Journal of the Senate

TUESDAY, MAY 4, 2010

The Senate was called to order by the President.

Devotional Exercises

A moment of silence was observed in lieu of devotions.

Message from the House No. 68

A message was received from the House of Representatives by Ms. H. Gwynn Zakov, its Second Assistant Clerk, as follows:

Mr. President:

I am directed to inform the Senate that:

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

S. 263. An act relating to the Vermont Benefit Corporations Act.

S. 292. An act relating to term probation, the right to bail, medical care of inmates, and a reduction in the number of nonviolent prisoners, probationers, and detainees.

And has passed the same in concurrence with proposals of amendment in the adoption of which the concurrence of the Senate is requested.

Pursuant to the request of the Senate for a Committee of Conference upon the disagreeing votes of the two Houses on Senate bill of the following title:

S. 97. An act relating to a Vermont state employees' cost-savings incentive program.

The Speaker has appointed as members of such committee on the part of the House:

Rep. Evans of Essex
Rep. Martin of Wolcott
Rep. McDonald of Berlin

Pursuant to the request of the Senate for a Committee of Conference upon the disagreeing votes of the two Houses on Senate bill of the following title:

S. 295. An act relating to the creation of an agricultural development director.

The Speaker has appointed as members of such committee on the part of the House:

Rep. Stevens of Shoreham
Rep. Taylor of Barre City
Rep. Malcolm of Pawlet

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

H. 243. An act relating to the creation of a mentored hunting license.

H. 622. An act relating to solicitation by prescreened trigger lead information.

And has severally concurred therein.

The House has considered Senate proposals of amendment to House bill of the following title:

H. 281. An act relating to the removal of bodily remains.

And has severally concurred therein with a further proposal of amendment thereto, in the adoption of which the concurrence of the Senate is requested.

Third Reading Ordered; Rules Suspended; Passed in Concurrence

H. 770.

Senator Doyle, for the Committee on Government Operations, to which was referred House bill entitled:

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

Reported that the bill ought to pass in concurrence.

Thereupon, the bill was read the second time by title only pursuant to Rule 43, and third reading of the bill was ordered.

Thereupon, on motion of Senator Shumlin, the rules were suspended and the bill was placed on all remaining stages of its passage in concurrence forthwith.

Thereupon, the bill was read the third time and passed in concurrence.

Report of Committee of Conference Accepted and Adopted on the Part of the Senate

H. 540.

Senator Hartwell, for the Committee of Conference, submitted the following report:

To the Senate and House of Representatives:

The Committee of Conference to which were referred the disagreeing votes of the two Houses upon House bill entitled:

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

Respectfully reports that it has met and considered the same and recommends that the Senate recede from its proposal of amendment and that the bill be amended by striking out all after the enacting clause and by inserting in lieu thereof the following:

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

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

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

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

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

(1) The driver of a motor vehicle overtaking another motor vehicle proceeding in the same direction may pass to its left at a safe distance, and when so doing shall exercise due care, ~~may~~ shall not pass to the left of the center of the highway unless the way ahead is clear of approaching traffic, and shall not again drive to the right side of the roadway until safely clear of the overtaken vehicle.

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

(b) Passing vulnerable users. The operator of a motor vehicle approaching or passing a vulnerable user as defined in subdivision 4(81) of this title shall exercise due care, which includes increasing clearance, to pass the vulnerable user safely, and shall cross the center of the highway only as provided in subdivision (a)(1) of this section.

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

§ 1039. FOLLOWING TOO CLOSELY, CROWDING, AND HARASSMENT

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

* * *

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

§ 1065. HAND SIGNALS

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

(1) Left turn. – Hand and arm extended horizontally.

(2) Right turn. – Hand and arm extended upward.

(3) Stop or decrease speed. – Hand and arm extended downward.

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

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

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

(a) Whenever upon a public highway and approaching a vehicle drawn by a ~~horse or other~~ draft animal, ~~or approaching a horse or other~~ an animal upon

which a person is riding, or animals being herded, the operator of a motor vehicle shall operate the vehicle in such a manner as to exercise every reasonable precaution to prevent the frightening of ~~such horse or~~ any animal and to ~~insure~~ ensure the safety and protection of the animal and the person riding ~~or,~~ driving, or herding.

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

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

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

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

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

(3) overtaking another highway user; or

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

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

(a) ~~No~~ A person ~~may~~ shall not operate a bicycle at nighttime from one-half hour after sunset until one-half hour before sunrise unless ~~it~~ the bicycle or the bicyclist is equipped with a lamp on the front~~,~~ which emits a white light visible from a distance of at least 500 feet to the front~~, and with a red reflector on the rear, which shall be visible at least 300 feet to the rear when directly in front of lawful upper beams of head lamps on a motor vehicle. Lamps emitting red lights visible to the rear may be used in addition to the red reflector~~. In addition, bicyclists shall operate during these hours with either a lamp on the rear of the bicycle or bicyclist which emits a flashing or steady red light visible at least 300 feet to the rear, or with reflective, rear-facing material or reflectors, or both, with a surface area totaling at least 20 square inches on the bicycle or bicyclist and visible at least 300 feet to the rear.

Sec. 8. REPEAL

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

ROBERT M. HARTWELL
M. JANE KITCHEL
PHILIP B. SCOTT

Committee on the part of the Senate

MOLLIE SULLIVAN BURKE
ADAM B. HOWARD
DIANE M. LANPHER

Committee on the part of the House

Thereupon, the question, Shall the Senate accept and adopt the report of the Committee of Conference?, was decided in the affirmative.

Third Reading Ordered; Rules Suspended; Consideration Postponed

H. 769.

Senator Giard, for the Committee on Agriculture, to which was referred House bill entitled:

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

Reported that the bill ought to pass in concurrence.

Senator Giard, for the Committee on Finance, to which the bill was referred, reported recommended that the bill ought to pass in concurrence.

Thereupon, the bill was read the second time by title only pursuant to Rule 43, and third reading of the bill was ordered.

Thereupon, on motion of Senator Campbell, the rules were suspended and the bill was placed on all remaining stages of its passage in concurrence forthwith.

Thereupon, the bill was read the third time and pending the question, Shall the bill pass in concurrence?, on motion of Senator Shumlin, consideration of the bill was postponed.

Consideration Postponed

House bill entitled:

H. 528.

An act relating to the illegal cutting, removal, or destruction of forest products.

Was taken up.

Thereupon, without objection consideration of the bill was postponed until the next legislative day.

Proposal of Amendment; Bill Passed in Concurrence with Proposals of Amendment

H. 470.

House bill entitled:

An act relating to restructuring of the judiciary.

Was taken up.

Thereupon, pending third reading of the bill, Senators Shumlin, Illuzzi, Mullin and Sears moved that the Senate proposal of amendment be amended in Sec. 17, 4 V.S.A. § 272, by striking out subsection (b) in its entirety, and by re-lettering the remaining subsection to be alphabetically correct.

Thereupon, pending the question, Shall the Senate proposal of amendment be amended as proposed by Senators Shumlin, Illuzzi, Mullin and Sears?, on motion of Senator Shumlin consideration of the proposal of amendment was postponed.

Senator Shumlin Assumes the Chair

Thereupon, pending third reading of the bill, Senator Sears moved that the Senate proposal of amendment be amended as follows:

First: By adding a new section to be numbered Sec. 29a, to read as follows:

Sec. 29a. 4 V.S.A. § 461a is amended to read:

§ 461a. ESSEX COUNTY; POWERS OF ASSISTANT JUDGES AND MAGISTRATES IN FAMILY COURT PROCEEDINGS

(a) Notwithstanding any other provision of law to the contrary, an assistant judge of Essex County who has satisfactorily completed the training provided by the Vermont supreme court pursuant to Sec. 20 of Act No. 221 of the 1990 adjourned session, or a similar course of training that has been approved by the supreme court, shall act as a magistrate and hear and dispose of proceedings for the establishment, modification and enforcement of child support and establishment of parentage in all cases filed or pending in the family division of the superior court in Essex County.

(b) The administrative judge may appoint and may specially assign ~~the~~ a magistrate ~~assigned to Essex County~~ to serve as the presiding ~~family court~~ judge in the family division of the superior court in Essex County. ~~The magistrate assigned shall not hear and dispose of proceedings assigned to the~~

~~assistant judges in subsection (a) of this section, unless authorized by section 463 of this title.~~

(c) No Vermont family court action filed or pending in Essex County, except for temporary abuse prevention ~~orders that are sought as emergency relief pursuant to V.R.F.P. 9(c) after regular court hours~~ proceedings and juvenile proceedings under Title 33, shall be heard at or transferred to ~~any other location, except Guildhall~~ the family division in another unit of the superior court.

Second: By adding a new section to be numbered Sec. 29b, to read as follows:

Sec. 29b. 4 V.S.A. § 461c is amended to read:

§ 461c. POWERS OF ASSISTANT JUDGES IN DIVORCE PROCEEDINGS

(a) Notwithstanding any other provision of law to the contrary, an assistant judge ~~who has served in that office for a minimum of two years~~ may elect to hear and determine a complaint or action which seeks a divorce, legal separation, or civil union dissolution in cases where a final stipulation of the parties has been ~~reached~~ filed with the court.

(b) When an assistant judge elects to hear such cases, the clerk shall set it for hearing before the assistant judge if available. ~~In the event both assistant judges elect to hear such cases, the senior assistant judge shall make case assignments.~~

(c) ~~Assistant judges~~ Prior to hearing an uncontested domestic matter, an assistant judge shall sit with a superior judge on domestic proceedings for a minimum of 100 hours, satisfactorily complete a minimum of 30 hours of training ~~on the subjects of child support and divorce, which shall be provided by the office of child support, and in order to hear and determine complaints under this section upon completion of the training, assistant judges not already conducting hearings under this section as of July 1, 1995, shall~~ on subjects relevant to domestic proceedings and the code of judicial conduct, and conduct a minimum of three uncontested ~~divorce~~ domestic hearings with a ~~family court~~ superior judge who shall, in his or her sole discretion, certify to the ~~supreme court~~ administrative judge that the assistant judge is qualified to preside over matters under this section. Upon application of an assistant judge, some or all of these requirements may be waived by the administrative judge based on equivalent experience. The requirements set forth herein shall only apply to assistant judges who elect to conduct uncontested final hearings in domestic cases after July 1, 2010. An assistant judge already conducting hearings under

this section as of July 1, 2010, shall be deemed to have complied with these requirements.

Third: In Sec. 199, 32 V.S.A. § 1142, by striking out subsection (c) in its entirety and inserting in lieu thereof a new subsection (c) to read as follows:

(c) A probate judge whose salary is less than $45,701.00 shall only be eligible for the least expensive medical benefit plan option available to state employees or may apply the state share of a single-person premium for the least expensive benefit plan option toward the purchase of another state or private health insurance plan. A probate judge whose salary is less than $45,701.00 may participate in other state employee benefit plans.

Fourth: In Sec. 203a, 32 V.S.A. § 1431(c), by striking out subdivision (2) in its entirety and inserting in lieu thereof a new subdivision (2) to read as follows:

(2) All fees paid to the clerk pursuant to this subsection shall be for the benefit of the county, except that such fees shall be for the benefit of the state in a county where court facilities are provided by the state.

Fifth: By adding a new section to be numbered Sec. 203b, to read as follows:

Sec. 203b. 32 V.S.A. § 1431 is amended to read:

§ 1431. FEES IN SUPREME AND SUPERIOR COURTS

* * *

(c)(1) Prior to the entry of a small claims action, there shall be paid to the clerk in lieu of all other fees not otherwise set forth in this section, a fee of $75.00 if the claim is for more than $1,000.00 and $50.00 if the claim is for $1,000.00 or less. Prior to the entry of any postjudgment motion in a small claims action, there shall be paid to the clerk a fee of $50.00. The fee for every counterclaim in small claims proceedings shall be $25.00, payable to the clerk, if the counterclaim is for more than $500.00, and $15.00 if the counterclaim is for $500.00 or less.

(2) ~~All fees paid to the clerk pursuant to this subsection shall be for the benefit of the county, except that such fees shall be for the benefit of the state in a county where court facilities are provided by the state.~~

(A) Except as provided in subdivision (B) of this subdivision (2), fees paid to the clerk pursuant to this subsection shall be divided as follows: 50 percent of the fee shall be for the benefit of the county and 50 percent of the fee shall be for the benefit of the state.

(B) In a county where court facilities are provided by the state, all fees paid to the clerk pursuant to this subsection shall be for the benefit of the state.

* * *

Sixth: In Sec. 237, by adding a new subsection, to be lettered as subsection (i), to read as follows:

(i) The establishment of six new exempt positions for the superior court with position titles to be assigned by the court administrator is authorized in FY 2011.

Seventh: In Sec. 238(a), after the following: "456 (appeals from family court)," by inserting the following: 4 V.S.A. § 461b (powers of assistant judges in Essex and Orleans Counties in parentage proceedings),

Eighth: In Sec. 239(c), after the following: "201," by inserting the following: 203b,

Which was agreed to.

Thereupon, pending third reading of the bill, Senator Illuzzi moved that the Senate proposal of amendment be amended as follows

First: By adding a new section to be numbered Sec. 55b to read as follows:

Sec. 55b. 4 V.S.A. § 1106(d) is amended to read:

(d) ~~With approval of his or her supervisor, a~~ A law enforcement officer may void or amend a complaint issued by that officer by so marking the complaint and returning it to the bureau, regardless of whether the amended complaint is a lesser included violation. At the hearing, a law enforcement officer may void or amend a complaint issued by that officer ~~subject to the approval of the hearing~~ in the discretion of that officer.

Second: By adding a new section to be numbered Sec. 181a to read as follows:

Sec. 181a. 24 V.S.A. § 1940(c) is amended to read:

(c) A specialized investigative unit grants board is created which shall be comprised of the attorney general, the secretary of administration, the executive director of the department of state's attorneys, the commissioner of the department of public safety, a representative of the Vermont sheriffs' association, a representative of the Vermont association of chiefs of police, the executive director of the center for crime victim services, and the executive director of the Vermont League of Cities and Towns~~, Inc~~. Specialized investigative units organized and operating under this section for the

investigation of sex crimes, child abuse, elder abuse, domestic violence, or crimes against those with physical or developmental disabilities may apply to the board for a grant or grants covering the costs of salaries and employee benefits to be expended during a given year for the performance of unit duties as well as unit operating costs for rent, utilities, equipment, training, and supplies. Grants under this section shall be approved by a majority of the entire board and shall not exceed 50 percent of the yearly salary and employee benefit costs of the unit. Preference shall be given to grant applications which include the participation of the department of public safety, the department for children and families, sheriffs' departments, community victims' advocacy organizations, and municipalities within the region. However, a sheriff's department in a county with a population of less than 8,000 residents shall upon application receive a grant of $20,000.00 to support a part-time specialized investigative unit investigator which shall be paid to the department as time is billed on a per hour rate as agreed by contract up to the maximum amount of the grant.

Third: By adding a new section to be numbered Sec. 17a to read as follows:

Sec. 17a. 4 V.S.A. § 278 is added to read:

§ 278. AUTHORIZATION OF ASSISTANT JUDGES

(a) Notwithstanding any provision of law to the contrary, an assistant judge or a candidate for the office of assistant judge may also seek election to the office of probate judge, and if elected to both offices, may serve both as an assistant judge and as probate judge.

(b) In the event a probate matter arises in the superior court over which an assistant judge is also the probate judge that presides, or has presided, over the same or related probate matter in the probate court, the assistant judge shall be disqualified from hearing and deciding the probate matter in the superior court.

(c) In the event a probate matter arises in the probate court over which a probate judge is also an assistant judge that presides, or has presided, over the same or related probate matter in the superior court, the probate judge shall be disqualified from hearing and deciding the probate matter in the probate court.

Fourth: In Sec. 239(d), after the following "Secs." by adding the following: 17a,

President Assumes the Chair

Which was agreed to.

Thereupon, pending third reading of the bill, consideration of the proposal of amendment of Senators Shumlin, Illuzzi, Mullin and Sears was resumed.

Thereupon, the question, Shall the Senate proposal of amendment be amended as recommended by Senators Shumlin, Illuzzi, Mullin and Sears?, was disagreed to on a roll call, Yeas 14, Nays 16.

Senator Sears having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Carris, Choate, Flanagan, Hartwell, Illuzzi, Kittell, Lyons, Mazza, Mullin, Scott, Sears, Shumlin, Starr, White.

Those Senators who voted in the negative were: Ashe, Ayer, Bartlett, Brock, Campbell, Cummings, Doyle, Flory, Giard, Kitchel, MacDonald, McCormack, Miller, Nitka, Racine, Snelling.

Thereupon, pending third reading of the bill, Senators Cummings, on behalf of the Committee on Judiciary moved that the Senate proposal of amendment be amended as follows:

First: In Sec. 199, 32 V.S.A. § 1142, by striking subsection (a) in its entirety and inserting in lieu thereof a new subsection (a) to read as follows:

(a) The annual salaries of the ~~judges of~~ probate judges in the several probate districts, which shall be paid by the state in lieu of all fees or other compensation, shall be as follows:

	~~Annual Salary as of July 8, 2007~~	
(1) Addison	~~$59,321~~	52,439
(2) Bennington	~~59,321~~	61,235
(3) Caledonia	~~59,321~~	46,956
(4) Chittenden	~~91,402~~	91,395
(5) Essex	~~28,853~~	15,000
~~(6) Fair Haven~~	~~43,594~~	
~~(7)~~(6) Franklin	~~59,321~~	52,439
~~(8)~~(7) Grand Isle	~~28,853~~	15,000
~~(9) Hartford~~	~~59,321~~	
~~(10)~~(8) Lamoille	~~53,594~~	37,816

~~(11) Marlboro~~	~~51,559~~	
~~(12)~~(9) Orange	~~51,559~~	44,214
~~(13)~~(10) Orleans	~~51,559~~	43,300
~~(14)~~(11) Rutland	~~75,859~~	86,825
~~(15)~~(12) Washington	~~75,859~~	70,718
~~(16)~~(13) ~~Westminster~~ Windham	~~43,594~~	57,923
~~(17)~~(14) Windsor	~~51,559~~	75,859

Second: By striking Sec. 205 in its entirety and inserting in lieu thereof a new Sec. 205 to read as follows:

Sec. 205. 32 V.S.A. § 1436 is amended to read:

§ 1436. FEE FOR CERTIFICATION OF APPOINTMENT AS NOTARY PUBLIC

~~(a)~~ For the issuance of a certificate of appointment as a notary public, the county clerk shall collect a fee of ~~$20.00~~ $30.00, of which ~~$5.00~~ $10.00 shall accrue to the state and ~~$15.00~~ $20.00 shall accrue to the county.

~~(b) Notwithstanding any statute to the contrary, fees collected as a result of this section shall be in lieu of any payments by the state to the county for the use of the county courthouse by the supreme, district, family, and environmental courts or by the judicial bureau.~~

Which was agreed to.

Thereupon, the bill was read the third time and passed in concurrence with proposals of amendment on a roll call, Yeas 30, Nays 0.

Senator Sears having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Bartlett, Brock, Campbell, Carris, Choate, Cummings, Doyle, Flanagan, Flory, Giard, Hartwell, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, Mazza, McCormack, Miller, Mullin, Nitka, Racine, Scott, Sears, Shumlin, Snelling, Starr, White.

Those Senators who voted in the negative were: None.

House Proposal of Amendment Concurred In

S. 138.

House proposal of amendment to Senate bill entitled:

An act relating to unfair business practices of credit card companies and fraudulent use of scanning devices and re-encoders.

Was taken up.

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

Sec. 1. FINDINGS

(a) While credit card use offers benefits to consumers and merchants, including safety of financial information, convenience, and guaranteed payment to merchants, courts have found that Visa and MasterCard and their member banks have major market power.

(b) Electronic payment system networks, such as those incorporated by Visa and MasterCard, set the level of credit and debit card interchange fees charged by their member banks, even though those banks are supposed to be competitors.

(c) Credit and debit card interchange fees inflate the prices consumers pay for goods and services. Competitors should set their own prices and compete on that basis.

(d) Consumers are increasingly using credit and debit card electronic payment systems to purchase goods and services.

(e) In order to provide the desired convenience to consumers, most merchants agree to accept credit and debit cards.

(f) Some electronic payment system networks market themselves as currency and promote use of their products as though they were a complete substitution for legal tender.

(g) Due to the market power of the two largest electronic payment system networks, merchants do not have negotiating power with regard to the contract for acceptance of credit and debit cards and the cost of the interchange fees for such acceptance.

(h) Merchants are subject to contracts that allow the electronic payment system networks to change the terms without notice, subject merchants to substantial fines, or reinterpret the rules and hold the merchant responsible.

(i) Merchants have expressed interest in working with customers to give customers the types of pricing options they would like but that are currently blocked by the terms or interpretations of contracts necessary to accept credit and debit cards.

(j) Businesses in Vermont are also consumers. The protections of this bill are intended to apply to all consumers, including businesses, in Vermont.

Sec. 2. 9 V.S.A. chapter 63, subchapter 4 is added to read:

Subchapter 4. Prevention of Credit Card Company Unfair Business Practices

§ 2480o. DEFINITIONS

For purposes of this subchapter:

(1) "Electronic payment system" means an entity that directly or through licensed members, processors or agents provides the proprietary services, infrastructure and software that route information and data to facilitate transaction authorization, clearance and settlement, and that merchants are required to access in order to accept a specific brand of general-purpose credit cards, charge cards, debit cards or stored-value cards as payment for goods and services.

(2) "Merchant" means a person or entity that, in Vermont:

(A)(i) does business; or

(ii) offers goods or services for sale; and

(B) has a physical presence.

§ 2480p. ELECTRONIC PAYMENT SYSTEMS

With respect to transactions involving Vermont merchants, no electronic payment system may directly or through any agent, processor or member of the system:

(1) Impose any requirement, condition, penalty, or fine in a contract with a merchant to inhibit the ability of any merchant to provide a discount or other benefit for payment through the use of a card of another electronic payment system, cash, check, debit card, stored-value card, charge card or credit card rather than another form of payment.

(2) Impose any requirement, condition, penalty or fine in a contract with a merchant to prevent the ability of any merchant to set a minimum dollar value of no more than $10.00 for its acceptance of a form of payment, provided that if a minimum dollar value is set by a merchant, it shall be prominently displayed and printed in not less than 16-point boldface type at the point of sale.

(3) Impose any requirement, condition, penalty or fine in a contract with a merchant to inhibit the ability of any merchant to decide to accept an electronic payment system at one or more of its locations but not at others.

§ 2480q. PENALTIES

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

(1) Any electronic payment system found to have violated section 2480p of this subchapter shall reimburse all affected merchants for all fines related to the prohibitions described in section 2480p which were collected from affected merchants directly or through any agent, processor or member of the system during the period of time in which the electronic payment system was in violation and shall be liable for a civil penalty of $10,000.00 per fine levied in violation of section 2480p of this subchapter.

(2) Any merchant whose rights under this subchapter have been violated may maintain a civil action for damages or equitable relief as provided for in this section, including attorney's fees, if any.

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

(b) These penalties shall not apply to entities acting exclusively as agents, processors or members that are not electronic payment systems.

§ 2480r. SEVERABILITY

If any provision of this subchapter or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this subchapter which can be given effect without the invalid provision or application, and, to this end, the provisions of this subchapter are severable.

Sec. 3. 13 V.S.A. § 1816 is added to read:

§ 1816. POSSESSION OR USE OF CREDIT CARD SKIMMING DEVICES AND RE-ENCODERS

(a) A person who knowingly, wittingly and with the intent to defraud possesses a scanning device, or who knowingly, wittingly and with intent to defraud uses a scanning device to access, read, obtain, memorize or store, temporarily or permanently, information encoded on the computer chip or magnetic strip of a payment card without the permission of the authorized user

of the payment card shall be imprisoned not more than 10 years and fined not more than $10,000.00, or both.

(b) A person who knowingly, wittingly and with the intent to defraud possesses a re-encoder, or who knowingly, wittingly and with the intent to defraud uses a re-encoder to place encoded information on the computer chip or magnetic strip or stripe of a payment card or any electronic medium that allows an authorized transaction to occur without the permission of the authorized user of the payment card from which the information is being re-encoded shall be imprisoned not more than 10 years or fined not more than $10,000.00, or both.

(c) Any scanning device or re-encoder described in subsection (e) of this section allegedly possessed or used in violation of subsection (a) or (b) of this section shall be seized and upon conviction shall be forfeited. Upon forfeiture, any information on the scanning device or re-encoder shall be removed permanently.

(d) Any computer, computer system, computer network, or any software or data owned by the defendant which are used during the commission of any public offense described in this section or any computer owned by the defendant which is used as a repository for the storage of software or data illegally obtained in violation of this section shall be subject to forfeiture.

(e) For purposes of this section:

(1) "Payment card" means a credit card, debit card or any other card that is issued to an authorized user and that allows the user to obtain, purchase, or receive goods, services, money, or anything else of value.

(2) "Re-encoder" means an electronic device that places encoded information from the computer chip or magnetic strip or stripe of a payment card onto the computer chip or magnetic strip or stripe of a different payment card or any electronic medium that allows an authorized transaction to occur.

(3) "Scanning device" means a scanner, reader or any other electronic device that is used to access, read, scan, obtain, memorize or store, temporarily or permanently, information encoded on the computer chip or magnetic strip or stripe of a payment card.

(f) Nothing in this section shall preclude prosecution under any other provision of law.

Sec. 4. STUDY; REPORT

On or before December 15, 2011, the department of banking, insurance, securities, and health care administration shall:

(1) collect, examine, organize and categorize by author entity, such as government or private, the available studies that have been performed on credit card interchange fees; and

(2) report to the senate committees on judiciary and on finance and the house committees on commerce and economic development and on judiciary its findings, recommendations and legislative proposals, if any, relating to its findings.

Sec. 5. EFFECTIVE DATES

(a) Secs. 1, 2 and 4 of this act shall take effect January 1, 2011.

(b) This section and Sec. 3 of this act shall take effect upon passage.

Thereupon, the question, Shall the Senate concur in the House proposal of amendment?, was decided in the affirmative.

House Proposal of Amendment Concurred In

S. 161.

House proposal of amendment to Senate bill entitled:

An act relating to National Crime Prevention and Privacy Compact.

Was taken up.

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

*** * * Providing Complete Out-of-State Conviction Records for School Employees * * ***

Sec. 2. 16 V.S.A. § 252(1) is amended to read:

(1) "Criminal record" means the record of:

(A) convictions in Vermont, including whether any of the convictions is an offense listed in 13 V.S.A. § 5401(10) (sex offender definition for registration purposes); and

(B) convictions in other jurisdictions recorded in other state repositories or by the Federal Bureau of Investigation (FBI) ~~for the following crimes or for crimes of an equivalent nature:~~

~~(i) Crimes listed in subdivision 5301(7) of Title 13.~~

~~(ii) Contributing to juvenile delinquency under section 1301 of Title 13.~~

~~(iii) Cruelty to children under section 1304 of Title 13.~~

~~(iv) Cruelty by person having custody under section 1305 of Title 13.~~

~~(v) Prohibited acts under sections 2632 and 2635 of Title 13.~~

~~(vi) Displaying obscene materials to minors under section 2804b of Title 13.~~

~~(vii) Sexual exploitation of children under chapter 64 of Title 13.~~

~~(viii) Drug sales, including selling or dispensing under sections 4230(b), 4231(b), 4232(b), 4233(b), 4234(b), 4235(c), 4235a(b), and 4237 of Title 18.~~

~~(ix) Sexual activity by a caregiver, under subsection 6913(d) of Title 33~~.

Sec. 3. 16 V.S.A. § 255 is amended to read:

§ 255. PUBLIC AND INDEPENDENT SCHOOL EMPLOYEES; CONTRACTORS

* * *

(d)(1) Upon completion of a criminal record check, the Vermont criminal information center shall send to the superintendent ~~or headmaster~~ a notice that no record exists or, if a record exists~~:~~,

~~(1)~~ a copy of any criminal record ~~for Vermont convictions; and~~

(2) ~~if the requester is a superintendent, a notice of any criminal record which is located in either another state repository or FBI records, but not a record of the specific convictions except those relating to crimes of a sexual nature involving children~~.

~~(3) if the requester is a headmaster, a~~

Upon completion of a criminal record check, the Vermont criminal information center shall send to the headmaster a notice that no record exists or, if a record exists:

(A) A copy of Vermont criminal convictions.

(B) A notice of any criminal record which is located in either another state repository or FBI records, but not a record of the specific convictions. However, if there is a record relating to any crimes of a sexual nature involving children, the Vermont criminal information center shall send this record to the commissioner who shall notify the headmaster in writing, with a copy to the person about whom the request-was made, that the record includes one or more convictions for a crime of a sexual nature involving children.

(f) Information sent to a person by the commissioner, a headmaster, a superintendent or a contractor under ~~subsections (d)(3) and~~ subsection (e) of this section shall be accompanied by a written notice of the person's rights under subsection (g) of this section, a description of the policy regarding maintenance and destruction of records, and the person's right to request that the notice of no record or record be maintained for purposes of using it to comply with future criminal record check requests pursuant to section 256 of this title.

(g)(1) Following notice that a headmaster was notified that a criminal record which is located in either another state repository or FBI records exists, a person may:

~~(1)~~(A) Sign a form authorizing the Vermont criminal information center to release a detailed copy of the criminal record ~~to a superintendent or~~ to the person.

(B) Decline or resign employment.

(2) ~~Challenge~~ Any person subject to a criminal record check pursuant to this section may challenge the accuracy of the record by appealing to the Vermont criminal information center pursuant to rules adopted by the commissioner of public safety.

~~(3) Decline or resign employment.~~

Sec. 4. Sec. 5 of No. 1 of the Acts of 2009 is amended to read:

Sec. 5. 16 V.S.A. § 255 is amended to read:

§ 255. PUBLIC AND INDEPENDENT SCHOOL EMPLOYEES; CONTRACTORS

* * *

(d)(1) Upon completion of a criminal record check, the Vermont criminal information center shall send to the superintendent a notice that no record exists or, if a record exists, a copy of any criminal record

(2) Upon completion of a criminal record check, the Vermont criminal information center shall send to the headmaster a notice that no record exists or, if a record exists:

(A) A copy of Vermont criminal convictions.

(B) A notice of any criminal record which is located in either another state repository or FBI records, but not a record of the specific convictions. However, if there is a record relating to any crimes of a sexual nature involving children, the Vermont criminal information center shall send this record to the

commissioner who shall notify the headmaster in writing, with a copy to the person about whom the request-was made, that the record includes one or more convictions for a crime of a sexual nature involving children.

* * *

*** * * Commercial Driver License Disqualifiers * * ***

Sec. 5. 23 V.S.A. § 4108 is amended to read:

§ 4108. COMMERCIAL DRIVER LICENSE QUALIFICATION STANDARDS

(a) Before issuing a commercial driver license, the commissioner shall request the applicant's complete operating record from any state in which the applicant was previously licensed to operate any type of motor vehicle in the past 10 years and conduct a check of the applicant's operating record by querying the national driver register established under 49 U.S.C. § 30302 and the commercial driver's license information system established under 49 U.S.C. § 31309 to determine if:

(1) the applicant has already been issued a commercial driver license;

(2) the applicant's commercial driver license has been suspended, revoked, or canceled; or

(3) the applicant has been convicted of any offense listed in Section 205(a)(3) of the National Driver Register Act of 1982 (49 U.S.C. § 30304(a)(3)).

(b) ~~Except as otherwise provided, the~~ The commissioner shall not issue a commercial driver license ~~and~~ or commercial driver instruction permit to any person:

(1) under the age of 21 years except as otherwise provided.

~~(b)~~(2) who, within three years of the license application and for initial applicants only, has been convicted of an offense listed in subsection 4116(a) of this title (or a comparable offense in any jurisdiction), or convicted of an offense listed in 49 U.S.C. § 30304(a)(3) in any jurisdiction.

(3) ~~No person may be issued a commercial driver license~~ unless that person is a resident of this state and has passed a knowledge and skills test for driving a commercial motor vehicle which complies with minimum federal standards established by federal regulation enumerated in 49 C.F.R. part 383, subparts G and H and has satisfied all other requirements of ~~Title XII of Public Law 99-570~~ the Commercial Motor Vehicle Safety Act of 1986, as amended,

in addition to other requirements imposed by state law or federal regulation. The tests shall be prescribed and conducted by the commissioner.

* * *

Sec. 6. 23 V.S.A. § 4110(a) is amended to read:

(a) The application for a commercial driver license or commercial driver instruction permit shall include the following:

* * *

(6) Certifications that:

* * *

(C) the applicant is not subject to any disqualification under 49 C.F.R. ~~part 385.51~~ section 383.51, or any license suspension, revocation, or cancellation under ~~state law~~ the law of any jurisdiction; ~~and~~

(D) the applicant does not have a driver's license from more than one state or jurisdiction; and

(E) for initial applicants only, the applicant has not been convicted of an offense listed in subsection 4116(a) of this title (or a comparable offense in any jurisdiction) or an offense listed in 49 U.S.C. § 30304(a)(3) in any jurisdiction within three years of the license application.

Sec. 7. 23 V.S.A. § 4111(c) is amended to read:

(c) ~~Before issuing a commercial driver license, the commissioner shall request the applicant's complete operating record from any state in which the applicant was previously licensed to operate any type of motor vehicle in the past 10 years, conduct a check of the applicant's operating record by querying the national driver register, established under 49 U.S.C. § 30302 and the commercial driver's license information system, established under 49 U.S.C. § 31309, to determine if:~~

~~(1) the applicant has already been issued a commercial driver license; and the applicant's commercial driver license has been suspended, revoked, or canceled;~~

~~(2) the applicant had been convicted of any offenses contained in Section 205(a)(3) of the National Driver Register Act of 1982 (23 U.S.C. § 401 note).~~ [Repealed.]

*** * * Conditioning Motor Vehicle Registration on Proof of Financial Responsibility * * ***

Sec.8. PROOF OF FINANCIAL RESPONSIBILITY AS A CONDITION OF MOTOR VEHICLE REGISTRATION; IMPLEMENTATION; REPORTING

The commissioner of motor vehicles shall examine the administrative tasks that would be needed to implement legislation requiring issuance of an initial or renewal motor vehicle registration to be conditional on the commissioner's receipt of proof of liability insurance or financial responsibility required under 23 V.S.A. § 800(a). The commissioner also shall examine the costs associated with and earliest feasible time frame for implementing such legislation so that the general assembly may advance the goal of bringing more operators of motor vehicles into compliance with their legal obligation to maintain financial responsibility. The commissioner shall report his or her findings to the senate and house committees on judiciary and on transportation by January 15, 2011.

*** * * Municipality Exemption to Records Law * * ***

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

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

* * *

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

* * *

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

*** * * Consider Expanding Out-of-state Criminal Record Checks * * ***

Sec. 10. VERMONT CRIMINAL INFORMATION CENTER

No later than December 1, 2010, the Vermont criminal information center and the defender general shall report to the house and senate committees on judiciary on the legal, policy, and procedural issues involved with broadening access to fingerprint-supported national record checks.

*** * * Constable Training * * ***

Sec. 11. Sec. 13 of No. 195 of the 2007 Adj. Sess. (2008) is amended to read:

Sec. 13. EFFECTIVE DATE

Secs. 8 and 9 of this act shall take effect ~~July 1, 2010~~ July 1, 2012.

*** * * Interstate Compact for Juveniles * * ***

Sec. 12. 33 V.S.A. chapter 57 is amended by repealing sections 5701–5715 and adding sections 5721–5733 to read:

§ 5721. PURPOSE

(a) The compacting states to this Interstate Compact recognize that each state is responsible for the proper supervision or return of juveniles, delinquents, and status offenders who are on probation or parole and who have absconded, escaped, or run away from supervision and control and in so doing have endangered their own safety and the safety of others. The compacting states also recognize that each state is responsible for the safe return of juveniles who have run away from home and in so doing have left their state of residence. The compacting states also recognize that Congress, by enacting the Crime Control Act, 4 U.S.C. Section 112 (1965), has authorized and encouraged compacts for cooperative efforts and mutual assistance in the prevention of crime.

(b) It is the purpose of this compact, through means of joint and cooperative action among the compacting states, to:

(1) ensure that the adjudicated juveniles and status offenders subject to this compact are provided adequate supervision and services in the receiving state as ordered by the adjudicating judge or parole authority in the sending state;

(2) ensure that the public safety interests of the citizens, including the victims of juvenile offenders, in both the sending and receiving states are adequately protected;

(3) return juveniles who have run away, absconded, or escaped from supervision or control or have been accused of an offense to the state requesting their return;

(4) make contracts for the cooperative institutionalization in public facilities in member states for delinquent youth needing special services;

(5) provide for the effective tracking and supervision of juveniles;

(6) equitably allocate the costs, benefits, and obligations of the compacting states;

(7) establish procedures to manage the movement between states of juvenile offenders released to the community under the jurisdiction of courts, juvenile departments, or any other criminal or juvenile justice agency which has jurisdiction over juvenile offenders;

(8) ensure immediate notice to jurisdictions where defined offenders are authorized to travel or to relocate across state lines;

(9) establish procedures to resolve pending charges (detainers) against juvenile offenders prior to transfer or release to the community under the terms of this compact;

(10) establish a system of uniform data collection on information pertaining to juveniles subject to this compact that allows access by authorized juvenile justice and criminal justice officials, and regular reporting of compact activities to heads of state, executive, judicial, and legislative branches, and juvenile and criminal justice administrators;

(11) monitor compliance with rules governing interstate movement of juveniles and initiate interventions to address and correct noncompliance;

(12) coordinate training and education regarding the regulation of interstate movement of juveniles for officials involved in such activity; and

(13) coordinate the implementation and operation of the compact with the Interstate Compact for the Placement of Children, the Interstate Compact for Adult Offender Supervision, and other compacts affecting juveniles, particularly in those cases where concurrent or overlapping supervision issues arise.

(c) It is the policy of the compacting states that the activities conducted by the Interstate Commission created in this chapter are the formation of public policies and therefore are public business. Furthermore, the compacting states shall cooperate and observe their individual and collective duties and responsibilities for the prompt return and acceptance of juveniles subject to the provisions of this compact. The provisions of this compact shall be reasonably and liberally construed to accomplish the purposes and policies of the compact.

§ 5722. DEFINITIONS

As used in this chapter, unless the context clearly requires a different construction:

(1) "Bylaws" means those bylaws established by the Interstate Commission for its governance, or for directing or controlling its actions or conduct.

(2) "Commissioner" means the voting representative of each compacting state appointed pursuant to section 5723 of this title.

(3) "Compact administrator" means the individual in each compacting state appointed pursuant to the terms of this compact responsible for the administration and management of the state's supervision and transfer of juveniles subject to the terms of this compact, the rules adopted by the Interstate Commission, and policies adopted by the state council under this compact.

(4) "Compacting state" means any state which has enacted the enabling legislation for this compact.

(5) "Court" means any court having jurisdiction over delinquent, neglected, or dependent children.

(6) "Deputy compact administrator" means the individual, if any, in each compacting state appointed to act on behalf of a compact administrator pursuant to the terms of this compact responsible for the administration and management of the state's supervision and transfer of juveniles subject to the terms of this compact, the rules adopted by the interstate commission, and policies adopted by the state council under this compact.

(7) "Interstate commission" means the Interstate Commission for juveniles created by section 5723 of this title.

(8) "Juvenile" means any person defined as a juvenile in any member state or by the rules of the Interstate Commission, including:

(A) an accused delinquent (a person charged with an offense that, if committed by an adult, would be a criminal offense);

(B) an adjudicated delinquent (a person found to have committed an offense that, if committed by an adult, would be a criminal offense);

(C) an accused status offender (a person charged with an offense that would not be a criminal offense if committed by an adult);

(D) an adjudicated status offender (a person found to have committed an offense that would not be a criminal offense if committed by an adult); and

(E) a nonoffender (a person in need of supervision who has not been accused or adjudicated a status offender or delinquent).

(9) "Noncompacting state" means any state which has not enacted the enabling legislation for this compact.

(10) "Probation or parole" means any kind of supervision or conditional release of juveniles authorized under the laws of the compacting states.

(11) "Rule" means a written statement by the Interstate Commission promulgated pursuant to section 5726 of this title that is of general applicability; implements, interprets, or prescribes a policy or provision of the compact, or an organizational, procedural, or practice requirement of the commission; and has the force and effect of statutory law in a compacting state, and includes the amendment, repeal, or suspension of an existing rule.

(12) "State" means a state of the United States, the District of Columbia (or its designee), the Commonwealth of Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands.

§ 5723. INTERSTATE COMMISSION FOR JUVENILES

(a) The compacting states hereby create the Interstate Commission for Juveniles. The commission shall be a body corporate and joint agency of the compacting states. The commission shall have all the responsibilities, powers, and duties set forth in this chapter, and such additional powers as may be conferred upon it by subsequent action of the respective legislatures of the compacting states in accordance with the terms of this compact.

(b) The Interstate Commission shall consist of commissioners appointed by the appropriate appointing authority in each state pursuant to the rules and requirements of each compacting state and in consultation with the state council for interstate juvenile supervision created in this chapter. The commissioner shall be the compact administrator, deputy compact administrator, or designee from that state who shall serve on the Interstate Commission in such capacity under or pursuant to the applicable law of the compacting state.

(c) In addition to the commissioners who are the voting representatives of each state, the Interstate Commission shall include individuals who are not commissioners, but who are members of interested organizations. The noncommissioner members shall include a member of the National Organizations of Governors, legislators, state chief justices, attorneys general, Interstate Compact for Adult Offender Supervision, Interstate Compact for the Placement of Children, juvenile justice and juvenile corrections officials, and crime victims. All noncommissioner members of the Interstate Commission shall be ex-officio (nonvoting) members. The Interstate Commission may provide in its bylaws for such additional ex-officio members, including

members of other national organizations, in such numbers as shall be determined by the commission.

(d) Each compacting state represented at any meeting of the commission is entitled to one vote. A majority of the compacting states shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission.

(e) The commission shall meet at least once each calendar year. The chairperson may call additional meetings and, upon the request of a simple majority of the compacting states, shall call additional meetings. Public notice shall be given of all meetings, and meetings shall be open to the public.

(f) The Interstate Commission shall establish an executive committee, which shall include commission officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission during periods when the Interstate Commission is not in session, with the exception of rulemaking or amending the compact. The executive committee shall: oversee the day-to-day activities of the administration of the compact, managed by an executive director and Interstate Commission staff; administer enforcement and compliance with the provisions of the compact, its bylaws, and rules; and perform such other duties as directed by the Interstate Commission or set forth in the bylaws.

(g) Each member of the Interstate Commission shall have the right and power to cast a vote to which that compacting state is entitled and to participate in the business and affairs of the Interstate Commission. A member shall vote in person and shall not delegate a vote to another compacting state. However, a commissioner, in consultation with the state council, shall appoint another authorized representative, in the absence of the commissioner from that state, to cast a vote on behalf of the compacting state at a specified meeting. The bylaws may provide for members' participation in meetings by telephone or other means of telecommunication or electronic communication.

(h) The Interstate Commission's bylaws shall establish conditions and procedures under which the Interstate Commission shall make its information and official records available to the public for inspection or copying. The Interstate Commission may exempt from disclosure any information or official records to the extent they would adversely affect personal privacy rights or proprietary interests.

(i) Public notice shall be given of all meetings and all meetings shall be open to the public, except as set forth in the rules or as otherwise provided in the compact. The Interstate Commission and any of its committees may close

a meeting to the public where it determines by two-thirds vote that an open meeting would be likely to:

(1) relate solely to the Interstate Commission's internal personnel practices and procedures;

(2) disclose matters specifically exempted from disclosure by statute;

(3) disclose trade secrets or commercial or financial information which is privileged or confidential;

(4) involve accusing any person of a crime, or formally censuring any person;

(5) disclose information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(6) disclose investigative records compiled for law enforcement purposes;

(7) disclose information contained in or related to examination, operating, or condition reports prepared by or on behalf of or for the use of the Interstate Commission with respect to a regulated person or entity for the purpose of regulation or supervision of such person or entity;

(8) disclose information, the premature disclosure of which would significantly endanger the stability of a regulated person or entity; or

(9) specifically relate to the Interstate Commission's issuance of a subpoena, or its participation in a civil action or other legal proceeding.

(j) For every meeting closed pursuant to this provision, the Interstate Commission's legal counsel shall publicly certify that, in the legal counsel's opinion, the meeting may be closed to the public, and shall reference each relevant exemptive provision. The Interstate Commission shall keep minutes which shall fully and clearly describe all matters discussed in any meeting and shall provide a full and accurate summary of any actions taken, and the reasons therefore, including a description of each of the views expressed on any item and the record of any roll call vote (reflected in the vote of each member on the question). All documents considered in connection with any action shall be identified in such minutes.

(k) The Interstate Commission shall collect standardized data concerning the interstate movement of juveniles as directed through its rules which shall specify the data to be collected, the means of collection, and data exchange and reporting requirements. Such methods of data collection, exchange, and reporting shall, insofar as is reasonably possible, conform to up-to-date

technology and coordinate its information functions with the appropriate repository of records.

§ 5724. POWERS AND DUTIES

(a) The commission shall have the following powers and duties:

(1) To provide for dispute resolution among compacting states.

(2) To promulgate rules to effect the purposes and obligations as enumerated in this compact, which shall have the force and effect of statutory law and shall be binding in the compacting states to the extent and in the manner provided in this compact.

(3) To oversee, supervise, and coordinate the interstate movement of juveniles subject to the terms of this compact and any bylaws adopted and rules promulgated by the Interstate Commission.

(4) To enforce compliance with the compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including the use of judicial process.

(5) To establish and maintain offices which shall be located within one or more of the compacting states.

(6) To purchase and maintain insurance and bonds.

(7) To borrow, accept, hire, or contract for services of personnel.

(8) To establish and appoint committees and hire staff which it deems necessary for the carrying out of its functions, including an executive committee as required by section 5723 of this title which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties hereunder.

(9) To elect or appoint such officers, attorneys, employees, agents, or consultants, and to fix their compensation, define their duties, and determine their qualifications; and to establish the Interstate Commission's personnel policies and programs relating to, inter alia, conflicts of interest, rates of compensation, and qualifications of personnel.

(10) To accept any and all donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of it.

(11) To lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed.

(12) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed.

(13) To establish a budget and make expenditures and levy dues as provided in section 5728 of this title.

(14) To sue and be sued.

(15) To adopt a seal and bylaws governing the management and operation of the Interstate Commission.

(16) To perform such functions as may be necessary or appropriate to achieve the purposes of this compact.

(17) To report annually to the legislatures, governors, judiciary, and state councils of the compacting states concerning the activities of the Interstate Commission during the preceding year. Such reports shall also include any recommendations that may have been adopted by the Interstate Commission.

(18) To coordinate education, training, and public awareness regarding the interstate movement of juveniles for officials involved in such activity.

(19) To establish uniform standards of the reporting, collecting, and exchanging of data.

(b) The Interstate Commission shall maintain its corporate books and records in accordance with the bylaws.

§ 5725. ORGANIZATION AND OPERATION

(a) Bylaws. The Interstate Commission shall, by a majority of the members present and voting, within 12 months after the first Interstate Commission meeting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the compact, including:

(1) establishing the fiscal year of the Interstate Commission;

(2) establishing an executive committee and such other committees as may be necessary;

(3) providing for the establishment of committees governing any general or specific delegation of any authority or function of the Interstate Commission;

(4) providing reasonable procedures for calling and conducting meetings of the Interstate Commission, and ensuring reasonable notice of each such meeting;

(5) establishing the titles and responsibilities of the officers of the Interstate Commission;

(6) providing a mechanism for concluding the operations of the Interstate Commission and the return of any surplus funds that may exist upon the termination of the compact after the payment or reserving of all of its debts and obligations.

(7) providing start-up rules for initial administration of the compact; and

(8) establishing standards and procedures for compliance and technical assistance in carrying out the compact.

(b) Officers and staff.

(1) The Interstate Commission shall, by a majority of its members, elect annually from among its members a chairperson and a vice chairperson, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson or, in the chairperson's absence or disability, the vice chairperson, shall preside at all meetings of the Interstate Commission. The officers so elected shall serve without compensation or remuneration from the Interstate Commission, provided that, subject to the availability of budgeted funds, the officers shall be reimbursed for any ordinary and necessary costs and expenses incurred by them in the performance of their duties and responsibilities as officers of the Interstate Commission.

(2) The Interstate Commission shall, through its executive committee, appoint or retain an executive director for such period, upon such terms and conditions, and for such compensation as the Interstate Commission may deem appropriate. The executive director shall serve as secretary to the Interstate Commission, but shall not be a member and shall hire and supervise such other staff as may be authorized by the Interstate Commission.

(c) Qualified immunity, defense, and indemnification.

(1) The commission's executive director and employees shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused or arising out of or relating to any actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided, that any such person shall not be protected from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of any such person.

(2) The liability of any commissioner, or the employee or agent of a commissioner, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person's state may not exceed the limits of liability set forth under the Constitution and laws of that

state for state officials, employees, and agents. Nothing in this subsection shall be construed to protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of any such person.

(3) The Interstate Commission shall defend the executive director or the employees or representatives of the Interstate Commission and, subject to the approval of the attorney general of the state represented by any commissioner of a compacting state, shall defend such commissioner or the commissioner's representatives or employees in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(4) The Interstate Commission shall indemnify and hold the commissioner of a compacting state, or the commissioner's representatives or employees, or the Interstate Commission's representatives or employees, harmless in the amount of any settlement or judgment obtained against such persons arising out of any actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

§ 5726. RULEMAKING

(a) The Interstate Commission shall promulgate and publish rules in order to effectively and efficiently achieve the purposes of the compact.

(b) Rulemaking shall occur pursuant to the criteria set forth in this section and the bylaws and rules adopted under it. Such rulemaking shall substantially conform to the principles of the "Model State Administrative Procedures Act," 1981 Act, Uniform Laws Annotated, Vol. 15, p.1 (2000), or such other administrative procedures act as the Interstate Commission deems appropriate, consistent with due process requirements under the United States and Vermont Constitutions. All rules and amendments shall become binding as of the date specified, as published with the final version of the rule as approved by the Commission.

(c) When promulgating a rule, the Interstate Commission shall, at a minimum:

(1) publish the proposed rule's entire text, stating the reason for the proposed rule;

(2) allow and invite any and all persons to submit written data, facts, opinions, and arguments, which information shall be added to the record and made publicly available;

(3) provide an opportunity for an informal hearing if petitioned by 10 or more persons; and

(4) promulgate a final rule and its effective date, if appropriate, based on input from state or local officials, or interested parties.

(d) The Interstate Commission shall allow any interested person to file a petition for judicial review of a rule not later than 60 days after the rule is promulgated. The petition shall be filed in the United States District Court for the District of Columbia or in the Federal District Court where the Interstate Commission's principal office is located. If the court finds that the Interstate Commission's action is not supported by substantial evidence in the rulemaking record, the court shall hold the rule unlawful and set it aside. For purposes of this subsection, evidence is substantial if it would be considered substantial evidence under the Model State Administrative Procedures Act.

(e) If a majority of the legislatures of the compacting states rejects a rule, those states may, by enactment of a statute or resolution in the same manner used to adopt the compact, cause that such rule shall have no further force and effect in any compacting state.

(f) The existing rules governing the operation of the Interstate Compact on Juveniles superseded by this chapter shall be null and void 12 months after the second meeting of the Interstate Commission created by section 5723 of this title.

(g) Upon determination by the Interstate Commission that a state-of-emergency exists, it may promulgate an emergency rule which shall become effective immediately upon adoption, provided that the usual rulemaking procedures of this section shall be retroactively applied to said rule as soon as reasonably possible, but no later than 90 days after the effective date of the emergency rule.

§ 5727. OVERSIGHT; ENFORCEMENT; DISPUTE RESOLUTION

(a) Oversight.

(1) The Interstate Commission shall oversee the administration and operations of the interstate movement of juveniles subject to this compact in the compacting states and shall monitor such activities being administered in noncompacting states which may significantly affect compacting states.

(2) The courts and executive agencies in each compacting state shall enforce this compact and shall take all actions necessary and appropriate to effectuate the compact's purposes and intent. The provisions of this compact and the rules promulgated hereunder shall be received by all the judges, public officers, commissions, and departments of the state government as evidence of the authorized statute and administrative rules. All courts shall take judicial notice of the compact and the rules. In any judicial or administrative proceeding in a compacting state pertaining to the subject matter of this compact which may affect the powers, responsibilities or actions of the Interstate Commission, it shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes.

(b) Dispute resolution.

(1) The compacting states shall report to the Interstate Commission on all issues and activities necessary for the administration of the compact as well as issues and activities pertaining to compliance with the provisions of the compact and its bylaws and rules.

(2) The Interstate Commission shall attempt, upon the request of a compacting state, to resolve any disputes or other issues which are subject to the compact and which may arise among compacting states and between compacting and noncompacting states. The commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes among the compacting states.

(3) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of this compact using any or all means set forth in section 5731 of this title.

§ 5728. FINANCE

(a) The Interstate Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(b) The Interstate Commission shall levy on and collect an annual assessment from each compacting state to cover the cost of the internal

operations and activities of the Interstate Commission and its staff which must be in a total amount sufficient to cover the Interstate Commission's annual budget as approved each year. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Interstate Commission, taking into consideration the population of each compacting state and the volume of interstate movement of juveniles in each compacting state, and the Interstate Commission shall promulgate a rule binding upon all compacting states which governs said assessment.

(c) The Interstate Commission shall not incur any obligations of any kind prior to securing the funds adequate to meet them. The Interstate Commission shall not pledge the credit of any of the compacting states, except by and with the authority of the compacting state.

(d) The Interstate Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Interstate Commission shall be subject to the audit and accounting procedures established under its bylaws, provided that all receipts and disbursements of funds handled by the Interstate Commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in and become part of the annual report of the Interstate Commission.

§ 5729. STATE COUNCIL

Each member state shall create a state council for Interstate Juvenile Supervision. Each state may determine the membership of its own state council, provided that its membership must include at least one representative from the legislative, judicial, and executive branches of government, victims groups, and the compact administrator, deputy compact administrator, or designee. Each compacting state retains the right to determine the qualifications of the compact administrator or deputy compact administrator. Each state council shall advise and may exercise oversight and advocacy concerning that state's participation in Interstate Commission activities and other duties as may be determined by that state, including development of policy concerning operations and procedures of the compact within that state.

§ 5730. COMPACTING STATES; EFFECTIVE DATE; AMENDMENT

(a) Any state as defined in subdivision 5722(12) of this title is eligible to become a compacting state.

(b) The compact shall become effective and binding upon legislative enactment of the compact into law by no less than 35 of the states. The initial effective date shall be the later of July 1, 2004, or upon enactment into law by the 35th jurisdiction. Thereafter it shall become effective and binding as to

any other compacting state upon enactment of the compact into law by that state. The governors of nonmember states or their designees shall be invited to participate in the activities of the Interstate Commission on a nonvoting basis prior to adoption of the compact by all states and territories of the United States.

(c) The Interstate Commission may propose amendments to the compact for enactment by the compacting states. No amendment shall become effective and binding upon the Interstate Commission and the compacting states unless and until it is enacted into law by unanimous consent of the compacting states.

§ 5731. WITHDRAWAL; DEFAULT; TERMINATION; JUDICIAL ENFORCEMENT

(a) Withdrawal.

(1) Once effective, the compact shall continue in force and remain binding upon each and every compacting state, provided that a compacting state may withdraw from the compact by specifically repealing the statute which enacted the compact into law.

(2) The effective date of withdrawal is the effective date of the repeal.

(3) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing this compact in the withdrawing state. The Interstate Commission shall notify the other compacting states of the withdrawing state's intent to withdraw within 60 days of its receipt thereof.

(4) The withdrawing state is responsible for all assessments, obligations, and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal.

(5) Reinstatement following withdrawal of any compacting state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the Interstate Commission

(b) Technical assistance, fines, suspension, termination, and default.

(1) If the Interstate Commission determines that any compacting state has at any time defaulted in the performance of any of its obligations or responsibilities under this compact, or the bylaws or duly promulgated rules, the Interstate Commission may impose any or all of the following penalties:

(A) remedial training and technical assistance as directed by the Interstate Commission;

(B) alternative dispute resolution;

(C) fines, fees, and costs in such amounts as are deemed to be reasonable as fixed by the Interstate Commission; or

(D) suspension or termination of membership in the compact, which shall be imposed only after all other reasonable means of securing compliance under the bylaws and rules have been exhausted and the Interstate Commission has determined that the offending state is in default. Immediate notice of suspension shall be given by the Interstate Commission to the governor, the chief justice or the chief judicial officer of the state, the majority and minority leaders of the defaulting state's legislature, and the state council. The grounds for default include failure of a compacting state to perform such obligations or responsibilities imposed upon it by this compact, the bylaws, or duly promulgated rules, and any other grounds designated in commission bylaws and rules. The Interstate Commission shall immediately notify the defaulting state in writing of the penalty imposed by the Interstate Commission and of the default pending a cure of the default. The commission shall stipulate the conditions and the time period within which the defaulting state must cure its default. If the defaulting state fails to cure the default within the time period specified by the commission, the defaulting state shall be terminated from the compact upon an affirmative vote of a majority of the compacting states, and all rights, privileges, and benefits conferred by this compact shall be terminated from the effective date of termination.

(2) Within 60 days of the effective date of termination of a defaulting state, the commission shall notify the governor, the chief justice or chief judicial officer, the majority and minority leaders of the defaulting state's legislature, and the state council of such termination.

(3) The defaulting state is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including any obligations the performance of which extends beyond the effective date of termination.

(4) The Interstate Commission shall not bear any costs relating to the defaulting state unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(5) Reinstatement following termination of any compacting state requires both a reenactment of the compact by the defaulting state and the approval of the Interstate Commission pursuant to the rules.

(c) Judicial enforcement. The Interstate Commission may, by majority vote of the members, initiate legal action in the United States District Court for

the District of Columbia or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its offices, to enforce compliance with the provisions of the compact its duly promulgated rules and bylaws against any compacting state in default. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney's fees.

(d) Dissolution of compact.

(1) The compact dissolves effective upon the date of the withdrawal or default of the compacting state which reduces membership in the compact to one compacting state.

(2) Upon the dissolution of this compact, the compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded and any surplus funds shall be distributed in accordance with the bylaws.

§ 5732. SEVERABILITY; CONSTRUCTION

(a) The provisions of this compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the compact shall be enforceable.

(b) The provisions of this compact shall be liberally construed to effectuate its purposes.

§ 5733. BINDING EFFECT; OTHER LAWS

(a) Other laws.

(1) Nothing in this chapter prevents the enforcement of any other law of a compacting state that is not inconsistent with this compact.

(2) All compacting states' laws other than state Constitutions and other interstate compacts conflicting with this compact are superseded to the extent of the conflict.

(b) Binding effect of compact.

(1) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Interstate Commission, are binding upon the compacting states.

(2) All agreements between the Interstate Commission and the compacting states are binding in accordance with their terms.

(3) Upon the request of a party to a conflict over meaning or interpretation of Interstate Commission actions, and upon a majority vote of

the compacting states, the Interstate Commission may issue advisory opinions regarding such meaning or interpretation.

(4) In the event any provision of this compact exceeds the constitutional limits imposed on the legislature of any compacting state, the obligations, duties, powers, or jurisdiction sought to be conferred by such provision upon the Interstate Commission shall be ineffective, and such obligations, duties, powers, or jurisdiction shall remain in the compacting state and shall be exercised by the agency thereof to which such obligations, duties, powers, or jurisdiction are delegated by law in effect at the time this compact becomes effective.

Sec. 13. EFFECTIVE DATE

Secs. 5 – 7 shall take effect July 1, 2011, and the remainder of the act shall take effect July 1, 2010.

Thereupon, the question, Shall the Senate concur in the House proposal of amendment?, was decided in the affirmative.

House Proposal of Amendment Not Concurred In; Committee of Conference Requested

S. 103.

House proposal of amendment to Senate bill entitled:

An act relating to the study and recommendation of ignition interlock device legislation.

Was taken up.

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

Sec. 1. LEGISLATIVE INTENT

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

Sec. 2. LEGISLATIVE FINDINGS

The general assembly finds that:

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

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

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

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

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

Sec. 3. IGNITION INTERLOCK DEVICE STUDY

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

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

(2) Consider whether legislation should:

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

(B) authorize operation during a suspension period, and, if so, the period of "hard" suspension that must be served prior to such authorization for different classes of DUI offenders;

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

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

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

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

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

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

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

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

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

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

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

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

additional authority or resources this agency or these agencies will need to perform these tasks.

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

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

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

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

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

Sec. 4. EFFECTIVE DATE

This act shall take effect on passage.

And that after passage, the title of the bill be amended to read:

"An act relating to the study and recommendation of ignition interlock device legislation."

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment?, on motion of Senator Mazza, the Senate refused to concur in the House proposal of amendment and requested a Committee of Conference.

House Proposal of Amendment Not Concurred In; Committee of Conference Requested

S. 207.

House proposal of amendment to Senate bill entitled:

An act relating to handling of milk samples.

Was taken up.

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

Sec. 1. MEETING CONCERNING PRELIMINARY INCUBATION COUNTS

(a) The secretary of agriculture, food and markets or the secretary's designee shall convene a meeting of persons with knowledge of Vermont's dairy industry by July 1, 2010 for the purpose of developing consensus findings and recommendations regarding the use of the preliminary incubation (PI) count of raw milk as a quality indicator.

(b) Participants invited shall include organic and conventional dairy producers and handlers, representatives from farm organizations, laboratory researchers, dairy haulers, employees of the agency of agriculture, food and markets, and representatives from Vermont colleges and universities.

(c) Participants shall discuss, at a minimum, proper milk sample handling protocol, buyer and producer responsibilities in addressing PI count problems, and the availability to producers of technical assistance, information, procedures, and access to laboratory results.

Sec. 2. EFFECTIVE DATE

This act shall take effect upon passage.

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment?, on motion of Senator Kittell, the Senate refused to concur in the House proposal of amendment and requested a Committee of Conference.

House Proposals of Amendment to Senate Proposals of Amendment Concurred In

H. 524.

House proposals of amendment to Senate proposals of amendment to House bill entitled:

An act relating to interference with or cruelty to a guide dog.

Were taken up.

The House proposes to the Senate to amend the Senate proposal of amendment as follows:

First: In Sec. 1, 13 V.S.A. § 355, in subdivision (a)(2), by striking out the following: "with visible identification of its status" and inserting in lieu thereof the following: whose status is reasonably identifiable

Second: In Sec. 1, 13 V.S.A. § 355, in subdivision (a)(3), by striking out the subparagraph (B) in its entirety and inserting in lieu thereof a new subparagraph (B) to read as follows:

(B) a written or oral confirmation submitted to a law enforcement officer, either by the owner of the guide dog or another person on his or her behalf, which shall include a statement that the warning and request to stop the behavior was given and shall include the complainant's telephone number.

Third: In Sec. 3, 20 V.S.A. § 3621, after the following: "waive the license fee" by inserting the following: for a dog or wolf-hybrid impounded pursuant to subsection (a) of this section

Fifth: In Sec. 4, in 13 V.S.A. § 351(4), by striking out the following: "animal control officer elected or appointed by the legislative body of a municipality," and after the following: "employee or agent," by inserting the following: elected animal control officer, animal control officer appointed by the legislative body of a municipality,

Sixth: By striking out Secs. 5 and 6 in their entirety

And by renumbering the remaining sections to be numerically correct.

Thereupon, the question, Shall the Senate concur in the House proposals of amendment to the Senate proposals of amendment?, was decided in the affirmative.

Committees of Conference Appointed

S. 103.

An act relating to the study and recommendation of ignition interlock device legislation.

Was taken up. Pursuant to the request of the Senate, the President announced the appointment of

Senator Kitchel
Senator Scott
Senator Sears

as members of the Committee of Conference on the part of the Senate to consider the disagreeing votes of the two Houses.

S. 207.

An act relating to handling of milk samples.

Was taken up. Pursuant to the request of the Senate, the President announced the appointment of

Senator Choate
Senator Kittell
Senator Starr

as members of the Committee of Conference on the part of the Senate to consider the disagreeing votes of the two Houses.

Rules Suspended; Bills Messaged

On motion of Senator Shumlin, the rules were suspended, and the following bills were severally ordered messaged to the House forthwith:

S. 103, S. 207, H. 470, H. 524, H. 540, H. 770.

Rules Suspended; Bills Delivered

On motion of Senator Shumlin, the rules were suspended, and the following bills were severally ordered delivered to the Governor forthwith:

S, 138, S. 161.

Adjournment

On motion of Senator Shumlin, the Senate adjourned until five o'clock in the afternoon.

Evening

The Senate was called to order by the President.

Message from the House No. 69

A message was received from the House of Representatives by Ms. H. Gwynn Zakov, its Second Assistant Clerk, as follows:

Mr. President:

I am directed to inform the Senate that:

The House has passed a House bill of the following title:

H. 782. An act relating to a voluntary school district merger incentive program, supervisory union duties, and other education issues.

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

The House has considered a bill originating in the Senate of the following title:

S. 247. An act relating to bisphenol A.

And has passed the same in concurrence.

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

H. 555. An act relating to youth hunting.

H. 562. An act relating to the regulation of professions and occupations.

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.

H. 788. An act relating to approval of amendments to the charter of the town of Berlin.

And has severally concurred therein.

The House has adopted House concurrent resolutions of the following titles:

H.C.R. 342. House concurrent resolution congratulating the Vermont Youth Conservation Corps on its 25th anniversary.

H.C.R. 343. House concurrent resolution honoring Sally and Don Goodrich on the occasion of The Goodrich Dragonfly Celebration.

H.C.R. 344. House concurrent resolution congratulating the Mount Anthony Union High School Interact Club on winning a 2010 Governor's Award for Outstanding Community Service.

H.C.R. 345. House concurrent resolution honoring Tom Howard of East Montpelier for his career accomplishments in youth services.

H.C.R. 346. House concurrent resolution in memory of University of Vermont history professor emeritus and former senator Robert V. Daniels of Burlington.

H.C.R. 347. House concurrent resolution in memory of the American military personnel who have died in the service of their nation in Iraq or Afghanistan from January 1, 2010 to April 10, 2010.

H.C.R. 348. House concurrent resolution honoring retiring Bennington Police Chief Richard B. Gauthier.

H.C.R. 349. House concurrent resolution in memory of Junior Harwood of Shaftsbury.

H.C.R. 350. House concurrent resolution honoring the outstanding educators who are retiring from the Southwest Vermont Supervisory Union.

H.C.R. 351. House concurrent resolution in memory of Stevenson H. Waltien, Jr., of Shelburne.

H.C.R. 352. House concurrent resolution congratulating Gabriella Pacht of Thetford and Katie Ann Dutcher of Bennington on earning the Girl Scout Gold Award.

H.C.R. 353. House concurrent resolution congratulating GW Plastics on being named *Plastic News* magazine's 2010 Plastics Processor of the Year.

H.C.R. 354. House concurrent resolution congratulating the Rutland Regional Medical Center on its receipt of the American Nurses Credentialing Center's Magnet designation and the Vermont Council on Quality's 2009 Governor's Award for Performance Excellence.

H.C.R. 355. House concurrent resolution honoring the municipal public service of St. Johnsbury town manager Michael A. Welch.

In the adoption of which the concurrence of the Senate is requested.

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

S.C.R. 50. Senate concurrent resolution recognizing the efforts of the Vermont Fallen Families in building Vermont's Global War on Terror Memorial at the Vermont Veterans Memorial Cemetery in Randolph Center, Vermont.

S.C.R. 51. Senate concurrent resolution congratulating Central Vermont Public Service Corporation on its designation as one of Forbes' 100 Most Trustworthy Companies.

And has adopted the same in concurrence.

Message from the House No. 70

A message was received from the House of Representatives by Ms. H. Gwynn Zakov, its Second Assistant Clerk, as follows:

Mr. President:

I am directed to inform the Senate that:

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

S. 64. An act relating to growth center designations and appeals of such designations.

S. 205. An act relating to the Revised Uniform Anatomical Gift Act.

And has passed the same in concurrence with proposals of amendment in the adoption of which the concurrence of the Senate is requested.

Pursuant to the request of the Senate for a Committee of Conference upon the disagreeing votes of the two Houses on Senate bill of the following title:

S. 103. An act relating to the study and recommendation of ignition interlock device legislation.

The Speaker has appointed as members of such committee on the part of the House:

Rep. Grad of Moretown
Rep. French of Shrewsbury
Rep. Marek of Newfane

Pursuant to the request of the Senate for a Committee of Conference upon the disagreeing votes of the two Houses on Senate bill of the following title:

S. 207. An act relating to handling of milk samples.

The Speaker has appointed as members of such committee on the part of the House:

Rep. Ainsworth of Royalton
Rep. Toll of Danville
Rep. McNeil of Rutland Town

Bill Referred

House bill of the following title was read the first time and referred:

H. 782.

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

To the Committee on Rules.

Rules Suspended; Bill Committed

H. 778.

Pending entry on the Calendar for notice, on motion of Senator Campbell, the rules were suspended and House bill entitled:

An act relating to amending miscellaneous provisions in Vermont's public retirement systems.

Was taken up for immediate consideration.

Thereupon, pending the reading of the report of the Committee on Government Operations, Senator Campbell moved that Senate Rule 49 be suspended in order to commit the bill to the Committee on Appropriations with the report of the Committee on Government Operations *intact*,

Which was agreed to.

House Proposal of Amendment Concurred In with Amendment

S. 222.

House proposal of amendment to Senate bill entitled:

An act relating to recognition of Abenaki tribes.

Was taken up.

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

Sec. 1. 1 V.S.A. § 851 is amended to read:

§ 851. FINDINGS

The general assembly finds that:

(1) At least 1,700 Vermonters claim to be direct descendants of the several indigenous Native American peoples, now known as Western Abenaki tribes, who originally inhabited all of Vermont and New Hampshire, parts of western Maine, parts of southern Quebec, and parts of upstate New York for hundreds of years, beginning long before the arrival of Europeans.

(2) There is ample archaeological evidence that demonstrates that the Missisquoi Abenaki were indigenous to and farmed the river floodplains of Vermont at least as far back as the 1100s A.D.

(3) The Western Abenaki, including the Missisquoi, have a very definite and carefully maintained oral tradition that consistently references the Champlain valley in western Vermont.

(4) State recognition confers official acknowledgment of the long-standing existence in Vermont of Native American Indians who predated European settlement and enhances dignity and pride in their heritage and community.

~~(4)~~(5) Many contemporary Abenaki families continue to produce traditional crafts and intend to continue to pass on these indigenous traditions to the younger generations. In order to create and sell Abenaki crafts that may be labeled as Indian- or Native American-produced, the Abenaki must be recognized by the state of Vermont.

~~(5) Federal programs may be available to assist with educational and cultural opportunities for Vermont Abenaki and other Native Americans who reside in Vermont~~

(6) In May 2006, the general assembly passed S.117, Act No. 125, which created the Vermont Commission on Native American Affairs and recognized the Abenaki and all other Native American people living in Vermont as a minority population. According to Indian case law, recognition as a racial minority population prevents the group from being recognized as a tribal political entity, a designation that would provide the group with access to federal resources.

(7) According to a public affairs specialist with the U.S. Bureau of Indian Affairs (BIA), state recognition of Indian tribes plays a very small role with regard to federal recognition. The only exception is when a state recognized a tribe before 1900.

(8) At least 15 other states have recognized their resident indigenous people as Native American Indian tribes without any of those tribes previously or subsequently acquiring federal recognition.

(9) State-recognized Native American Indian tribes and their members will continue to be subject to all laws of the state, and recognition shall not be construed to create any basis or authority for tribes to establish or promote any form of prohibited gambling activity or to claim any interest in land or real estate in Vermont.

Sec. 2. 1 V.S.A. chapter 23 is amended to read:

CHAPTER 23. ~~ABENAKI~~ NATIVE AMERICAN INDIAN PEOPLE

Sec. 3. 1 V.S.A. § 852 is amended to read:

§ 852. VERMONT COMMISSION ON NATIVE AMERICAN AFFAIRS ESTABLISHED; AUTHORITY

(a) In order to recognize the historic and cultural contributions of Native Americans to Vermont, to protect and strengthen their heritage, and to address their needs in state policy, programs, and actions, there is hereby established the Vermont commission on Native American affairs (the "commission").

(b) The commission shall ~~comprise seven~~ be composed of nine members appointed by the governor for staggered two-year terms from a list of candidates compiled by the division for historic preservation. The governor shall appoint ~~a chair from among the members of the commission.~~ members who reflect a diversity of affiliations and geographic locations in Vermont. A member may serve for no more than two consecutive terms. The division shall compile a list of ~~candidates' recommendations from the following:~~

~~(1) Recommendations from the Missisquoi Abenaki and other Abenaki and other Native American regional tribal councils and communities in Vermont.~~

~~(2) Applicants~~ candidates who apply ~~in response to solicitations, publications, and website notification by~~ to the division ~~of historical preservation~~ and are residents of Vermont, and of documented Native American ancestry.

(c) The commission shall ~~have the authority to assist Native American tribal councils, organizations, and individuals to~~:

~~(1) Secure social services, education, employment opportunities, health care, housing, and census information.~~

~~(2) Permit the creation, display, and sale of Native American arts and crafts and legally to label them as Indian- or Native American-produced as provided in 18 U.S.C. § 1159(c)(3)(B) and 25 U.S.C. § 305e(d)(3)(B).~~

~~(3) Receive assistance and support from the federal Indian Arts and Crafts Board, as provided in 25 U.S.C. § 305 et seq.~~

~~(4) Become eligible for federal assistance with educational, housing, and cultural opportunities.~~

~~(5) Establish and continue programs offered through the U.S. Department of Education Office on Indian Education pursuant to Title VII of the Elementary and Secondary Education Act established in 1972 to support educational and cultural efforts of tribal entities that have been either state or federally recognized.~~

(1) Elect a chair each year.

(2) Participate in protecting unmarked burial sites and designate appropriate repatriation of remains in any case in which lineal descendants cannot be ascertained.

(3) Provide technical assistance and an explanation of the process to applicants for state recognition.

(4) Compile and maintain a list of individuals for appointment to a review panel.

(5) Appoint a three-member panel to review supporting documentation of an application for recognition to advise the commission of its accuracy and relevance.

(6) Review each application, supporting documentation, and findings of the review panel and make recommendations for or against state recognition.

(7) Assist Native American Indian tribes recognized by the state to:

(A) Secure assistance for social services, education, employment opportunities, health care, and housing.

(B) Develop and market Vermont Native American fine and performing arts, craft work, and cultural events.

(8) Develop policies and programs to benefit Vermont's Native American Indian population.

(d) The commission shall meet at least three times a year and at any other times at the request of the chair. The division of historic preservation within the agency of commerce and community development ~~and the department of education~~ shall provide administrative support to the commission, including providing communication and contact resources.

(e) The commission may seek and receive funding from federal and other sources to assist with its work.

Sec. 4. 1 V.S.A. § 853 is amended to read:

§ 853. CRITERIA AND PROCESS FOR STATE RECOGNITION OF ~~ABENAKI PEOPLE~~ NATIVE AMERICAN INDIAN TRIBES

~~(a) The state of Vermont recognizes the Abenaki people and recognizes all Native American people who reside in Vermont as a minority population.~~

~~(b) Recognition of the Native American or Abenaki people provided in subsection (a) of this section shall be for the sole purposes specified in subsection 852(c) of this title and shall not be interpreted to provide any Native American or Abenaki person with any other special rights or privileges that the state does not confer on or grant to other state residents.~~

~~(c) This chapter shall not be construed to recognize, create, extend, or form the basis of any right or claim to land or real estate in Vermont for the Abenaki people or any Abenaki individual and shall be construed to confer only those rights specifically described in this chapter.~~

(a) For the purposes of this section:

(1) "Applicant" means a group or band seeking formal state recognition as a Native American Indian tribe.

(2) "Legislative committees" means the house committee on general, housing and military affairs and the senate committee on economic development, housing and general affairs.

(3) "Recognized" or "recognition" means acknowledged as a Native American Indian tribe by the Vermont general assembly.

(4) "Tribe" means an assembly of Native American Indian people who are related to each other by kinship and who trace their ancestry to a kinship group which has historically maintained influence and authority over its members.

(b) In order to be eligible for recognition, an applicant must file an application with the commission and demonstrate compliance with subdivisions (1) through (8) of this subsection which may be supplemented by subdivision (9) of this subsection:

(1) A majority of the applicant's members currently reside in a specific geographic location within Vermont.

(2) A substantial number of the applicant's members are related to each other by kinship and trace their ancestry to a kinship group through genealogy.

(3) The applicant has maintained a connection with Native American Indian tribes and bands that have historically inhabited Vermont.

(4) The applicant has historically maintained influence and authority over its members that are supported by documentation of their structure, membership criteria, the tribal roll that indicates the members' names and residential addresses, and the methods by which the applicant conducts its affairs.

(5) The applicant has an enduring community presence within the boundaries of Vermont that is documented by archaeology, ethnography, physical anthropology, history, folklore, or any other applicable scholarly research and data.

(6) The applicant is organized in part:

(A) To preserve, document, and promote its Native American Indian culture and history, and this purpose is reflected in its bylaws.

(B) To address the social, economic, or cultural needs of the members with ongoing educational programs and activities.

(7) The applicant can document traditions, customs, oral stories, and histories that signify the applicant's Native American heritage and connection to their historical homeland.

(8) The applicant has not been recognized as a tribe in any other state, province, or nation.

(9) Submission of letters, statements, and documents from:

(A) Municipal, state, or federal authorities that document the applicant's history of tribe-related business and activities.

(B) Tribes in and outside Vermont that attest to the Native American Indian heritage of the applicant.

(c) The commission shall consider the application pursuant to the following process which shall include at least the following requirements:

(1) The commission shall:

(A) Provide public notice of receipt of the application and supporting documentation.

(B) Hold at least one public hearing on the application.

(C) Provide written notice of completion of each step of the recognition process to the applicant.

(2) Established appropriate time frames that include a requirement that the commission and the review panel shall complete a review of the application and issue a determination regarding recognition within one year after an application and all the supporting documentation have been filed, and if a recommendation is not issued, the commission shall provide written explanation to the applicant and the legislative committees of the reasons for the delay and the expected date that a decision will be issued.

(3) A process for appointing a three-member review panel for each application to review the supporting documentation and determine its sufficiency, accuracy, and relevance. The review panel shall provide a detailed written report of its findings and conclusions to the commission, the applicant, and legislative committees. Members of each review panel shall be appointed cooperatively by the commission and the applicant from a list of professionals and academic scholars with expertise in cultural or physical anthropology, Indian law, archaeology, Native American Indian genealogy, history, or another related Native American Indian subject area. If the applicant and the commission are unable to agree on a panel, the state historic preservation officer shall appoint the panel. No member of the review panel may be a

member of the commission or affiliated with or on the tribal rolls of the applicant.

(4) The commission shall review the application, the supporting documentation, the report from the review panel, and any other relevant information to determine compliance with subsection (b) of this section and make a determination to recommend or deny recognition. The decision to recommend recognition shall require a majority vote of all eligible members of the commission. A member of the commission who is on the tribal roll of the applicant is ineligible to participate in any action regarding the application. If the commission denies recognition, the commission shall provide the applicant and the legislative committees with written notice of the reasons for the denial, including specifics of all insufficiencies of the application.

(5) The applicant may file additional supporting documentation for reconsideration within one year after receipt of the notice of denial.

(6) An applicant may withdraw an application any time before the commission issues a recommendation, and may not file a new application for two years following withdrawal. A new application and supporting documentation shall be considered a de novo filing, and the commission shall not consider the withdrawn application or its supporting documentation.

(7) If the commission recommends that the applicant be recognized as a Native American Indian tribe, the commission shall provide a detailed written report of its findings and conclusions to the applicant and the legislative committees along with a recommendation that the general assembly recognize the applicant as a Native American Indian tribe.

(8) All proceedings, applications, and supporting documentation shall be public except material exempt pursuant to subsection 317 of this title.

(d) An applicant for recognition shall be recognized as follows:

(1) By approval of the general assembly.

(2) Two years after a recommendation to recognize a tribe by the commission is filed with the legislative committees, provided the general assembly took no action on the recommendation.

(e) A decision by the commission to recommend denial of recognition is final unless an applicant or a successor of interest to the applicant that has previously applied for and been denied recognition under this chapter provides new and substantial documentation and demonstrates that the new documentation was not reasonably available at the time of the filing of the original application.

(f) Vermont Native American Indian bands and tribes and individual members of those bands and tribes remain subject to all the laws of the state.

(g) Recognition of a Native American Indian tribe shall not be construed to create, extend, or form the basis of any right or claim to land or real estate in Vermont or right to conduct any gambling activities prohibited by law, but confers only those rights specifically described in this chapter.

Sec. 5. EFFECTIVE DATE

This act shall take effect on passage.

And that the bill title be amended to read:

"An act relating to state recognition of Native American Indian tribes in Vermont."

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment?, Senator Miller, on behalf of the Committee on Economic Development, Housing and General Affairs, recommends that the Senate concur with the House proposal of amendment with the following recommendation of amendment as follows:

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

Sec. 1. 1 V.S.A. § 851 is amended to read:

§ 851. FINDINGS

The general assembly finds that:

(1) At least 1,700 Vermonters claim to be direct descendants of the several indigenous Native American peoples, now known as Western Abenaki tribes, who originally inhabited all of Vermont and New Hampshire, parts of western Maine, parts of southern Quebec, and parts of upstate New York for hundreds of years, beginning long before the arrival of Europeans.

(2) There is ample archaeological evidence that demonstrates that the Missisquoi and Cowasuck Abenaki were indigenous to and farmed the river floodplains of Vermont at least as far back as the 1100s A.D.

(3) The Western Abenaki, including the Missisquoi, have a very definite and carefully maintained oral tradition that consistently references the Champlain valley in western Vermont.

(4) State recognition confers official acknowledgment of the long-standing existence in Vermont of Native American Indians who predated European settlement and enhances dignity and pride in their heritage and community.

~~(4)~~(5) Many contemporary Abenaki families continue to produce traditional crafts and intend to continue to pass on these indigenous traditions to the younger generations. In order to create and sell Abenaki crafts that may be labeled as Indian- or Native American-produced, the Abenaki must be recognized by the state of Vermont.

~~(5) Federal programs may be available to assist with educational and cultural opportunities for Vermont Abenaki and other Native Americans who reside in Vermont~~

(6) According to a public affairs specialist with the U.S. Bureau of Indian Affairs (BIA), state recognition of Indian tribes plays a very small role with regard to federal recognition. The only exception is when a state recognized a tribe before 1900.

(7) At least 15 other states have recognized their resident indigenous people as Native American Indian tribes without any of those tribes previously or subsequently acquiring federal recognition.

(8) State-recognized Native American Indian tribes and their members will continue to be subject to all laws of the state, and recognition shall not be construed to create any basis or authority for tribes to establish or promote any form of prohibited gambling activity or to claim any interest in land or real estate in Vermont.

Sec. 2. 1 V.S.A. chapter 23 is amended to read:

CHAPTER 23. ~~ABENAKI~~ NATIVE AMERICAN INDIAN PEOPLE

Sec. 3. 1 V.S.A. § 852 is amended to read:

§ 852. VERMONT COMMISSION ON NATIVE AMERICAN AFFAIRS ESTABLISHED; AUTHORITY

(a) In order to recognize the historic and cultural contributions of Native Americans to Vermont, to protect and strengthen their heritage, and to address their needs in state policy, programs, and actions, there is hereby established the Vermont commission on Native American affairs (the "commission").

(b) The commission shall ~~comprise seven~~ be composed of nine members appointed by the governor for staggered two-year terms from a list of candidates compiled by the division for historic preservation. The governor

shall appoint ~~a chair from among the members of the commission~~ members who have been residents of Vermont for a minimum of three years and reflect a diversity of affiliations and geographic locations in Vermont. A member may serve for no more than two consecutive terms, unless there are insufficient eligible candidates. The division shall compile a list of ~~candidates' recommendations~~ candidates from the following:

(1) Recommendations from ~~the Missisquoi Abenaki and other Abenaki and other~~ Native American ~~regional tribal councils and~~ communities residing in Vermont. Once a Native American Indian tribe has been recognized under this chapter, a qualified candidate recommended by that tribe shall have priority for appointment to fill the next available vacancy on the commission.

~~(2) Applicants~~ Individuals who apply ~~in response to solicitations, publications, and website notification by~~ to the division of historical preservation. Candidates shall indicate their residence and Native American affiliation.

(c) The commission shall ~~have the authority to assist Native American tribal councils, organizations, and individuals to~~:

~~(1) Secure social services, education, employment opportunities, health care, housing, and census information.~~

~~(2) Permit the creation, display, and sale of Native American arts and crafts and legally to label them as Indian- or Native American-produced as provided in 18 U.S.C. § 1159(c)(3)(B) and 25 U.S.C. § 305e(d)(3)(B).~~

~~(3) Receive assistance and support from the federal Indian Arts and Crafts Board, as provided in 25 U.S.C. § 305 et seq.~~

~~(4) Become eligible for federal assistance with educational, housing, and cultural opportunities.~~

~~(5) Establish and continue programs offered through the U.S. Department of Education Office on Indian Education pursuant to Title VII of the Elementary and Secondary Education Act established in 1972 to support educational and cultural efforts of tribal entities that have been either state or federally recognized.~~

(1) Elect a chair each year.

(2) Provide technical assistance and an explanation of the process to applicants for state recognition.

(3) Compile and maintain a list of professionals and scholars for appointment to a review panel.

(4) Appoint a three-member panel acceptable to both the applicant and the commission to review supporting documentation of an application for recognition and advise the commission of its accuracy and relevance.

(5) Review each application, supporting documentation and findings of the review panel, and make recommendations for or against state recognition to the legislative committees.

(6) Assist Native American Indian tribes recognized by the state to:

(A) Secure assistance for social services, education, employment opportunities, health care, and housing.

(B) Develop and market Vermont Native American fine and performing arts, craft work, and cultural events.

(7) Develop policies and programs to benefit Vermont's Native American Indian population within the scope of the commission's authority.

(d) The commission shall meet at least three times a year and at any other times at the request of the chair. The division of historic preservation within the agency of commerce and community development ~~and the department of education~~ shall provide administrative support to the commission, including providing communication and contact resources.

(e) The commission may seek and receive funding from federal and other sources to assist with its work.

Sec. 4. 1 V.S.A. § 853 is amended to read:

§ 853. CRITERIA AND PROCESS FOR STATE RECOGNITION OF ~~ABENAKI PEOPLE~~ NATIVE AMERICAN INDIAN TRIBES

~~(a) The state of Vermont recognizes the Abenaki people and recognizes all Native American people who reside in Vermont as a minority population.~~

~~(b) Recognition of the Native American or Abenaki people provided in subsection (a) of this section shall be for the sole purposes specified in subsection 852(c) of this title and shall not be interpreted to provide any Native American or Abenaki person with any other special rights or privileges that the state does not confer on or grant to other state residents.~~

~~(c) This chapter shall not be construed to recognize, create, extend, or form the basis of any right or claim to land or real estate in Vermont for the Abenaki people or any Abenaki individual and shall be construed to confer only those rights specifically described in this chapter.~~

(a) For the purposes of this section:

(1) "Applicant" means a group or band seeking formal state recognition as a Native American Indian tribe.

(2) "Legislative committees" means the house committee on general, housing and military affairs and the senate committee on economic development, housing and general affairs.

(3) "Recognized" or "recognition" means acknowledged as a Native American Indian tribe by the Vermont general assembly.

(4) "Tribe" means an assembly of Native American Indian people who are related to each other by kinship and who trace their ancestry to a kinship group that has historically maintained an organizational structure that exerts influence and authority over its members.

(b) The state recognizes all individuals of Native American Indian heritage who reside in Vermont as an ethnic minority. This designation does not confer any status to any collective group of individuals.

(c) In order to be eligible for recognition, an applicant must file an application with the commission and demonstrate compliance with subdivisions (1) through (8) of this subsection which may be supplemented by subdivision (9) of this subsection:

(1) A majority of the applicant's members currently reside in a specific geographic location within Vermont.

(2) A substantial number of the applicant's members are related to each other by kinship and trace their ancestry to a kinship group through genealogy or other methods. Genealogical documents shall be limited to those that show a descendency from identified Vermont or regional native people.

(3) The applicant has a connection with Native American Indian tribes and bands that have historically inhabited Vermont.

(4) The applicant has historically maintained an organizational structure that exerts influence and authority over its members that is supported by documentation of the structure, membership criteria, the names and residential addresses of its members, and the methods by which the applicant conducts its affairs.

(5) The applicant has an enduring community presence within the boundaries of Vermont that is documented by archaeology, ethnography, physical anthropology, history, folklore, or any other applicable scholarly research and data.

(6) The applicant is organized in part:

(A) To preserve, document, and promote its Native American Indian culture and history, and this purpose is reflected in its bylaws.

(B) To address the social, economic, political or cultural needs of the members with ongoing educational programs and activities.

(7) The applicant can document traditions, customs, oral stories, and histories that signify the applicant's Native American heritage and connection to their historical homeland.

(8) The applicant has not been recognized as a tribe in any other state, province, or nation.

(9) Submission of letters, statements, and documents from:

(A) Municipal, state, or federal authorities that document the applicant's history of tribe-related business and activities.

(B) Tribes in and outside Vermont that attest to the Native American Indian heritage of the applicant.

(d) The commission shall consider the application pursuant to the following process which shall include at least the following requirements:

(1) The commission shall:

(A) Provide public notice of receipt of the application and supporting documentation.

(B) Hold at least one public hearing on the application.

(C) Provide written notice of completion of each step of the recognition process to the applicant.

(2) Established appropriate time frames that include a requirement that the commission and the review panel shall complete a review of the application and issue a determination regarding recognition within one year after an application and all the supporting documentation have been filed, and if a recommendation is not issued, the commission shall provide written explanation to the applicant and the legislative committees of the reasons for the delay and the expected date that a decision will be issued.

(3) A process for appointing a three-member review panel for each application to review the supporting documentation and determine its sufficiency, accuracy, and relevance. The review panel shall provide a detailed written report of its findings and conclusions to the commission, the applicant, and legislative committees. Members of each review panel shall be appointed cooperatively by the commission and the applicant from a list of professionals and academic scholars with expertise in cultural or physical anthropology,

Indian law, archaeology, Native American Indian genealogy, history, or another related Native American Indian subject area. If the applicant and the commission are unable to agree on a panel, the state historic preservation officer shall appoint the panel. No member of the review panel may be a member of the commission or affiliated with or on the tribal rolls of the applicant.

(4) The commission shall review the application, the supporting documentation, the report from the review panel, and any other relevant information to determine compliance with subsection (b) of this section and make a determination to recommend or deny recognition. The decision to recommend recognition shall require a majority vote of all eligible members of the commission. A member of the commission who is on the tribal roll of the applicant is ineligible to participate in any action regarding the application. If the commission denies recognition, the commission shall provide the applicant and the legislative committees with written notice of the reasons for the denial, including specifics of all insufficiencies of the application.

(5) The applicant may file additional supporting documentation for reconsideration within one year after receipt of the notice of denial.

(6) An applicant may withdraw an application any time before the commission issues a recommendation, and may not file a new application for two years following withdrawal. A new application and supporting documentation shall be considered a de novo filing, and the commission shall not consider the withdrawn application or its supporting documentation.

(7) The commission shall provide a detailed written report of its findings and conclusions to the applicant and the legislative committees along with a recommendation that the general assembly recognize or deny recognition to the applicant as a Native American Indian tribe.

(8) All proceedings, applications, and supporting documentation shall be public except material exempt pursuant to subsection 317(40) of this title. Any documents relating to genealogy submitted in support of the application shall be available only to the three-member review panel.

(e) An applicant for recognition shall be recognized as follows:

(1) By approval of the general assembly.

(2) Two years after a recommendation to recognize a tribe by the commission is filed with the legislative committees, provided the general assembly took no action on the recommendation.

(f) A decision by the commission to recommend denial of recognition is final unless an applicant or a successor of interest to the applicant that has previously applied for and been denied recognition under this chapter provides new and substantial documentation and demonstrates that the new documentation was not reasonably available at the time of the filing of the original application.

(g) Vermont Native American Indian bands and tribes and individual members of those bands and tribes remain subject to all the laws of the state.

(h) Recognition of a Native American Indian tribe shall not be construed to create, extend, or form the basis of any right or claim to land or real estate in Vermont or right to conduct any gambling activities prohibited by law, but confers only those rights specifically described in this chapter.

Sec. 5. 1 V.S.A. § 317(40) is added to read:

(40) Records of genealogy provided in support of an application for tribal recognition pursuant to chapter 23 of this title.

Sec. 6. TRANSITIONAL PROVISIONS

(a) The terms of the present members of the commission on Native American affairs shall be deemed expired and the governor shall appoint all nine members of the commission.

(b) The present members of the commission may not reapply for appointment to the commission for two years following the end of their term.

(c) Appointments to the commission shall be made no later than September 1, 2010, provided a sufficient number of qualified candidates have been submitted to the governor.

Sec. 7. EFFECTIVE DATE

This act shall take effect on passage.

And that the bill title be amended to read:

"An act relating to state recognition of Native American Indian tribes in Vermont".

Which was agreed to on a roll call, Yeas 28, Nays 0.

Senator Miller having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Bartlett, Brock, Campbell, Carris, Choate, Cummings, Doyle, Flanagan, Flory, Giard, Hartwell, Illuzzi, Kitchel, Kittell, Lyons, Mazza, McCormack, Miller, Mullin, Nitka, Racine, Scott, Sears, Snelling, Starr, White.

Those Senators who voted in the negative were: None.

Those Senators absent and not voting were: MacDonald, Shumlin.

House Proposal of Amendment Concurred In with Amendment

S. 88.

House proposal of amendment to Senate bill entitled:

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

Was taken up.

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) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.

(5) 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.

(6) 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.

(7) 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.

(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 ~~the physician and patient relationship~~ 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 subsection to superior court. Appeal shall be on the record as developed by the commissioner in the administrative proceeding and the standard of review shall be as provided in 8 V.S.A. § 16.

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

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

(1) review utilization information;

(2) consider the goals and recommendations of the health resource allocation plan;

(3) consider the expenditure analysis for the previous year and the proposed expenditure analysis for the year under review;

(4) consider any reports from professional review organizations;

(5) solicit public comment on all aspects of hospital costs and use and on the budgets proposed by individual hospitals;

(6) meet with hospitals to review and discuss hospital budgets for the forthcoming fiscal year;

(7) give public notice of the meetings with hospitals, and invite the public to attend and to comment on the proposed budgets;

(8) consider the extent to which costs incurred by the hospital in connection with services provided to Medicaid beneficiaries are being charged to non-Medicaid health benefit plans and other non-Medicaid payers;

(9) require each hospital to file an analysis that reflects a reduction in net revenue needs from non-Medicaid payers equal to any anticipated increase in Medicaid, Medicare, or another public health care program reimbursements, and to any reduction in bad debt or charity care due to an increase in the number of insured individuals;

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

Sec. 25. 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 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~~.

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* * * 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.

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment?, Senator Racine moved that the Senate concur in the House proposal of amendment with an amendment as follows:

By striking out 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) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.

(5) 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.

(6) 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.

(7) 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.

(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 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)(A) 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. The proposal shall contain the analysis and recommendations as provided for in subsection (g) of this section.

(B) 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)(A) 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.

(B) 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.

(C) A third and 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.

(b)(1) 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 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.

(2) The commission shall serve as a resource for the consultant by providing information and feedback to the consultant upon request, by recommending additional resources, and by receiving periodic progress reports by the consultant as needed. In order to maintain the independence of the consultant, the commission shall not direct the consultant's recommendations or 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 regional delivery systems;

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

(4) financing and estimated costs, including federal financings; 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) For each design option, the consultant shall consider including 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) For each proposed package of health services, the consultant shall consider including a cost-sharing proposal that may provide 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) For each proposed package of health services, the consultant shall consider including a proposal that has no cost-sharing. If this proposal is included, the consultant shall provide 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 consider whether 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 a coordinated 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, organization, or another mechanism to manage health services for that region's population, which may

include 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; or other functions necessary to manage the region's health system.

(3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs.

(4) 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) 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.

(C) 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.

(D) 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, a waiver from these provisions when available.

(5) 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) In the proposal and implementation plan provided to the general assembly and the governor as provided for in subsection (a) of this section, the consultant shall include:

(1) A recommendation for key indicators to measure and evaluate the design option chosen by the general assembly.

(2) An analysis of each design option, including:

(A) the financing and cost estimates outlined in subdivision (e)(4) 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.

(3) A comparative analysis of the coverage, benefits, payments, health care delivery, and other features in each design option with Vermont's current health care system and health care reform efforts. The comparative analysis should be in a format to allow the general assembly to compare easily each design option with the current system and efforts. If appropriate, the analysis

shall include a comparison of financial or other changes in Medicaid and Medicaid-funded programs in a format currently used by the department of Vermont health access in order to compare the estimates for the design option to the most current actual expenditures available.

(4) 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 for in subdivision (a)(1)(B) of this section.

(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 that health care is a public good for all Vermonters and to 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. It is also the intent of the general assembly to ensure sufficient state involvement and action in designing and implementing payment reform pilot projects in order to comply with federal anti-trust provisions by replacing competition between payers and others with state regulation and supervision.

Sec. 12. BLUEPRINT FOR HEALTH; COMMITTEES

It is the intent of the general assembly to codify and recognize the existing expansion design and evaluation committee and payer implementation work group and to codify the current consensus-building process provided for by these committees in order to develop payment reform models in the Blueprint

for Health. The director of the Blueprint may continue the current composition of the committees and need not reappoint members as a result of this act.

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

CHAPTER 13. CHRONIC CARE INFRASTRUCTURE AND PREVENTION MEASURES

§ 701. DEFINITIONS

For the purposes of this chapter:

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

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

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

(4) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for ~~the physician and patient relationship~~ 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 time lines and strategies. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration.

~~(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 among 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 of health insurer expenditures from disease management contracts to financial support for 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 hospital, nursing home, or other institution setting;

(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 of health insurers offering a stand-alone dental plan or specific disease or other limited benefit coverage in the Blueprint for Health. 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's not meeting the participation requirement in section 707 of this title. The certification process, including the appeal process, 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 required by subsection (a) of this section shall include the number of participating insurers, health care professionals, and patients; the progress made in 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 made 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. PAYMENT REFORM; PILOTS

(a)(1) The department of Vermont health access shall be responsible for developing pilot projects to test payment reform methodologies as provided

under this section. The director of payment reform shall oversee the development, implementation, and evaluation of the payment reform 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 payment reform 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) Payment reform 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) payment reform pilot projects should be organized around primary care professionals and be structured to serve the population using the primary care professionals;

(B) payment reform pilot projects should align with the Blueprint for Health strategic plan and the statewide health information technology plan;

(C) health care providers and professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care;

(D) health insurers, Medicaid, Medicare, and all other payers should reimburse health care providers and professionals for coordinating patient care through a single system of payments; a global budget; a system of cost-containment, health care outcome, and patient satisfaction targets which may include shared savings, risk-sharing, or other incentives designed to reduce costs while maintaining or improving health outcomes and patient satisfaction; or another payment method providing an incentive to coordinate care;

(E) the design and implementation of the payment reform pilot projects should be aligned with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform;

(F) the global budget should include a broad, comprehensive set of services, including prescription drugs, diagnostic services, services received in a hospital, and services from a licensed health care practitioner;

(G) with input from long-term care providers, the global budget may also include home health services, and long-term care services if feasible;

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

(4)(A) No later than February 1, 2011, the director of payment reform shall provide a strategic plan for the pilot projects to the house committee on health care and the senate committee on health and welfare. The strategic plan shall provide:

(i) A description of the proposed payment reform pilot projects, including a description of the possible organizational model or models for health care providers or professionals to coordinate patient care, a detailed design of the financial model or models, and an estimate of savings to the health care system from cost reductions due to reduced administration, from a reduction in health care inflation, or from other sources.

(ii) An ongoing program evaluation and improvement protocol.

(iii) 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.

(B) The director shall not implement the pilot projects until the strategic plan has been approved or modified by the general assembly.

(b) Health insurer participation.

(1)(A) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and, after approval by the general assembly, in the implementation of the 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 payment 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 or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the commissioner. Health insurers shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's

assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(C) After the pilot projects are implemented, 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 payment reform pilot projects, including by creating a shared incentive pool if appropriate. 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 design and implementation of the pilot projects.

(e) If the pilot projects are approved by the general assembly, the director of payment reform shall report annually by January 15 beginning in 2012 on the status of implementation of the pilot projects for the prior calendar year, including any analysis or evaluation of the effectiveness of the pilot projects, 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.

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. A health insurer shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

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, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, the secretary of human services may apply to the secretary of HHS to enable Vermont to include Medicare as a participant in the Blueprint for Health as described in chapter 13 of Title 18.

(2) Upon establishment by the secretary of HHS of a shared savings program pursuant to Sec. 3022 of the Patient Protection and Affordable Care

Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, the secretary of human services may apply to the secretary of HHS to enable Vermont to participate in the program by establishing payment reform pilot projects as provided for by 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 HHS of a health home demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, 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. [DELETED]

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 no later than October 1, 2013, to primary care practices statewide whose owners wish to participate.

* * * 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 and 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 goal 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 that such authority is necessary to carry out the purposes of this subsection, subsection (h) of this section, or subdivision 9454(a)(7) of this title. As used in this subsection, a rebuttable presumption of "control" is created if the entity, hospital, or other person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 20 percent or more of the voting securities or membership interest or other governing interest of the hospital or other controlled entity.

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 (2)(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 (2)(B) without written or oral notice to the hospital. Where an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. The hearing shall be held within 30 days of receipt of the hospital's request for a hearing, and a decision shall be issued within 30 days after conclusion of the hearing. The commissioner may increase the time to hold the hearing or to render the decision for good cause shown. Hospitals may appeal any decision in this subsection to superior court. Appeal shall be on the record as developed by the commissioner 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 existing 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 may include imposing limits on:

(1) administrative costs as a percentage of the premium;

(2) contributions to reserves;

(3) producer commissions in specified markets;

(4) medical trends;

(5) pharmacy trends; and

(6) such other areas as the commissioner deems appropriate.

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 occur at the time a rate increase is sought and shall be in the manner and form as directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

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 occur at the time a rate increase is sought and shall be in the manner and form directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

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 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 of the Vermont health care workforce development partners;

(13) a mental health or substance abuse treatment professional currently in practice, to be appointed by the commissioner of Vermont health access;

(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 established in subsection (a) of this section 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 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 Vermont health access in collaboration with AHEC and the department of health 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 Vermont health access. The commissioner of Vermont health access shall call the first meeting of the committee and shall jointly operate with the representative from AHEC to cochair of the committee.

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

Sec. 31a. 1 V.S.A. § 376 is added to read:

§ 376. HEALTH CARE CAREER AWARENESS MONTH

October of each year is designated as health care career awareness month.

* * * 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 April 1 of each year beginning in 2012, each manufacturer of prescribed products shall disclose to the office of the attorney general all free samples of prescribed products provided to health care providers during the preceding calendar year, identifying for each sample the product, recipient, number of units, and dosage.

(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~~ section 4631a ~~and 4632~~ of ~~Title 18~~ this title and under this section. 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 per year of tobacco cessation medication, including over-the-counter medication, 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 18 V.S.A. § 9402, as well as Medicaid, the Vermont health access plan, and any other public health care assistance program offered or administered by the state or by any subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(2) "Tobacco cessation medication" means all 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~~ 3V.S.A. § 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~~ 18 V.S.A. § 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~~ 18 V.S.A. § 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. POSITION

In fiscal year 2011, the department of Vermont health access may establish one new exempt position to create a director of payment reform 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) It is the intent of the general assembly to fund the payment reform pilot projects described in Sec. 14 of this act, including the position provided for in Sec. 39 of this act for a total of $250,000.00 in a budget neutral manner through the reallocation of existing sources in the fiscal year 2011 appropriations act.

(b) In fiscal year 2011, $250,000.00 in general funds is appropriated to the joint fiscal committee for hiring the consultant required under Sec. 6 of this act.

(c) 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 committee for hiring the consultant required in Sec. 6 of this act.

Sec. 41. EFFECTIVE DATES

(a) This section and 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), 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 (payment reform pilots), 15 (8 V.S.A. § 4088h), 16 (hospital certification), 19 (Blueprint Expansion), 26 through 28 (insurer rate review), 31a (health care career awareness month), 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.

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment with further proposal of amendment?, Senators Ashe and Giard moved to amend the Senate proposal of amendment to the House proposal of amendment as follows:

By adding a new section to be numbered Sec. 20a to read as follows:

Sec. 20a. VERMONT NONPROFIT HOSPITAL SERVICE CORPORATIONS; VERMONT NONPROFIT MEDICAL CORPORATIONS; BOARD OF DIRECTORS; COMPENSATION

The total combined compensation of the board of directors of any Vermont nonprofit hospital service corporation or Vermont nonprofit medical service corporation, excluding nonprofit stand-alone dental plans, in calendar year 2011 shall be no more than 90 percent of the total combined compensation of the board in calendar year 2010.

Thereupon, pending the question, Shall the Senate proposal of amendment to the House proposal of amendment be amended as recommended by Senators Ashe and Giard?, Senator Sears moved that the bill be committed to the Committee on Judiciary.

Thereupon, pending the question, Shall the bill be committed to the Committee on Judiciary?, Senators Sears requested and was granted leave to withdraw his motion.

Thereupon, the pending question, Shall the Senate proposal of amendment to the House proposal of amendment be amended as recommended by Senators Ashe and Giard?, was disagreed to on a roll call, Yeas 10, Nays 19.

Senator Starr having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Ashe, Campbell, Carris, Flanagan, Giard, Illuzzi, Kittell, MacDonald, Starr, White.

Those Senators who voted in the negative were: Ayer, Bartlett, Brock, Choate, Cummings, Doyle, Flory, Hartwell, Kitchel, Lyons, Mazza, McCormack, Miller, Mullin, Nitka, Racine, Scott, Sears, Snelling.

The Senator absent and not voting was: Shumlin.

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment with further proposal of amendment?, Senators Sears, Bartlett, Brock, Choate, Cummings, Doyle, Flory, Giard, Hartwell, Mazza, McCormack, Miller, Mullin, Nitka, Scott, Snelling, and Starr moved to amend the Senate proposal of amendment to the House proposal of amendment as follows:

By striking out Sec. 33 in its entirety and inserting in lieu thereof a new Sec. 33 to read as follows:

Sec. 33. 18 V.S.A. § 4632 is amended to read:

§ 4632. DISCLOSURE OF ALLOWABLE EXPENDITURES AND GIFTS BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a)(1) Annually on or before October 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the fiscal year ending the previous June 30th the value, nature, purpose, and recipient information of:

(A) any allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title to any health care provider, except:

(i) royalties and licensing fees as described in subdivision 4631a(a)(1)(F) of this title;

(ii) rebates and discounts for prescribed products provided in the normal course of business as described in subdivision 4631a(b)(2)(F) of this title;

(iii) payments for clinical trials as described in subdivision 4631a(a)(1)(C) of this title, which shall be disclosed after the earlier of the date of the approval or clearance of the prescribed product by the Food and Drug Administration or two calendar years after the date the payment was made. For a clinical trial for which disclosure is delayed under this subdivision (iii), the manufacturer shall identify to the attorney general the clinical trial, the start date, and the web link to the clinical trial registration on the national clinical trials registry; ~~and~~

(iv) samples of a prescription drug provided to a health care professional for free distribution to patients;

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

(vi) coffee or other snacks or refreshments at a booth at a conference or seminar.

(B) any allowable expenditure or gift ~~permitted under subdivision 4631a(b)(2) of this title~~ to an academic institution, to a nonprofit hospital foundation, or to a professional, educational, or patient organization representing or serving health care providers or consumers, located in or providing services in Vermont, except:

(i) royalties and licensing fees as described in subdivision 4631a(a)(1)(F) of this title;

(ii) rebates and discounts for prescribed products provided in the normal course of business as described in subdivision 4631a(b)(2)(F) of this title;

(iii) payments for clinical trials as described in subdivision 4631a(a)(1)(C) of this title, which shall be disclosed after the earlier of the date of the approval or clearance of the prescribed product by the Food and Drug Administration or two calendar years after the date the payment was made. For a clinical trial for which disclosure is delayed under this subdivision (iii), the manufacturer shall identify to the attorney general the clinical trial, the start date, and the web link to the clinical trial registration on the national clinical trials registry; and

(iv) samples of a prescription drug provided to a health care professional for free distribution to patients.

(2) Annually on July 1, each manufacturer of prescribed products also shall disclose to the office of the attorney general the name and address of the individual responsible for the manufacturer's compliance with the provisions of this section.

(3) Disclosure shall be made on a form and in a manner prescribed by the office of the attorney general and shall require manufacturers of prescribed products to report each allowable expenditure or gift permitted under subdivision 4631a(b)(2) of this title including:

(A) except as otherwise provided in subdivision (a)(2) of this section, the value, nature, and purpose of each allowable expenditure, and gift permitted under subdivision 4631a(b)(2) of this title according to specific categories identified by the office of the attorney general;

(B) the name of the recipient;

(C) the recipient's address;

(D) the recipient's institutional affiliation;

(E) prescribed product or products being marketed, if any; and

(F) the recipient's state board number.

(4) The office of the attorney general shall report annually on the disclosures made under this section to the general assembly and the governor on or before April 1. The report shall include:

(A) Information on allowable expenditures and gifts required to be disclosed under this section, which shall be presented in both aggregate form and by selected types of health care providers or individual health care providers, as prioritized each year by the office.

(B) Information on violations and enforcement actions brought pursuant to this section and section 4631a of this title.

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

(6) The office of Vermont health access shall examine the data available from the office of the attorney general for relevant expenditures and determine whether and to what extent prescribing patterns by health care providers of prescribed products reimbursed by Medicaid, VHAP, Dr. Dynasaur, VermontRx, and VPharm may reflect manufacturer influence. The office may select the data most relevant to its analysis. The office shall report its analysis annually to the general assembly and the governor on or before October 1.

(b)(1) Annually on July 1, the office of the attorney general shall collect a $500.00 fee from each manufacturer of prescribed products filing annual disclosures of expenditures greater than zero described in subsection (a) of this section.

(2) Fees collected under this section shall fund collection and analysis of information on activities related to the marketing of prescribed products under ~~sections~~ section 4631a of this title and ~~4632 of Title 18~~ this section. 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.

Which was agreed to on a roll call, Yeas 18, Nays 10.

Senator Sears having demanded the yeas and nays, they were taken and are as follows:

Roll Call

Those Senators who voted in the affirmative were: Bartlett, Brock, Campbell, Cummings, Doyle, Flory, Giard, Hartwell, Illuzzi, Mazza, McCormack, Miller, Mullin, Nitka, Scott, Sears, Snelling, Starr.

Those Senators who voted in the negative were: Ashe, Ayer, Carris, Flanagan, Kitchel, Kittell, Lyons, MacDonald, Racine, White.

Those Senators absent and not voting were: Choate, Shumlin.

Thereupon, pending the question, Shall the Senate concur in the House proposal of amendment with further proposal of amendment?, Senator Mullin moved to amend the Senate proposal of amendment to the House proposal of amendment as follows:

First: By adding a Sec. 38a to read:

Sec. 38a. STATUTORY REVISION

18 V.S.A. §§ 4051–4071 shall be recodified as subchapter 1 (labeling for marketing and sale) of chapter 82 of Title 18.

Second: By adding a Sec. 38b to read:

Sec. 38b. 18 V.S.A. chapter 82, subchapter 2 is added to read:

Subchapter 2. Menu Labeling

§ 4086. MENUS AND MENU BOARDS

(a) Except as otherwise provided in 4091 of this title, in the case of food that is a standard menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name, regardless of the type of ownership of the locations and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subsection (b) of this section.

(b) Except as otherwise provided in section 4091 of this title, the restaurant or similar retail food establishment shall disclose in a clear and conspicuous manner:

(1) On a menu listing an item for sale:

(A) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

(B) a succinct statement concerning suggested daily caloric intake, as specified by federal regulation or, in the absence of an applicable federal regulation, by the commissioner of health by rule, posted prominently on the menu and designed to enable the public to understand, in the context of a total daily diet, the significance of the caloric information that is provided on the menu.

(2) On a menu board, including a drive-through menu board:

(A) in a nutrient content disclosure statement adjacent to the name of the standard menu item, so as to be clearly associated with the standard menu item, the number of calories contained in the standard menu item, as usually prepared and offered for sale; and

(B) a succinct statement concerning suggested daily caloric intake, as specified by federal regulation or, in the absence of an applicable federal regulation, by the commissioner of health by rule, posted prominently on the menu board, designed to enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board.

(3)(A) In a written form, available on the premises of the restaurant or similar retail establishment and to the consumer upon request, the following nutrition information:

(i) the total number of calories in each serving size or other unit of measure of the food that are:

(I) derived from any source; and

(I) derived from the total fat; and

(ii) the amount of each of the following nutrients: Total fat, saturated fat, cholesterol, sodium, total carbohydrates, complex carbohydrates, sugars, dietary fiber, and total protein contained in each serving size or other unit of measure;

(B) To the extent that federal statutes or regulations require disclosure of different or additional nutrition information, a restaurant or similar retail establishment that follows the federal law shall be deemed to be in compliance with the requirements of this subdivision (3).

(4) On the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in subdivision (3) of this subsection.

§ 4087. SELF-SERVICE FOOD AND FOOD ON DISPLAY

Except as otherwise provided in section 4091 of this title, in the case of food sold at a salad bar, buffet line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

§ 4088. REASONABLE BASIS

For the purposes of this chapter, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including nutrient databases, cookbooks, laboratory analyses, and other reasonable means, as described in Section 101.10 of Title 21, Code of Federal Regulations, or any successor regulation, or in a related guidance of the United States Food and Drug Administration.

§ 4089. MENU VARIABILITY AND COMBINATION MEALS

Except as otherwise provided by federal law or regulation, the commissioner of health shall establish by rule, pursuant to chapter 25 of Title 3, standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the commissioner, including ranges, averages, or other methods.

§ 4090. ADDITIONAL INFORMATION

Except as otherwise provided by federal law or regulation, if the commissioner of health determines that a nutrient, other than a nutrient required under subdivision 4086(b)(3) of this title, should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the commissioner may require, by rule, disclosure of such nutrient in the written form required under subdivision 4086(b)(3).

§ 4091. NONAPPLICABILITY TO CERTAIN FOOD

Sections 4086 through 4090, inclusive, of this chapter shall not apply to:

(1) items that are not listed on a menu or menu board, such as condiments and other items placed on the table or counter for general use;

(2) daily specials, temporary menu items appearing on the menu for fewer than 60 days per calendar year, or custom orders;

(3) such other food that is part of a customary market test appearing on the menu for fewer than 90 days, under terms and conditions established by federal law or regulation, if applicable; if not applicable, then under terms and conditions established by the commissioner of health by rule; or

(4) alcoholic beverages.

§ 4092. VOLUNTARY PROVISION OF NUTRITION INFORMATION

(a) An authorized official of any restaurant or similar retail food establishment not subject to the requirements of this chapter may elect to be subject to such requirements by registering biannually the name and address of such restaurant or similar retail food establishment with the Secretary of the U.S. Department of Health and Human Services and the commissioner of health, as specified by the Secretary by regulation and the commissioner by rule.

(b) To the extent allowed by federal law, within 120 days following the effective date of this chapter, the commissioner of health shall engage in rulemaking pursuant to chapter 25 of Title 3 specifying the terms and conditions for implementation of subsection (a) of this section.

(c) Nothing in this section shall be construed to authorize the commissioner of health to require an application, review, or licensing process for any entity to register with the Secretary pursuant to subsection (a) of this section.

§ 4093. RULEMAKING

(a) To the extent permitted under federal law, within one year after the effective date of this chapter, the commissioner of health shall adopt rules pursuant to chapter 25 of Title 3 to carry out the purposes of this chapter.

(b) In adopting rules, the commissioner shall:

(1) consider standardization of recipes and methods of preparation, reasonable variation in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredients, and other factors, as the commissioner shall determine;

(2) specify the format and manner of the nutrient content disclosure requirements under this chapter; and

(3) reasonably align the rules, to the extent practicable, with federal and other states' laws on menu labeling.

(c) No later than January 15, 2011, the commissioner shall report to the house committee on human services and the senate committee on health and welfare a report on the commissioner's progress toward adopting rules under this section.

§ 4094. DEFINITIONS

To the extent not inconsistent with federal law, as used in this chapter:

(1) "Menu" or "menu board" means the primary writing of the restaurant or other similar retail food establishment from which a consumer makes an order selection.

(2) "Restaurant" or "other similar retail food establishment" means an establishment from which food or beverage of the type for immediate consumption is sold, whether such food is consumed on the premises or not.

(A) "Restaurant" shall not include any school, hospital, nursing home, assisted living facility, or any restaurant-like facility operated by or in connection with a school, hospital, medical clinic, nursing home, or assisted living facility providing food for students, patients, visitors, and their families.

(B) "Restaurant" shall not include grocery stores, except for separately owned food facilities to which this section otherwise applies that are located in a grocery store. For purposes of this subdivision, "grocery store" means a store primarily engaged in the retail sale of canned food, dry goods, fresh fruits and vegetables, and fresh meats, fish, and poultry. The term "grocery store" includes convenience stores.

(C) "Restaurant" shall not include any fraternal organization or any organization whose members consist solely of veterans of the armed forces of the United States.

(3) "Standard menu item" means any item listed on a menu or menu board by a restaurant, but excluding alcoholic beverages.

§ 4095. ENFORCEMENT; LIABILITY; PENALTY

(a) The commissioner of health or duly authorized agents or employees who inspect restaurants and food establishments on behalf of the department of health shall be required to determine that the nutrition information required under this subchapter is listed on the menu or menu board, and that any

additional required information is available for customers upon request. If, upon inspection, the required information is not clearly visible on a menu or menu board or the additional required information is not available upon request, the commissioner or inspector shall note such fact on the inspection report and cause a corresponding reduction in points from the restaurant's or other food establishment's rating score.

(b) Nothing in this section shall be construed to create or enhance any claim, right of action, or civil liability that did not previously exist under state or federal law or to limit any claim, right of action, or civil liability that otherwise exists under state or federal law.

(c) No private right of action shall arise from this subchapter. The sole enforcement authority for this subchapter shall be the state of Vermont.

§ 4096. RELATION TO OTHER LAWS

To the extent permitted by federal law, nothing in this chapter shall be construed to restrict the ability of cities or towns to impose labeling requirements in excess of those required by this chapter.

Which was agreed to.

Thereupon, the pending question, Shall the Senate concur in the House Proposal of amendment with further proposal of amendment?, was agreed to.

Rules Suspended; Bills Messaged

On motion of Senator Campbell, the rules were suspended, and the following bills were severally ordered messaged to the House forthwith:

S. 88, S. 222.

Adjournment

On motion of Senator Campbell, the Senate adjourned until one o'clock in the afternoon.