nonpayment of rent.

* * *

(Committee vote: 4-0-1)

(No House amendments.)

House Proposal of Amendment

S. 237

An act relating to operational standards for salvage yards.

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

Sec. 1. 24 V.S.A. §§ 2248 and 2249 are added to read:

§ 2248. SALVAGE YARD OPERATIONAL STANDARDS

(a) Beginning July 1, 2010, a salvage yard shall meet the following operational standards:

(1) The salvage yard shall comply with the screening and fencing requirements of section 2257 of this title.

(2) Motor vehicles shall be drained of all fluids prior to crushing and within 365 days of receipt by the salvage yard, except that a vehicle with visible signs of leaking fluids shall be drained immediately. Fluids shall be drained, collected, and stored according to standards established by the secretary in order to prevent release to the environment. The fluids that shall be drained, collected, and stored under this subdivision include antifreeze, oil, brake fluid, fuel, refrigerants, and transmission fluid.

(3) Vehicles shall be drained and crushed:

(A) on or over a surface that is designed to retain seepage or draining fluids and that is designed to prevent releases to groundwater, discharges to surface waters, or other releases to the environment; or

(B) by a crusher with an onboard fluid-recovery and storage system that prevents releases to groundwater, discharges to surface waters, or other releases to the environment.

(4) A salvage yard issued a certificate of registration under section 2242 of this title after July 1, 2010, shall not be sited or operated within 100 feet of a Class I or Class II wetland as those terms are defined in 10 V.S.A. § 902. This subdivision shall not apply to the renewal of a valid certificate of registration under this subchapter.

(5)(A) A salvage yard issued a certificate of registration under section 2242 of this title after July 1, 2010, shall not be sited or operated within 300 feet of a potable water supply, as that term is defined in 10 V.S.A. § 1972, unless:

(i) the water supply provides water to the salvage yard; or

(ii) the agency of natural resources approves management practices or remedial measures to prevent contamination of the potable water supply.

(B) This subdivision shall not apply to the renewal of a valid certificate of registration under this subchapter.

(b) On or before March 31, 2011, the secretary shall adopt by rule requirements for the siting, operation, and closure of salvage yards. The rules shall establish requirements for:

(1) the siting of salvage yards, including setbacks from surface waters, wetlands, and potable water supplies. Siting requirements under this subdivision may include site-specific conditions for salvage yards operating under a valid certificate of registration under section 2242 of this title, provided that such site-specific conditions are designed to prevent releases to groundwater, discharges to surface waters, or other risks to public health and the environment. A site-specific condition under this subdivision may include the requirement that the owner or operator of a salvage yard obtain an individual certificate of registration under section 2242 of this title instead of operating under a general permit adopted by the secretary under subsection (c) of this section;

(2) exemptions from the requirement to obtain a certificate of registration under section 2242 of this title;

(3) when an instrument of financial responsibility may be required by the secretary in amounts necessary to:

(A) remediate potential or existing environmental contamination caused by the salvage yard; or

(B) assure proper management of salvage materials upon closure of the salvage yard;

(4) removal of solid waste or tires from the salvage yard for proper disposal;

(5) establishment and maintenance of screening or fencing of salvage yards from public view;

(6) assuring proper closure of a salvage yard facility;

(7) postclosure environmental monitoring of a salvage yard;

(8) classes or categories of salvage yards, including those handling total loss vehicles from insurance; and

(9) additional measures that the secretary determines necessary for the protection of public health, safety, and the environment.

(c)(1) The secretary may issue a general permit for a certificate of registration issued to salvage yards under section 2242 of this title. The general permit may include a provision allowing a holder of a valid certificate of registration issued under this subchapter to self-certify compliance with the applicable standards of this subchapter and rules adopted under this subchapter. A general permit issued under this section shall be adopted by rule and may be incorporated into the rule required under subsection (b) of this section.

(2) If the secretary adopts a general permit for the regulation of salvage yards under subdivision (1) of this subsection, the secretary may require an owner or operator of a salvage yard that is operating under the general permit or that is applying for coverage under the general permit to obtain an individual certificate of registration under section 2242 of this title if any one of the following applies:

(A) the salvage yard does not qualify for the general permit;

(B) a salvage yard operating under the general permit is in violation of the terms and conditions of the general permit;

(C) the size, scope, or nature of the activity of the salvage yard exceeds the parameters of the general permit;

(D) the owner or operator of the salvage yard has a history of noncompliance; or

(E) the salvage yard presents a potential risk to public health or the environment.

(d) No person may deliver salvage vehicles to or operate a mobile salvage vehicle crusher at a salvage yard that does not hold a certificate of registration under this subchapter. A salvage yard holding a certificate of registration under this subchapter shall post a copy of its current certificate in a clearly visible location in the proximity of each entrance to the salvage yard.

(e) The requirement under subdivision (a)(2) of this section or rules adopted under this section to drain a vehicle within 365 days of receipt shall not apply to a salvage yard holding a certificate of registration under this subchapter that, as of January 1, 2010, is conducting business, the primary activity of which is the handling of total loss vehicles from insurance companies.

§ 2249. SALVAGE YARD OPERATOR TRAINING

At least annually, the owner or operator of a salvage yard shall attend a training workshop conducted by or approved by the agency of natural resources regarding the requirements of this subchapter, best management

practices, existing and proposed environmental standards, and other applicable federal, state, or municipal requirements.

Sec. 2. 24 V.S.A. § 2241 is amended to read:

§ 2241. DEFINITIONS

For the purposes of this subchapter:

(1) "Abandoned" means a motor vehicle as defined in 23 V.S.A. § 2151.

(2) "Board" means the state transportation board, or its duly delegated representative.

(3) "Highway" means any highway as defined in ~~section~~ 19 V.S.A. § 1 ~~of Title 19~~.

(4) "Interstate or primary highway" means any highway, including access roads, ramps and connecting links, which have been designated by the state with the approval of the Federal Highway Administration, Department of Transportation, as part of the National System of Interstate and Defense Highways, or as a part of the national system of primary highways.

(5) "Junk" means old or scrap copper, brass, iron, steel, and other old or scrap or nonferrous material, including but not limited to rope, rags, batteries, glass, rubber debris, waste, trash, or any discarded, dismantled, wrecked, scrapped, or ruined motor vehicles or parts thereof.

(6) "Junk motor vehicle" means a discarded, dismantled, wrecked, scrapped, or ruined motor vehicle or parts thereof, or ~~one~~ a motor vehicle, other than an on-premise utility vehicle, which is allowed to remain unregistered or uninspected for a period of ~~ninety~~ 90 days from the date of discovery.

(7) "Salvage yard" means any place of outdoor storage or deposit for storing, keeping, processing, buying, or selling junk or as a scrap metal processing facility. "Salvage yard" also means any ~~place of outdoor storage or deposit, not in connection with a business which is maintained or used for storing or keeping four or more junk motor vehicles which are visible from any portion of a public highway or navigable water, as that term is defined in section 1422 of Title 10~~ outdoor area used for operation of an automobile graveyard. It does not mean a garage where wrecked or disabled motor vehicles are stored for less than 90 days for inspection or repairs.

(8) "Legislative body" means the city council of a city, the board of selectmen of a town, or the board of trustees of a village.

(9) "Main traveled way" means the portion of a highway designed for the movement of motor vehicles, shoulders, auxiliary lanes, and roadside picnic, parking, rest, and observation areas and other areas immediately

adjacent and contiguous to the traveled portion of the highway and designated by the transportation board as a roadside area for the use of highway users and generally but not necessarily located within the highway right-of-way.

(10) "Motor vehicle" means any vehicle propelled or drawn by power other than muscular power, including trailers.

(11) "Notice" means by certified mail with return receipt requested.

(12) "Scrap metal processing facility" means a manufacturing business which purchases sundry types of scrap metal from various sources including the following: industrial plants, fabricators, manufacturing companies, railroads, junkyards, auto wreckers, salvage dealers, building wreckers, and plant dismantlers and sells the scrap metal in wholesale shipments directly to foundries, ductile foundries, and steel foundries where the scrap metal is melted down and utilized in their manufacturing process.

(13) "Secretary" means the secretary of natural resources or the secretary's designee.

(14) "Automobile hobbyist" means a person who is not primarily engaged in the business of:

(A) selling motor vehicles or motor vehicle parts; or

(B) accepting, storing, or dismantling junk motor vehicles.

(15) "Automobile graveyard" means a yard, field, or other outdoor area on a property owned or controlled by a person and used or maintained for storing or depositing four or more junk motor vehicles. "Automobile graveyard" does not include:

(A) an area used by an automobile hobbyist to store, organize, restore, or display motor vehicles or parts of such vehicles, provided that the hobbyist's activities comply with all applicable federal, state, and municipal law;

(B) an area used for the storage of motor vehicles exempt from registration under chapter 7 of Title 23;

(C) an area owned or used by a dealer registered under 23 V.S.A. § 453 for the storage of motor vehicles; or

(D) an area used or maintained for the parking or storage of operational commercial motor vehicles, as that term is defined in 23 V.S.A. § 4103(4), that are temporarily out of service and unregistered but are expected to be used in the future by the vehicle operator or owner.

Sec. 3. 24 V.S.A. § 2242 is amended to read:

§ 2242. REQUIREMENT FOR OPERATION OR MAINTENANCE

(a) A person shall not operate, establish, or maintain a salvage yard unless he or she:

(1) Holds a certificate of approval for the location of the salvage yard; and

(2) Holds a certificate of registration issued by the secretary to operate, establish, or maintain a salvage yard.

(b) The issuance of a certificate of registration under subsection (a) of this section shall not relieve a salvage yard from the obligation to comply with existing state and federal environmental laws and to obtain all permits required under state or federal environmental law.

(c) The secretary may require a person to obtain a salvage yard certificate of registration under this section upon a determination, based on available information, that the person has taken action to circumvent the requirements of this subchapter.

Sec. 3. 24 V.S.A. § 4454(a) is amended to read:

(a) An action, injunction, or other enforcement proceeding relating to the failure to obtain or comply with the terms and conditions of any required municipal land use permit may be instituted under ~~sections~~ section 1974a, 4451, or 4452 of this title against the alleged offender if the action, injunction, or other enforcement proceeding is instituted within 15 years from the date the alleged violation first occurred and not thereafter, except that the 15-year limitation for instituting an action, injunction, or enforcement proceeding shall not apply to any action, injunction, or enforcement proceeding instituted for a violation of subchapter 10 of chapter 61 of this title. The burden of proving the date the alleged violation first occurred shall be on the person against whom the enforcement action is instituted.

Sec. 4. 27 V.S.A. § 612(a) is amended to read:

(a) Notwithstanding the majority decision in Bianchi v. Lorenz (1997), for land development, as defined in 24 V.S.A. § 4303~~(3)~~(10), no encumbrance on record title to real estate or effect on marketability shall be created by the failure to obtain or comply with the terms or conditions of any required municipal land use permit as defined in 24 V.S.A. § 4303~~(24)~~(11).

Sec. 5. 24 V.S.A. § 4303(11) is amended to read:

(11) "Municipal land use permit" means any of the following whenever issued:

(A) A zoning, subdivision, site plan, or building permit or approval, any of which relate to "land development" as defined in this section, that has

received final approval from the applicable board, commission, or officer of the municipality.

(B) A wastewater system permit issued under any municipal ordinance adopted pursuant to chapter 102 of this title.

(C) Final official minutes of a meeting that relate to a permit or approval described in subdivision (11)(A) or (B) of this section that serve as the sole evidence of that permit or approval.

(D) A certificate of occupancy, certificate of compliance, or similar certificate that relates to the permits or approvals described in subdivision (11)(A) or (B) of this section, if the bylaws so require.

(E) An amendment of any of the documents listed in subdivisions (11)(A) through (D) and (F) of this section.

(F) A certificate of approved location for a salvage yard issued under subchapter 10 of chapter 61 of this title.

Sec. 6. REPEAL

24 V.S.A. § 2248(a) (statutory operational standards for salvage yards) is repealed March 31, 2011.

Sec. 7. EFFECTIVE DATE

This act shall take effect July 1, 2010.

S. 287

An act relating to the licensing and regulation of loan servicers.

The House proposes to the Senate to amend the bill in Sec. 1, 8 V.S.A. chapter 83, by striking out § 2900 in its entirety and by inserting in lieu thereof the following:

§ 2900. DEFINITIONS

As used in this chapter:

(1) "Commercial loan" means any loan or extension of credit that is described in 9 V.S.A. § 46(1), (2), or (4). The term does not include a loan or extension of credit that is secured by an owner occupied one- to four-unit dwelling.

(2) "Commissioner" means the commissioner of banking, insurance, securities, and health care administration.

(3) "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management or policies of a person, whether through the ownership of voting securities, by contract other than a

commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 10 percent or more of the voting securities or other interest of any other person.

(4) "Depository institution" has the same meaning as in Section 3 of the Federal Deposit Insurance Act, 12 U.S.C. § 1813(c), which includes any bank and any savings association as defined in Section 3 of the Federal Deposit Insurance Act. For purposes of this chapter, "depository institution" also includes any credit union organized and regulated as such under the laws of the United States or any state or territory of the United States.

(5) "Dwelling" has the same meaning as in subsection 103(v) of the Truth in Lending Act, 15 U.S.C. § 1602(v).

(6) "Individual" means a natural person.

(7) "Loan" means a residential mortgage loan.

(8) "Nationwide Mortgage Licensing System and Registry" means a licensing system developed and maintained by the Conference of State Bank Supervisors and the American Association of Residential Mortgage Regulators, or any successor to the Nationwide Mortgage Licensing System and Registry.

(9) "Person" shall have the meaning set forth in 1 V.S.A. § 128 and includes a natural person, corporation, company, limited liability company, partnership, or association.

(10) "Residential mortgage loan" means any loan primarily for personal, family, or household use that is secured by a mortgage, deed of trust, or other equivalent consensual security interest on either a dwelling or residential real estate, upon which is constructed or intended to be constructed a dwelling.

(11) "Residential real estate" means any real property located in Vermont, upon which is constructed or intended to be constructed a dwelling.

(12) "Servicing" means receiving a scheduled periodic payment from a borrower pursuant to the terms of a loan, including amounts for escrow accounts, and making the payments to the owner of the loan or other third party of principal and interest and other payments with respect to the amounts received from the borrower as may be required pursuant to the terms of the servicing loan document or servicing contract. In the case of a home equity conversion mortgage or a reverse mortgage, servicing includes making payment to the borrower.

(13) "Third party loan servicer" means a person who engages in the business of servicing a loan, directly or indirectly, owed or due or asserted to be owed or due another.

J.R.S. 50.

Joint resolution urging expedited federal initiation of the National Environmental Policy process relating to the proposed federal acquisition of Eagle Point Farm in Derby, Vermont.

The House proposes to the Senate to amend the resolution by striking all after the title and inserting in lieu thereof the following:

Whereas, the late Michael Dunn, the owner of the 800-acre Eagle Point Farm (approximately one-half of which is located in Derby, Vermont, and the balance in Quebec), conditionally donated through his trust the Vermont portion of this exceptional parcel as a gift to the United States of America for purposes of permanent preservation and public enjoyment, and

Whereas, Eagle Point Farm's Vermont acreage includes diverse freshwater wetland, woodland, and riparian habitats, rich agricultural land, and more than a mile of frontage on 27-mile-long Lake Memphremagog, and

Whereas, this impressive acreage provides land for high quality breeding, migratory, and wintering habitats for priority waterfowl and grassland bird species, and

Whereas, many rare plants and unique natural communities are also located at Eagle Point Farm, and

Whereas, for many decades, through the generosity of the Dunn family, many Vermonters have enjoyed Eagle Point Farm for walking, fishing, hunting, trapping, wildlife observation, and access to Lake Memphremagog, and

Whereas, because Eagle Point Farm is waterfront land, it is valuable monetarily and is at high risk of being developed should the United States not ultimately accept Michael Dunn's generous gift, and

Whereas, not only is this land attractive to developers, but also, in accordance with the terms of Michael Dunn's conditional donation, should the federal government not acquire the Vermont portion of Eagle Point Farm by September 1, 2010, then the trustee must dispose of the property in a manner that would maximize its cash value for the benefit of a secondary institutional beneficiary, and

Whereas, the northeastern office of the United States Fish and Wildlife Service (USFWS), in close collaboration with the state of Vermont, has

assessed the conservation value of the Vermont portion of Eagle Point Farm, and

Whereas, there is mutual agreement among federal and state authorities that the optimal disposition of the Vermont portion of Eagle Point Farm is to proceed with a proposal that the Vermont Land Trust has put forward – to wit: that the USFWS should acquire title to the land and that the Vermont Agency of Natural Resources should then administer Eagle Point Farm in Derby as a coordination area for recreational use in accordance with the Wildlife Management Area (WMA) guidelines of the Vermont Department of Fish and Wildlife and a jointly entered memorandum of understanding, and

Whereas, the Province of Quebec is simultaneously working toward accepting a gift of that portion of Michael Dunn's property located in the province, and such an acquisition would provide opportunities for cross-border collaboration, and

Whereas, the Vermont Fish and Wildlife Conservation Group, located in nearby East Charleston, has written to the Vermont congressional delegation, offering its full support for both the federal acquisition and subsequent state management of Eagle Point Farm, and

Whereas, the Memphremagog Watershed Association (MWA) in Derby, whose mission is "the preservation of the environment and natural beauty of the Memphremagog watershed," has written to public officials that it "cannot overstate the importance of and their support for keeping Michael Dunn's property in the public trust and for public use," and

Whereas, the MWA has worked collaboratively with Memphremagog Conservation, Inc. for the preservation of Eagle Point Farm on both sides of the border, and it has reminded public officials that preservation of the property is "consistent with the efforts and goals of the Quebec/Vermont Steering Committee which is charged with the restoration and protection of the international waters of Lake Memphremagog," and

Whereas, the northeastern office of the USFWS has submitted a proposal to its national office in Washington, D.C., to move forward immediately with the scientific assessment and public comment requirements of the National Environmental Policy Act (NEPA) in order that the acquisition process can occur prior to the September 1, 2010, deadline, and

Whereas, the NEPA process will provide the opportunity for the general public to offer its comments on the proposed federal acquisition and state management of Eagle Point Farm in Derby to help determine the best long-term outcome for this special piece of Vermont, *now therefore be it*

Resolved by the Senate and House of Representatives:

That the General Assembly urges the United States Fish and Wildlife Service to expedite the National Environmental Policy Act process relating to the proposed federal acquisition of Eagle Point Farm in Derby, Vermont, *and be it further*

Resolved: That the Secretary of State be directed to send a copy of this resolution to the United States Secretary of the Interior, the United States Fish and Wildlife Service Commissioner, the United States Fish and Wildlife Service Northeast Regional Director, the Vermont Congressional Delegation, and the Vermont Secretary of Natural Resources.

NEW BUSINESS

Third Reading

H. 229.

An act relating to mausoleums and columbaria.

H. 243.

An act relating to the creation of a mentored hunting license.

H. 281.

An act relating to the removal of bodily remains.

H. 622.

An act relating to solicitation by prescreened trigger lead information.

H. 689.

An act relating to the Uniform Common Interest Ownership Act.

H. 767.

An act relating to the livestock care standards advisory council.

PROPOSAL OF AMENDMENT TO H. 767 TO BE OFFERED BY SENATORS CAMPBELL, GIARD, AND ILLUZZI BEFORE THIRD READING

Senators Campbell, Giard, and Illuzzi moves that the Senate propose to the House to amend the bill by adding a new section to be numbered Sec. 2, to read as follows:

Sec. 2. 6 V.S.A. § 3134 is amended to read:

§ 3134. PENALTY

(a) A person who violates this chapter shall be fined not more than ~~$100.00 nor less than $50.00~~ $5,000.00 for the first violation, not more than $10,000.00 for the second violation, and not more than $25,000.00 for the third violation,

or imprisoned not more than ~~90 days~~ two years, or both. In addition to the penalty provided above, the secretary may seek an injunction against a slaughterer, packer, or stockyard operator who engages in practices which are prohibited by section 3132 of this title, by application to the superior court for the county in which such slaughterer, packer or stockyard operator resides, or where such violations occur. The secretary may also take any action authorized under chapter 1 of this title.

(b) The secretary shall permanently revoke the commercial operating license of any person who is found to be in violation of this chapter more than three times.

(c) In addition to the penalties set forth in subsection (a) of this section, the secretary shall require a person who violates this chapter to install video monitoring equipment in all areas in which livestock is handled. The video equipment shall record continuously while live livestock are handled. As an alternative to video monitoring, a live video stream accessible by the secretary may be provided with prior approval of the secretary. The video tapes or recording files of the video monitoring required by this subsection shall be retained by the facility for 90 days and shall be readily retrievable and available for inspection by the secretary. After the retention period of 90 days has expired, the video tapes or recording files of the live video stream shall be submitted to the secretary by the 15th of the following month, on a monthly basis.

(d) The secretary shall refer a violation of this chapter to the attorney general or the state's attorney for prosecution.

And by renumbering the remaining sections of the bill to be numerically correct.

House Proposal of Amendment

S. 88

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

The House proposes to the Senate to amend the bill 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 in 2010 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 licensed health care practitioner 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) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.

(6) 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.

(7) The health care system will recognize the primacy of the patient-provider relationship, respecting the professional judgment of providers and the informed decisions of patients.

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

(9) 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:

(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.

* * *

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. The recommendation section of the proposal shall not be finalized until after the receipt of public input as provided in subdivision (g)(1) of this section.

(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 and substance abuse 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 consultant 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; interdepartmental diagnosis and prevention services; 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.

(h) After receipt of the proposal and implementation plan pursuant to subdivision (g)(2) of this section, the general assembly shall solicit input from interested members of the public and engage in a full and open public review and hearing process on the proposal and implementation plan.

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 licensed health care practitioners and their patients, 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 the Vermont nurse practitioners association; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine ~~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 on a routine basis to 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 licensed health care practitioner.

(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 2012, 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 online 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. 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.

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 18 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;

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

(15) the commissioner of labor or designee.

(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 participate fully 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 perform significantly complex dental procedures safely and effectively;

(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 or by a licensed mental health professional, 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.

(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.

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 licensed health care practitioner 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 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.

(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.

(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.

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 prospective need), 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.

NOTICE CALENDAR

Second Reading

Favorable

H. 769.

An act relating to the licensing and inspection of plant and tree nurseries.

Reported favorably by Senator Giard for the Committee on Agriculture.

(Committee vote: 5-0-0)

(For House amendments, see House Journal of March 24, 2010, page 649.)

Favorable with Proposal of Amendment

H. 555.

An act relating to youth hunting.

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

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

Sec. 1. 10 V.S.A. § 4742a is amended to read:

§ 4742a. YOUTH DEER HUNTING WEEKEND

(a) The Saturday and Sunday prior to opening day of regular deer season shall be youth deer hunting weekend.

(b) A person who is age 15 and under on the weekend of the hunt, who has successfully completed a hunter safety course, may take one wild deer during youth deer hunting weekend in accordance with the rules of the board. In order to hunt under this section, a young person shall also hold a valid hunting license under section 4255 of this title, hold a youth deer hunting tag, and be accompanied by an unarmed adult who holds a valid Vermont hunting license and who is over 18 years of age. An adult accompanying a youth under this section shall accompany no more than two young people at one time.

(c) Each year, the board shall determine whether antlerless deer may be taken under this section in any deer management unit or units. A determination under this subsection shall be made by rule, shall be based on the game management study conducted pursuant to section 4081 of this title and, notwithstanding subsection (g) of that section, may allow taking of antlerless deer.

(d) No person shall hunt under this section on privately owned land without first obtaining the permission of the owner or occupant.

(e) Before the first youth deer hunting weekend and after each fall hunting season, the department shall collect information on youth deer hunting weekend during the regional public hearings held pursuant to subsection 4081(f) of this title. Information relative to the public's knowledge and concerns about the deer herd shall be gathered. The board shall administer youth deer hunting weekend, by deer management unit, based on public input and scientific information.

(f) The scheduled amount of a fine under section 4555 of this title shall be doubled for a violation of this section, and the fine shall be assessed against the licensed adult who is accompanying the youth pursuant to subsection (b) of this section and who has the youth hunter in his or her charge.

(g) For the purposes of this section, "accompany," "accompanied," or "accompanying" means direct control and supervision, including the ability to see and communicate with the youth hunter without the aid of artificial devices such as radios or binoculars, except for medically necessary devices such as hearing aids or eyeglasses. While hunting, an individual who holds a valid hunting license under subsection 4254(b) of this title shall accompany no more than two youth hunters at a time.

Sec. 2. 10 V.S.A. § 4908 is amended to read:

§ 4908. YOUTH TURKEY HUNTING WEEKEND

(a) The Saturday and Sunday prior to opening day of spring turkey season shall be youth turkey hunting weekend.

(b) A person who is age 15 ~~and~~ or under on the weekend of the hunt, who has successfully completed a hunter safety course, may take one wild turkey during youth turkey hunting weekend in accordance with the rules of the board. In order to hunt under this section, a young person shall also hold valid hunting and turkey licenses under section 4255 of this title, hold a youth turkey hunting tag, and be accompanied by an unarmed adult who holds a valid Vermont hunting license and is over 18 years of age. An adult accompanying a youth under this section shall accompany no more than two young people at one time.

(c) No person shall hunt under this section on privately owned land without first obtaining the permission of the owner or occupant.

(d) The scheduled amount of a fine under section 4555 of this title shall be doubled for a violation of this section, and the fine shall be assessed against the licensed adult who is accompanying the youth pursuant to subsection (b) of this section and who has the youth hunter in his or her charge.

(e) For the purposes of this section, "accompany," "accompanied," or "accompanying" means direct control and supervision, including the ability to see and communicate with the youth hunter without the aid of artificial devices such as radios or binoculars, except for medically necessary devices such as hearing aids or eyeglasses. While hunting, an individual who holds a valid hunting license under subsection 4254(b) of this title shall accompany no more than two youth hunters at a time.

Sec. 3. 10 V.S.A. § 4502(b) is amended to read:

(b) A person violating provisions of this part shall receive points for convictions in accordance with the following schedule (all sections are in Title 10 of Vermont Statutes Annotated):

(1) Five points shall be assessed for any violation of statutes or rules adopted under this part except those listed in subdivisions (2) and (3) of this subsection.

(2) Ten points shall be assessed for:

* * *

(II) Appendix § 37, as it ~~applied~~ applies to annual deer limits and as it applies to youth deer hunting weekend. Points assessed for violation of

Appendix 37 as it relates to youth turkey hunting weekend shall be assessed solely against the adult accompanying the youth hunter

(JJ) Appendix § 22, as it applies to youth turkey hunting weekend. Points assessed for violation of Appendix 22 as it relates to youth turkey hunting weekend shall be assessed solely against the adult accompanying the youth hunter.

(3) Twenty points shall be assessed for:

* * *

(P) Appendix § 22 (excluding § 22E). Turkey season, excluding requirements for youth turkey hunting season.

* * *

(U) Appendix § 37, excluding violations of annual deer limits, requirements for youth deer hunting weekend, and limitations on feeding of deer.

Sec. 4. 10 V.S.A. § 4001(14) is amended to read:

(14) Fur-bearing animals: beaver, otter, marten, mink, raccoon, fisher, fox, skunk, coyote, bobcat, weasel, opossum, lynx, wolf, and muskrat.

Sec. 5. REPEAL

10 V.S.A. § 4865 (muskrat shooting season) is repealed.

Sec. 6. FISH AND WILDLIFE BOARD REPORT ON YOUTH DEER HUNTING LIMITS

On or before January 15, 2011, the fish and wildlife board shall submit to the house committee on fish, wildlife and water resources and the senate committee on natural resources and energy a recommendation as to whether a youth who hunts deer under 10 V.S.A. § 4742a should be limited to the taking of one deer prior to the youth turning 16 years of age.

Sec. 7. EFFECTIVE DATE

This act shall take effect July 1, 2010.

(Committee vote: 5-0-0)

(For House amendments, see House Journal for March 16, 2010, page 405.)

House Proposal of Amendment

S. 165

An act relating to eliminating the statute of limitations for felonies.

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

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

House Proposal of Amendment

S. 268

An act relating to the building bright futures council.

The House proposes to the Senate to amend the bill 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.

ORDERED TO LIE

S. 99.

An act relating to amending the Act 250 criteria relating to traffic, scattered development, and rural growth areas.

S. 110.

An act relating to sheltering livestock.

S. 226.

An act relating to medical marijuana dispensaries.

H. 331.

An act relating to technical changes to the records management authority of the Vermont State Archives and Records Administration.

CONFIRMATIONS

The following appointments will be considered by the Senate, as a group, under suspension of the Rules, as moved by the President *pro tempore*, for

confirmation together and without debate, by consent thereby given by the Senate. However, upon request of any senator, any appointment may be singled out and acted upon separately by the Senate, with consideration given to the report of the Committee to which the appointment was referred, and with full debate; and further, all appointments for the positions of Secretaries of Agencies, Commissioners of Departments, Judges, Magistrates, and members of the Public Service Board shall be fully and separately acted upon.

Jonathan Wood of Cambridge - Secretary of the Agency of Natural Resources - By Senator Lyons for the Committee on Natural Resources and Energy. (3/10/10)

Jonathan Wood of Cambridge - Secretary of the Agency of Natural Resources - By Senator Lyons for the Committee on Natural Resources and Energy. (3/10/10)

Justin Johnson of Barre - Commissioner of the Department of Environmental Conservation - By Senator Lyons for the Committee on Natural Resources and Energy. (3/10/10)

Wayne Allen Laroche of Franklin - Commissioner of the Department of Fish & Wildlife - By Senator Lyons for the Committee on Natural Resources and Energy. (3/10/10)

Jason Gibbs of Duxbury - Commissioner of the Department of Forests, Parks & Recreation - By Senator Lyons for the Committee on Natural Resources and Energy. (3/10/10)

Jason Gibbs of Duxbury – Commissioner of the Department of Forests, Parks & Recreation – By Senator Lyons for the Committee on Natural Resources and Energy. (3/10/10)

Richard A. Westman of Cambridge – Commissioner of the Department of Taxes – By Senator MacDonald for the Committee on Finance. (3/16/10)

Bruce Hyde of Granville – Commissioner of the Department of Tourism & Marketing – By Sen. Ashe for the Committee on Economic Development, Housing and General Affairs. (3/24/10)

Kevin Dorn of Essex Junction – Secretary of the Agency of Commerce & Community Development – By Sen. Illuzzi for the Committee on Economic Development, Housing and General Affairs. (3/24/10)

Tayt Brooks of St. Albans – Commissioner of the Department of Economic, Housing and Community Affairs – By Sen. Miller for the Committee on Economic Development, Housing and General Affairs. (3/24/10)

PUBLIC HEARINGS

Thursday, April 29, 2010 – Room 11 – 5:00–7:00 P.M. – Re: Draft telecom plan - (House Committee on Commerce and Economic Development)