House Calendar

Wednesday, May 04, 2011

120th DAY OF THE BIENNIAL SESSION

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An act relating to early childhood educators

Rep. French of Randolph, for the Committee on **Human Services,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds:

(1) Quality early childhood education and care is essential to the quality of life in Vermont and is a vital contributor to the healthy development of children. Numerous studies have demonstrated that high-quality early childhood education and care during the first five years of a child's life is crucial to brain development and increases the likelihood of a child's success in school and later in life.

(2) The early childhood education and care a child receives before school age has a profound effect on future mental, psychological, and academic success. High-quality early childhood education and care lay the vital groundwork for the success of Vermont children.

(3) The state is committed to ensuring that all Vermont children are ready to succeed in school; that Vermont families have access to high quality early childhood education and care and after school services; and that the early childhood and after school supports and services administered by the

department for children and families are child-focused, family friendly, and fair to all child care providers.

(4) Home-based child-care providers should have the opportunity to work collectively with the state to improve the standards in their profession, enhance educational training courses, increase child-care subsidy assistance, and ensure the constant improvement of early childhood education and care for the benefit of Vermont children.

Sec. 2. 33 V.S.A. chapter 36 is added to read:

CHAPTER 36. EXTENSION OF LIMITED COLLECTIVE BARGAINING RIGHTS TO CHILD-CARE PROVIDERS

§ 3601. DEFINITIONS

For purposes of this chapter:

(1) "Board" means the state labor relations board established in 3 V.S.A. § 921.

(2) "Child-care provider" shall have the same meaning as in subdivision 3511(2) of this title and includes people who provide child-care services as defined by subdivisions 3511(3) and 4902(2)–(3) of this title, except that it shall not include licensed child-care centers. For purposes of this chapter, "child-care provider" means the owner or operator of a licensed family-care home or a registered family day-care home, or a legally exempt child-care provider.

(3) "Collective bargaining" or "bargaining collectively" means the process by which the state and the exclusive representative of the child-care providers negotiate terms or conditions as defined in subsection 3603(b) of this title with the intent to arrive at an agreement which, when reached, shall be legally binding on all parties.

(4) "Exclusive representative" means a labor organization that has been elected or recognized and certified under this chapter and has the right to represent child-care providers in an appropriate bargaining unit for the purpose of collective bargaining.

(5) "Grievance" means a child-care provider's or the exclusive representative's formal written complaint regarding the improper application of one or more terms of the collective bargaining agreement, which has not been resolved to a satisfactory result through informal discussion with the state.

(6) "Legally exempt child-care provider" means a person who has obtained an Exempt Child Care Provider Certificate, has been approved by the

department to provide legally exempt child care, and who is reimbursed for that care through the agency of human services.

(7) "Licensed family child-care home" means a home licensed by the department for children and families that provides child-care services for up to 12 children in the residence of the licensee, and the licensee is one of the primary caregivers.

(8) "Registered family day care home" means a home registered with the department for children and families that provides child-care services for up to six children at any one time, and which in addition to the six children, may provide care for up to four school-age children for not more than four hours per day.

(9) "Subsidy payment" means any payment made by the state to assist in the provision of child-care services through the state's child-care financial assistance programs.

§ 3602. RIGHTS OF CHILD-CARE PROVIDERS

(a) Child-care providers shall have the right to:

(1) Organize, form, join, or assist a union or labor organization for the purposes of collective bargaining without interference, restraint, or coercion.

(2) Bargain collectively through their chosen representatives.

(3) Engage in concerted activities for the purpose of supporting or engaging in collective bargaining or exercising their rights under this chapter.

(4) Pursue grievances as provided in this chapter.

(5) Refrain from any or all such activities.

(b) Child-care providers shall not strike or curtail their services in recognition of a picket line of any employee or labor organization, unless otherwise permitted to do so under federal or state law, including the National Labor Relations Act (29 U.S.C. § 151 et seq.) or the Vermont state labor relations act (21 V.S.A. § 1501 et seq.)

§ 3603. ESTABLISHMENT OF LIMITED COLLECTIVE BARGAINING; SCOPE OF BARGAINING

(a) Child-care providers, through their exclusive representative, shall have the right to bargain collectively with the state, through the governor's designee, under this chapter.

(b) The scope of collective bargaining for child-care providers under this section is limited to the following:

(1) child-care subsidy payments, including rates and reimbursement practices and rate variations reflecting different provider classifications and quality incentives;

(2) professional development and training, including financial assistance for child-care providers and their staff; and

(3) procedures for resolving grievances against the state.

(c) The state, acting through the governor's designee, shall meet with the exclusive representative for the purpose of entering into a written agreement that promotes access to high-quality early childhood education and care and after-school services and care for Vermont's children and families and ensures policies and practices that are child-focused, family friendly, and fair to all child-care providers. The negotiated agreement shall legally bind the state and the exclusive representative subject to subsection 3612(a) or subdivision 3613(a)(2) of this title.

§ 3604. PETITIONS FOR ELECTION; FILING; INVESTIGATIONS;

HEARINGS; DETERMINATION

(a) A petition may be filed with the board in accordance with regulations prescribed by the board:

(1) By a child-care provider or a group of child-care providers or by any individual or labor union acting on their behalf alleging:

(A) that not less than 30 percent of the child-care providers in the petitioned bargaining unit wish to be represented for collective bargaining, and that the state has declined to recognize their exclusive representative; or

(B) that the labor organization which has been certified or is being recognized by the state as the exclusive representative no longer represents a majority of child-care providers.

(2) By the state alleging that one or more individuals or labor organizations have presented the state with a claim for recognition as the exclusive representative.

(b) The board shall investigate the petition and, if it has reasonable cause to believe that a question of unit determination or representation exists, conduct an appropriate hearing. Written notice of the hearing shall be mailed by certified mail to the parties named in the petition not less than seven days before the hearing. If the board finds upon the record of the hearing that a question of representation exists, it shall conduct an election by secret ballot and certify to the parties the election's results.

(c) In determining whether a question of representation exists, the board

shall apply the same regulations and rules of decision regardless of the identity of the persons filing the petition or the kind of relief sought.

(d) Nothing in this chapter prohibits the waiving of hearings by stipulation for a consent election in conformity with the regulations and rules of the board.

(e) For the purposes of this chapter, the state may voluntarily recognize the exclusive representative of a unit of child-care providers, if the labor organization demonstrates that it has the support of a majority of the child-care providers in the unit it seeks to represent, no rival employee organization seeks to represent the child-care providers, and the bargaining unit is appropriate under section 3606 of this chapter.

§ 3605. ELECTION; RUNOFF ELECTIONS

(a) In determining the representation of child-care providers in a collective bargaining unit, the board shall conduct a secret ballot of the providers and certify the results to the interested parties and to the state. The original ballot shall be prepared so as to permit a vote against representation by anyone named on the ballot. No exclusive representative shall be certified or remain certified with less than a majority of all votes cast. The labor organization receiving a majority of votes cast shall be certified by the board as the exclusive representative of the unit of child-care providers.

(b) A runoff election shall be conducted by the board when an election, in which the ballot provides for no less than three choices, results in no choice receiving a majority of valid votes cast. The ballot in the runoff election shall provide for a selection between the two choices receiving the largest and second largest number of valid votes cast in the original election.

§ 3606. BARGAINING UNITS

(a) The board shall decide the unit appropriate for the purpose of collective bargaining in each case and those child care providers to be included in the units in order to promote the purposes of this statute. The board may consider as an appropriate bargaining unit or units, but is not restricted in its discretion, any of the following units:

(1) a unit composed of registered family day-care home providers;

(2) a unit composed of licensed family child-care home providers;

(3) a unit composed of legally exempt child-care providers;

(4) a unit composed of child-care providers in subdivisions (1)–(3) of this subsection;

(5) a unit composed of a combination of child-care providers in subdivisions (1)–(3) of this subsection.

(b) Child-care providers may elect an exclusive representative for the purpose of collective bargaining by using the election procedures set forth in section 3605 of this chapter.

(c) The exclusive representative of child-care providers is required to represent all of the child-care providers in the unit without regard to membership in the union.

§ 3607. MEMBER DUES

Member dues shall be sent to the exclusive representative by each individual dues-paying member.

§ 3608. POWERS OF REPRESENTATIVES

The exclusive representative certified by the board shall be the exclusive representative of all the child-care providers in the unit for the purposes of collective bargaining. However, any individual child-care provider or group of providers shall have the right at any time to present grievances to the board and have such grievances adjusted without the intervention of the exclusive representative, as long as the adjustment is not inconsistent with the terms of a collective bargaining agreement then in effect, and provided that the exclusive representative has been given an opportunity to be present at such an adjustment.

§ 3609. DUTY TO BARGAIN; PROHIBITED CONDUCT

(a) The state and all child-care providers and their representatives shall make every reasonable effort to make and maintain agreements concerning matters allowed under this chapter and to settle all disputes, whether arising out of the application of those agreements or disputes concerning the agreements. All such disputes between the state and child-care providers shall, upon request of either party, be considered within 15 days of the request or at such times as may be mutually agreed to and if possible settled with all expedition in conference between representatives designated and authorized to confer by the state or the interested child-care providers. This obligation does not compel either party to make any agreements or concessions.

(b) The state shall provide within seven days of a request by a labor organization the names, home addresses, telephone numbers, and workplace names of all registered family day-care homes, licensed family-care homes, and legally exempt child-care providers.

(c) The state shall not:

(1) Interfere with, restrain, or coerce child-care providers in the exercise of their rights under this chapter or by any law, rule, or regulation.

(2) Discriminate against a child-care provider because of the provider's affiliation with a labor organization or because a provider has filed charges or complaints or given testimony under this chapter.

(3) Take negative action against a child-care provider because the provider has taken actions demonstrating the provider's support for a labor organization, including signing a petition, grievance, or affidavit.

(4) Refuse to bargain collectively in good faith with the exclusive representative or fail to abide by any agreement reached.

(5) Discriminate against a child-care provider because of race, color, religion, ancestry, national origin, sex, sexual orientation, gender identity, place of birth, or age, or against a qualified disabled individual.

(6) Request or require a child-care provider to take an HIV-related blood test or discriminate against a child-care provider based on his or her HIV status.

(d) The exclusive representative or its agents shall not:

(1) Restrain or coerce child-care providers in the exercise of the rights guaranteed them by law, rule, or regulation. However, a labor organization may prescribe its own rules with respect to the acquisition or retention of membership, provided such rules are not discriminatory.

(2) Cause or attempt to cause the state to discriminate against a child-care provider in violation of this chapter or to discriminate against a child-care provider with respect to whom membership in the organization has been denied or terminated.

(3) Refuse to bargain collectively in good faith with the state.

(e) Complaints related to this section shall be made and resolved in accordance with the procedures set forth in 21 V.S.A. §§ 1622 and 1623.

§ 3610. MEDIATION; FACT-FINDING; LAST BEST OFFER

(a) If, after a reasonable period of negotiation, the representative of a collective bargaining unit and the state of Vermont reach an impasse, the board, upon petition of either party, may authorize the parties to submit their differences to mediation. Within five days after receipt of the petition, the board shall appoint a mediator who shall communicate with the parties and attempt to mediate an amicable settlement.

(b) If, after a minimum of 15 days after the appointment of a mediator, the impasse is not resolved, the mediator shall certify to the board that the impasse continues.

(c) Upon the request of either party, the board shall appoint a fact finder who has been mutually agreed upon by the parties. If the parties fail to agree on a fact finder within five days, the board shall appoint a fact finder. A member of the board or any individual who has actively participated in mediation proceedings for which fact-finding has been called shall not be eligible to serve as a fact finder under this section, unless agreed upon by the parties.

(d) The fact finder shall conduct hearings pursuant to rules of the board. Upon request of either party or of the fact finder, the board may issue subpoenas of persons and documents for the hearings, and the fact finder may require that testimony be given under oath and may administer oaths.

(e) Nothing in this section shall prohibit the fact finder from mediating the dispute at any time prior to issuing recommendations.

(f) The fact finder shall consider factors related to the scope of bargaining contained in this chapter in making a recommendation.

(g) Upon completion of the hearings as provided in subsection (d) of this section, the fact finder shall file written findings and recommendations with both parties.

(h) The costs of witnesses and other expenses incurred by either party in fact-finding proceedings shall be paid directly by the parties incurring them, and the costs and expenses of the fact finder shall be paid equally by the parties. The fact finder shall be paid a rate mutually agreed upon by the parties for each day or any part of a day while performing fact-finding duties and shall be reimbursed for all reasonable and necessary expenses incurred in the performance of his or her duties. A statement of fact-finding per diem and expenses shall be certified by the fact finder and submitted to the board for approval. The board shall provide a copy of approved fact-finding costs to each party with its order apportioning one-half of the total to each party for payment. Each party shall pay its half of the total within 15 days after receipt of the order. Approval by the board of fact-finding and the fact finder's costs and expenses and its order for payment shall be final as to the parties.

(i) If the dispute remains unresolved 15 days after transmittal of findings and recommendations, each party shall submit to the board its last best offer on all disputed issues as a single package. Each party's last best offer shall be certified to the board by the fact finder. The board may hold hearings and consider the recommendations of the fact finder. Within 30 days of the certifications, the board shall select between the last best offers of the parties, considered in their entirety without amendment, and shall determine its cost. The board shall not issue a recommendation under this subsection that is in

conflict with any law or rule or that relates to an issue that is not subject to bargaining. The board shall recommend its choice to the general assembly as the agreement which shall become effective subject to appropriations by the general assembly pursuant to subsection 3612(a) of this title.

§ 3611. GRIEVANCE PROCEDURES; BINDING ARBITRATION

The state and the exclusive representative shall negotiate a procedure for resolving complaints and grievances. A collective bargaining agreement may provide for binding arbitration as the final step of a grievance procedure.

§ 3612. COST ITEMS TO BE SUBMITTED TO GENERAL ASSEMBLY; ANTITRUST EXEMPTION

(a) Agreements reached between the parties shall be submitted to the governor who shall request sufficient funds from the general assembly to implement the agreement. If the general assembly rejects any of the cost items submitted to it, all the cost items shall be returned to the parties to the agreement for further bargaining. If the general assembly appropriates sufficient funds, the agreement shall become effective at the beginning of the next fiscal year. If the general assembly appropriates a different amount of funds, the terms of the agreement affected by that appropriation shall be renegotiated based on the amount of funds actually appropriated, and the new agreement shall become effective at the beginning of the next fiscal year.

(b) The activities of child-care providers and their exclusive representatives that are necessary for the exercise of their rights under this chapter shall be afforded state-action immunity under applicable state and federal antitrust laws. The state intends that the "State Action" exemption to federal antitrust laws be available only to the state, to child-care providers, and to their exclusive representative in connection with these necessary activities. Such exempt activities shall be actively supervised by the state.

§ 3613. RIGHTS UNALTERED

(a) This chapter does not alter or infringe upon the rights of:

(1) A parent or legal guardian to select, discontinue, or negotiate terms of child-care services.

(2) The general assembly and the judiciary to make modifications to the delivery of state services through child-care subsidy programs, including eligibility standards for families, legal guardians, and child-care providers participating in child-care subsidy programs and the nature of the services provided.

(b) Nothing in this chapter shall affect the rights and obligations of private sector employers and employees under the National Labor Relations Act

(29 U.S.C. § 151 et seq.) or the Vermont state labor relations act (21 V.S.A. § 1501 et seq.).

(c) Child-care providers shall not be eligible for participation in the Vermont state employees' retirement system or in the health insurance plans available to executive branch employees.

(d) Child-care providers bargaining under this section do not become employees of the state by virtue of such bargaining.

§ 3614. SEVERABILITY

If any of the provisions of this act or its application is held invalid as it relates to state law, federal law, or federal funding requirements, the invalidity shall not affect other provisions of this act which can be given effect without the invalid provision or application, and to this end, the provisions of this act are severable.

(Committee Vote: 6-5-0)

Rep. Andrews of Rutland City, for the Committee on **General, Housing and Military Affairs,** recommends the bill ought to pass when amended as recommended by the Committee on **Human Services.**

(Committee Vote: 5-3-0)

S. 15

An act relating to insurance coverage for midwifery services and home births

Rep. Pearson of Burlington, for the Committee on Health Care**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 8 V.S.A. § 4099d is added to read:

§ 4099d. MIDWIFERY COVERAGE; HOME BIRTHS

(a) A health insurance plan or health benefit plan providing maternity benefits shall also provide coverage for services rendered by a midwife licensed pursuant to chapter 85 of Title 26 or an advanced practice registered nurse licensed pursuant to chapter 28 of Title 26 who is certified as a nurse midwife for services within the licensed midwife's or certified nurse midwife's scope of practice and provided in a hospital or other health care facility or at home.

(b) Coverage for services provided by a licensed midwife or certified nurse midwife shall not be subject to any greater co-payment, deductible, or coinsurance than is applicable to any other similar benefits provided by the

plan.

(c) A health insurance plan may require that the maternity services be provided by a licensed midwife or certified nurse midwife under contract with the plan.

(d) As used in this section, "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 shall not include policies or plans providing coverage for specific disease or other limited benefit coverage.

Sec. 2. 18 V.S.A. chapter 30 is added to read:

CHAPTER 30. MATERNAL MORTALITY REVIEW PANEL

§ 1551. DEFINITIONS

As used in this chapter:

(1) "Maternal mortality" or "maternal death" means:

(A) pregnancy-associated death;

(B) pregnancy-related death; or

(C) pregnancy-associated but not pregnancy-related death.

(2) "Pregnancy-associated death" means the death of a woman while pregnant or within one year following the end of pregnancy, irrespective of cause.

(3) "Pregnancy-associated, but not pregnancy-related death" means the death of a woman while pregnant or within one year following the end of pregnancy due to a cause unrelated to pregnancy.

(4) "Pregnancy-related death" means the death of a woman while pregnant or within one year following the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes.

§ 1552. MATERNAL MORTALITY REVIEW PANEL ESTABLISHED

(a) There is established a maternal mortality review panel to conduct comprehensive, multidisciplinary reviews of maternal deaths in Vermont for the purposes of identifying factors associated with the deaths and making recommendations for system changes to improve health care services for women in this state. The members of the panel shall be appointed by the

commissioner of health as follows:

(1) Two members from the Vermont section of the American College of Obstetricians and Gynecologists, one of whom shall be a generalist obstetrician and one of whom shall be a maternal fetal medicine specialist.

(2) One member from the Vermont chapter of the American Academy of Pediatrics, specializing in neonatology.

(3) One member from the Vermont chapter of the American College of Nurse-Midwives.

(4) One member who is a midwife licensed pursuant to chapter 85 of Title 26.

(5) One member from the Vermont section of the Association of Women's Health, Obstetric and Neonatal Nurses.

(6) The director of the division of maternal and child health in the Vermont department of health, or designee.

(7) An epidemiologist from the department of health with experience analyzing perinatal data, or designee.

(8) The chief medical examiner or designee.

(9) A representative of the community mental health centers.

(10) A member of the public.

(b) The term of each member shall be three years and the terms shall be staggered. The commissioner shall appoint the initial chair of the panel, who shall call the first meeting of the panel and serve as chair for six months, after which time the panel shall elect its chair. Members of the panel shall receive no compensation.

(c) The commissioner may delegate to the Northern New England Perinatal Quality Improvement Network (NNEPQIN) the functions of collecting, analyzing, and disseminating maternal mortality information; organizing and convening meetings of the panel; and such other substantive and administrative tasks as may be incident to these activities. The activities of the NNEPQIN and its employees or agents shall be subject to the same confidentiality provisions as apply to members of the panel.

§ 1553. DUTIES

(a) The panel, in collaboration with the commissioner of health or designee, shall conduct comprehensive, multidisciplinary reviews of maternal mortality in Vermont.

(b) Each member of the panel shall be responsible for disseminating panel recommendations to his or her respective institution and professional organization, as applicable. All such information shall be disseminated through the institution's or organization's quality assurance program in order to protect the confidentiality of all participants and patients involved in any incident.

(c) On or before January 15 of each year, the commissioner of health shall submit a report to the house committees on health care and on human services and the senate committee on health and welfare containing at least the following information:

(1) a description of the adverse events reviewed by the panel during the preceding 12 months, including statistics and causes;

(2) corrective action plans to address, in the aggregate, such adverse events; and

(3) recommendations for system changes and legislation relating to the delivery of health care in Vermont.

(d) The panel shall not:

(1) Call witnesses or take testimony from any individual involved in the investigation of a maternal death.

(2) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except to the extent that a member of the panel is involved in the investigation of a maternal death or resulting prosecution and must participate in a legal proceeding in the course of performing his or her duties outside the panel.

§ 1554. CONFIDENTIALITY

(a) The panel's proceedings, records, and opinions shall be confidential and shall not be subject to inspection or review under subchapter 3 of chapter 5 of Title 1 or to discovery, subpoena, or introduction into evidence in any civil or criminal proceeding; provided, however, that nothing in this subsection shall be construed to limit or restrict the right to discover or use in any civil or criminal proceeding anything that is available from another source and entirely independent of the panel's proceedings.

(b) Members of the panel shall not be questioned in any civil or criminal proceeding regarding the information presented in or opinions formed as a result of a meeting of the panel; provided, however, that nothing in this subsection shall be construed to prevent a member of the panel from testifying to information obtained independently of the panel or which is public information.

§ 1555. INFORMATION RELATED TO MATERNAL MORTALITY

(a)(1) Health care providers; health care facilities; clinics; laboratories; medical records departments; and state offices, agencies, and departments shall report all maternal mortality deaths to the chair of the maternal mortality review panel and to the commissioner of health or designee.

(2) The commissioner and the chair may acquire the information described in subdivision (1) of this subsection from health care facilities, maternal mortality review programs, and other sources in other states to ensure that the panel's records of Vermont maternal mortality cases are accurate and complete.

(b)(1) The commissioner shall have access to individually identifiable information relating to the occurrence of maternal deaths only on a case-by-case basis where public health is at risk. As used in this section, "individually identifiable information" includes vital records; hospital discharge data; prenatal, fetal, pediatric, or infant medical records; hospital or clinic records; laboratory reports; records of fetal deaths or induced terminations of pregnancies; and autopsy reports.

(2) The commissioner or designee may retain identifiable information regarding facilities where maternal deaths occur and geographic information on each case solely for the purposes of trending and analysis over time. In accordance with the rules adopted pursuant to subdivision 1556(4) of this title, all individually identifiable information on individuals and identifiable information on facilities shall be removed prior to any case review by the panel.

(2) The chair shall not acquire or retain any individually identifiable information.

(c) If a root cause analysis of a maternal mortality event has been completed, the findings of such analysis shall be included in the records supplied to the review panel.

§ 1556. RULEMAKING

The commissioner of health, with the advice and recommendation of a majority of the members of the panel, shall adopt rules pursuant to chapter 25 of Title 3 related to the following:

(1) The system for identifying and reporting maternal deaths to the commissioner or designee.

(2) The form and manner through which the panel may acquire information under section 1555 of this title.

(3) The protocol to be used in carefully and sensitively contacting a family member of the deceased woman for a discussion of the events surrounding the death, including allowing grieving family members to delay or refuse such an interview.

(4) Ensuring de-identification of all individuals and facilities involved in the panel's review of cases.

Sec. 3. 18 V.S.A. § 5087 is amended to read:

§ 5087. ESTABLISHMENT OF BIRTH INFORMATION NETWORK

(a) The commissioner of health shall establish a statewide birth information network designed to identify newborns who have specified health conditions which may respond to early intervention and treatment by the health care system.

(b) The department of health is authorized to collect information for the birth information network for the purpose of preventing and controlling disease, injury, and disability. The commissioner of health, in collaboration with appropriate partners, shall coordinate existing data systems and records to enhance the network's comprehensiveness and effectiveness, including:

(1) Vital records (birth, death, and fetal death certificates).

(2) The children with special health needs database.

(3) Newborn metabolic screening.

(4) Universal newborn hearing screening.

(5) The hearing outreach program.

(6) The cancer registry.

(7) The lead screening registry.

(8) The immunization registry.

(9) The special supplemental nutrition program for women, infants, and children.

(10) The Medicaid claims database.

(11) The hospital discharge data system.

(12) Health records (such as discharge summaries, disease indexes, nursery logs, pediatric logs, and neonatal intensive care unit logs) from hospitals, outpatient specialty clinics, genetics clinics, and cytogenetics laboratories.

(13) The Vermont health care claims uniform reporting and evaluation

system.

(c) The commissioner of health shall refer to the report submitted to the general assembly by the birth information council, pursuant to section 5086 of this title, for the purpose of establishing guiding principles for the research and decision-making necessary for the development of the birth information network.

(d) The network shall provide information on public health activities, such as surveillance, assessment, and planning for interventions to improve the health and quality of life for Vermont's infants and children and their families. This information shall be used for improving health care delivery systems and outreach and referral services for families with children with special health needs and for determining measures that can be taken to prevent further medical conditions.

(e) The network shall be designed to follow infants and children up to one year of age with the 40 medical conditions listed in the matrix developed by the birth information council which have been selected as identifiable via existing Vermont data systems and are considered to be representative of the most significant health conditions of newborns in Vermont, including conditions relating to upper and lower limbs. The department of health is authorized to amend the list of medical conditions through rulemaking pursuant to chapter 25 of Title 3 to meet the objectives of this section.

(f) The network's data system shall be designed to coordinate with the data systems of other states so that data on out-of-state births to Vermont residents will be captured for vital records, case ascertainment, and follow-up services. The commissioner of health is authorized to enter into interstate agreements containing the necessary conditions for information transmission.

(g) The commissioner of health shall compile information every two years to document possible links between environmental and chemical exposure with the special health conditions of Vermont's infants and children.

(h) The department of health shall develop a form that contains a description of the birth information network and the purpose of the network. The form shall include a statement that the parent or guardian of a child may contact the department of health and have his or her child's personally identifying information removed from the network, using a process developed by the advisory committee.

Sec. 4. 18 V.S.A. chapter 104 is added to read:

CHAPTER 104. BIRTH RECORDS

§ 5112. ISSUANCE OF NEW BIRTH CERTIFICATE; CHANGE OF SEX

(a) Upon receiving from the probate division of the superior court a court order that an individual's sexual reassignment has been completed, the state registrar shall issue a new birth certificate to show that the sex of the individual born in this state has been changed.

(b) An affidavit by a licensed physician who has treated or evaluated the individual stating that the individual has undergone surgical, hormonal, or other treatment appropriate for that individual for the purpose of gender transition shall constitute sufficient evidence for the court to issue an order that sexual reassignment has been completed. The affidavit shall include the medical license number and signature of the physician.

(c) A new certificate issued pursuant to subsection (a) of this section shall be substituted for the original birth certificate in official records. The new certificate shall not show that a change in name or sex, or both, has been made. The original birth certificate, the probate court order, and any other records relating to the issuance of the new birth certificate shall be confidential and shall not be subject to public inspection pursuant to 1 V.S.A. § 317(c); however an individual may have access to his or her own records and may authorize the state registrar to confirm that, pursuant to court order, it has issued a new birth certificate to the individual that reflects a change in name or sex, or both.

(d) If an individual born in this state has an amended birth certificate showing that the sex of the individual has been changed, and the birth certificate is marked "Court Amended" or otherwise clearly shows that it has been amended, the individual may receive a new birth certificate from the state registrar upon application.

Sec. 5. 26 V.S.A. § 4187 is amended to read:

§ 4187. RENEWALS

(a)(1) Biennially, the director shall forward a renewal form to each licensed midwife. The completed form shall include verification that during the preceding two years, the licensed midwife has:

(A) completed 20 hours of continuing education approved by the director by rule;

(B) participated in at least four peer reviews;

(C) submitted individual practice data; ~~and~~

(D) maintained current cardiopulmonary resuscitation certification; and

(E) filed a timely certificate of birth for each birth at which he or she

was the attending midwife, as required by law.

(2) Upon receipt of the completed form and of the renewal fee, the director shall issue a renewal license to applicants who qualify under this section.

* * *

Sec. 6. 26 V.S.A. § 4190 is amended to read:

§ 4190. WRITTEN PLAN FOR CONSULTATION, EMERGENCY TRANSFER, AND TRANSPORT

(a) Every licensed midwife shall develop a written plan for consultation with physicians licensed under chapter 23 of this title and other health care providers for emergency transfer, for transport of an infant to a newborn nursery or neonatal intensive care nursery, and for transport of a woman to an appropriate obstetrical department or patient care area. The written plan shall be submitted to the director on an approved form with the application required by section 4184 of this title and biennially thereafter with the renewal form required by section 4187 of this title. The written transport plan shall be reviewed and approved by the advisors appointed pursuant to section 4186 of this title and shall be provided to any health care facility or health care professional identified in the plan. The director, in consultation with the advisors, the commissioner of health, and other interested parties, shall develop a single, uniform form for use in all cases in which a transfer or transport occurs, which shall include the medical information needed by the facility or professional receiving the transferred or transported patient.

(b)(1) A licensed midwife shall, within 30 days of a birth or sentinel event, complete any peer review that is both required by rules governing licensed midwives and which is generated due to a death, significant morbidity to client or child, transfer to hospital, or to practice performed outside the standards for midwives as set forth in the rules governing licensed midwives. This peer review report shall be submitted to the office of professional regulation within 30 days of its completion.

(2) During the peer review process, other health care professionals engaged in the care or treatment of the client may provide written input to the peer review panel related to quality assurance and other matters within or related to the licensed midwife's scope of practice. The written comments shall be filed with the office of professional regulation and subject to the same confidentiality provisions as apply to other documents related to peer reviews. Upon completion of the peer review process, the director shall provide notice of the final disposition of the peer review to all health care professionals who submitted input pursuant to this subdivision.

Sec. 7. DATA SUBMISSION

Each midwife licensed pursuant to chapter 85 of Title 26 and each advanced practice registered nurse licensed pursuant to chapter 28 of Title 26 who is certified as a nurse midwife shall submit data to the database maintained by the Division of Research of the Midwives Alliance of North America regarding each home birth in Vermont for which he or she is the attending midwife.

Sec. 8. DEPARTMENT OF HEALTH; REPORTING REQUIREMENT

(a) The department of health shall access the database maintained by the Division of Research of the Midwives Alliance of North America to obtain information relating to care provided in Vermont by midwives licensed pursuant to chapter 85 of Title 26 and by advanced practice registered nurses licensed pursuant to chapter 28 of Title 26 who are certified as nurse midwives.

(b) No later than March 15 of each year from 2012 through 2016, inclusive, the commissioner of health or designee shall provide testimony to the house committee on health care and the senate committee on health and welfare regarding the activities of licensed midwives and certified nurse midwives performing home births and providing prenatal and postnatal care in a nonmedical environment during the preceding year. The testimony shall include the number of home births in Vermont, the number of hospital transports associated with home births, the treatment of high-risk patients, and other relevant data, as well as the level of compliance of the licensed midwives and certified nurse midwives with the laws and rules governing their scope of practice.

Sec. 9. EFFECTIVE DATES

(a) Sec. 1 of this act shall take effect on October 1, 2011, and shall apply to all health insurance plans and health benefit plans on and after October 1, 2011, on such date as a health insurer issues, offers, or renews the plan, but in no event later than October 1, 2012.

(b) The remaining sections of this act shall take effect on passage.

(Committee vote: 10-0-1)

(For text see Senate Journal 4/5 - 4/6/11)

S. 17

An act relating to licensing a nonprofit organization to dispense marijuana for therapeutic purposes

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

Sec. 1. 18 V.S.A. chapter 86, subchapter 2 is amended to read:

Subchapter 2. Marijuana for Medical Symptom Use by Persons with Severe Illness

§ 4472. DEFINITIONS

For the purposes of this subchapter:

(1) "Bona fide ~~physician-patient~~ health care professional–patient relationship" means a treating or consulting relationship of not less than six months duration, in the course of which a ~~physician~~ health care professional has completed a full assessment of the registered patient's medical history and current medical condition, including a personal physical examination.

(2) "Clone" means a plant section from a female marijuana plant not yet root-bound, growing in a water solution, which is capable of developing into a new plant.

(3) "Criminal history record" means all information documenting an individual's contact with the criminal justice system, including data regarding identification, arrest or citation, arraignment, judicial disposition, custody, and supervision.

(4) "Debilitating medical condition," provided that, in the context of the specific disease or condition described in subdivision (A) or (B) of this subdivision ~~(2)~~(4), reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms, means:

(A) cancer, multiple sclerosis, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or the treatment of these conditions, if the disease or the treatment results in severe, persistent, and intractable symptoms; or

(B) a disease, medical condition, or its treatment that is chronic, debilitating, and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome; severe pain; severe nausea; or seizures.

(5) "Dispensary" means a nonprofit entity registered under section

4474e of this title which acquires, possesses, cultivates, manufactures, transfers, transports, supplies, sells, or dispenses marijuana, marijuana-infused products, and marijuana-related supplies and educational materials for or to a registered patient who has designated it as his or her center and to his or her registered caregiver for the registered patient's use for symptom relief. A dispensary may provide marijuana for symptom relief to registered patients at only one facility or location but may have a second location associated with the dispensary where the marijuana is cultivated. Both locations are considered to be part of the same dispensary.

(6) "Health care professional" means an individual licensed to practice medicine under chapter 23 or 33 of Title 26, an individual certified as a physician's assistant under chapter 31 of Title 26, or an individual licensed as an advanced practice registered nurse under chapter 28 of Title 26. This definition includes individuals who are professionally licensed under substantially equivalent provisions in New Hampshire, Massachusetts, or New York.

(7) "Immature marijuana plant" means a female marijuana plant that has not flowered and which does not have buds that may be observed by visual examination.

~~(3)~~(8) "Marijuana" shall have the same meaning as provided in subdivision 4201(15) of this title.

~~(4) "Physician" means a person who is:~~

~~(A) licensed under chapter 23 or chapter 33 of Title 26, and is licensed with authority to prescribe drugs under Title 26; or~~

~~(B) a physician, surgeon, or osteopathic physician licensed to practice medicine and prescribe drugs under comparable provisions in New Hampshire, Massachusetts, or New York.~~

(9) "Mature marijuana plant" means a female marijuana plant that has flowered and which has buds that may be observed by visual examination.

~~(5)~~(10) "Possession limit" means the amount of marijuana collectively possessed between the registered patient and the patient's registered caregiver which is no more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana.

~~(6)~~(11) "Registered caregiver" means a person who is at least 21 years old who has never been convicted of a drug-related crime and who has agreed to undertake responsibility for managing the well-being of a registered patient with respect to the use of marijuana for symptom relief.

~~(7)~~(12) "Registered patient" means a ~~person~~ resident of Vermont who

has been issued a registration card by the department of public safety identifying the person as having a debilitating medical condition pursuant to the provisions of this subchapter. "Resident of Vermont" means a person whose domicile is Vermont.

~~(8)~~(13) "Secure indoor facility" means a building or room equipped with locks or other security devices that permit access only by a registered caregiver ~~or~~, registered patient, or a principal officer or employee of a dispensary.

~~(9)~~(14) "Usable marijuana" means the dried leaves and flowers of marijuana, and any mixture or preparation thereof, and does not include the seeds, stalks, and roots of the plant.

~~(10)~~(15) "Use for symptom relief" means the acquisition, possession, cultivation, use, transfer, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a registered patient's debilitating medical condition which is in compliance with all the limitations and restrictions of this subchapter. For the purposes of this definition, "transfer" is limited to the transfer of marijuana and paraphernalia between a registered caregiver and a registered patient.

§ 4473. REGISTERED PATIENTS; QUALIFICATION STANDARDS AND PROCEDURES

(a) To become a registered patient, a person must be diagnosed with a debilitating medical condition by a ~~physician~~ health care professional in the course of a bona fide ~~physician-patient~~ health care professional–patient relationship.

(b) The department of public safety shall review applications to become a registered patient using the following procedures:

(1) A patient with a debilitating medical condition shall submit, under oath, a signed application for registration to the department. If the patient is under the age of 18, the application must be signed by both the patient and a parent or guardian. The application shall require identification and contact information for the patient and the patient's registered caregiver applying for authorization under section 4474 of this title, if any, and the patient's designated dispensary under section 4474e of this title, if any. The applicant shall attach to the application a medical verification form developed by the department pursuant to subdivision (2) of this subsection.

(2) The department of public safety shall develop a medical verification form to be completed by a ~~physician~~ health care professional and submitted by a patient applying for registration in the program. The form shall include:

(A) A cover sheet which includes the following:

(i) A statement of the penalties for providing false information.

(ii) Definitions of the following statutory terms:

(I) "Bona fide ~~physician-patient~~ health care professional–patient relationship" as defined in ~~subdivision 4472(1)~~ section 4472 of this title.

(II) "Debilitating medical condition" as defined in ~~subdivision 4472(2)~~ section 4472 of this title.

(III) "~~Physician~~ Health care professional" as defined in ~~subdivision 4472(4)~~ section 4472 of this title.

(B) A verification sheet which includes the following:

(i) A statement that a bona fide ~~physician-patient~~ health care professional–patient relationship exists under ~~subdivision 4472(1)~~ section 4472 of this title, or that under subdivision (3)(A) of this subsection (b), the debilitating medical condition is of recent or sudden onset, and the patient has not had a previous ~~physician~~ health care professional who is able to verify the nature of the disease and its symptoms.

(ii) A statement that reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms.

(iii) A statement that the patient has a debilitating medical condition as defined in ~~subdivision 4472(2)~~ section 4472 of this title, including the specific disease or condition which the patient has and whether the patient meets the criteria under ~~subdivision 4472(2)(A) or (B)~~ section 4472.

(iv) A signature line which provides in substantial part: "I certify that I meet the definition of ~~"physician' under 18 V.S.A. § 4472(4)(A) or 4472(4)(B)~~ 'health care professional' under 18 V.S.A. § 4472, that I am a ~~physician~~ health care professional in good standing in the state of ....., and that the facts stated above are accurate to the best of my knowledge and belief."

(v) The ~~physician's~~ health care professional's contact information, license number, category of his or her health care profession as defined in subdivision 4472(6) of this title, and contact information for the out-of-state licensing agency, if applicable. The department of public safety shall adopt rules for verifying the goodstanding of out-of-state health care professionals.

(3)(A) The department of public safety shall transmit the completed medical verification form to the ~~physician~~ health care professional and contact him or her for purposes of confirming the accuracy of the information contained in the form. The department may approve an application,

notwithstanding the six-month requirement in ~~subdivision 4472(1)~~ section 4472 of this title, if the department is satisfied that the medical verification form confirms that the debilitating medical condition is of recent or sudden onset, and that the patient has not had a previous ~~physician~~ health care professional who is able to verify the nature of the disease and its symptoms.

(B) If the ~~physician~~ health care professional is licensed in another state as provided ~~by subdivision~~ ~~4472(4)(B)~~ section 4472 of this title, the department shall ~~contact the state's medical practice board and~~ verify that the ~~physician~~ health care professional is in good standing in that state.

(4) The department shall approve or deny the application for registration in writing within 30 days from receipt of a completed registration application. If the application is approved, the department shall issue the applicant a registration card which shall include the registered patient's name and photograph, ~~as well as~~ the registered patient's designated dispensary, if any, and a unique identifier for law enforcement verification purposes under section 4474d of this title.

(5)(A) A review board is established. The medical practice board shall appoint three physicians licensed in Vermont to constitute the review board. If an application under subdivision (1) of this subsection is denied, within seven days the patient may appeal the denial to the board. Review shall be limited to information submitted by the patient under subdivision (1) of this subsection, and consultation with the patient's treating ~~physician~~ health care professional. All records relating to the appeal shall be kept confidential. An appeal shall be decided by majority vote of the members of the board.

(B) The board shall meet periodically to review studies, data, and any other information relevant to the use of marijuana for symptom relief. The board may make recommendations to the general assembly for adjustments and changes to this chapter.

(C) Members of the board shall serve for three-year terms, beginning February 1 of the year in which the appointment is made, except that the first members appointed shall serve as follows: one for a term of two years, one for a term of three years, and one for a term of four years. Members shall be entitled to per diem compensation authorized under ~~section 1010 of Title 32~~ 32 V.S.A. § 1010. Vacancies shall be filled in the same manner as the original appointment for the unexpired portion of the term vacated.

§ 4474. REGISTERED CAREGIVERS; QUALIFICATION STANDARDS AND PROCEDURES

(a) A person may submit a signed application to the department of public

safety to become a registered patient's registered caregiver. The department shall approve or deny the application in writing within 30 days. The department shall approve a registered caregiver's application and issue the person an authorization card, including the caregiver's name, photograph, and a unique identifier, after verifying:

(1) the person will serve as the registered caregiver for one registered patient only; and

(2) the person has never been convicted of a drug-related crime.

(b) Prior to acting on an application, the department shall obtain from the Vermont criminal information center a Vermont criminal record, an out-of-state criminal record, and a criminal record from the Federal Bureau of Investigation for the applicant. For purposes of this subdivision, "criminal record" means a record of whether the person has ever been convicted of a drug-related crime. Each applicant shall consent to release of criminal records to the department on forms substantially similar to the release forms developed by the center pursuant to ~~section 2056c of Title 20~~ 20 V.S.A. § 2056c. The department shall comply with all laws regulating the release of criminal history records and the protection of individual privacy. The Vermont criminal information center shall send to the requester any record received pursuant to this section or inform the department of public safety that no record exists. If the department disapproves an application, the department shall promptly provide a copy of any record of convictions and pending criminal charges to the applicant and shall inform the applicant of the right to appeal the accuracy and completeness of the record pursuant to rules adopted by the Vermont criminal information center. No person shall confirm the existence or nonexistence of criminal record information to any person who would not be eligible to receive the information pursuant to this subchapter.

(c) A registered caregiver may serve only one registered patient at a time, and a registered patient may have only one registered caregiver at a time.

§ 4474a. REGISTRATION; FEES

(a) The department shall collect a fee of $50.00 for the application authorized by sections 4473 and 4474 of this title. The fees received by the department shall be deposited into a registration fee fund and used to offset the costs of processing applications under this subchapter.

(b) A registration card shall expire one year after the date of issue, with the option of renewal, provided the patient submits a new application which is approved by the department of public safety, pursuant to section 4473 or 4474 of this title, and pays the fee required under subsection (a) of this section.

§ 4474b. EXEMPTION FROM CRIMINAL AND CIVIL PENALTIES; SEIZURE OF PROPERTY

(a) A person who has in his or her possession a valid registration card issued pursuant to this subchapter and who is in compliance with the requirements of this subchapter, including the possession limits in ~~subdivision 4472(4)~~ section 4472 of this title, shall be exempt from arrest or prosecution under subsection 4230(a) of this title and from seizure of marijuana, marijuana-infused products, and marijuana-related supplies.

(b) A ~~physician~~ health care professional who has participated in a patient's application process under subdivision 4473(b)(2) of this title shall not be subject to arrest, prosecution, or disciplinary action under chapter 23 of Title 26, penalized in any manner, or denied any right or privilege under state law, except for giving false information, pursuant to subsection 4474c(f) of this title.

(c) No person shall be subject to arrest or prosecution for constructive possession, conspiracy, or any other offense for simply being in the presence or vicinity of a registered patient or registered caregiver engaged in use of marijuana for symptom relief.

(d) A law enforcement officer shall not be required to return marijuana ~~or paraphernalia relating to its use~~, marijuana-infused products, and marijuana-related supplies seized from a registered patient or registered caregiver. However, if marijuana or marijuana-infused products are seized by a law enforcement officer and if there is a subsequent determination that the patient or caregiver was in compliance with this subchapter, the seized marijuana and marijuana-infused products shall not count toward the possession limits or dispensary allocation set forth in this subchapter for the patient or caregiver.

(e) A dispensary may donate marijuana, marijuana-infused products, and marijuana-related supplies to another dispensary in Vermont provided that no consideration is paid and that the recipient does not exceed the possession limits specified in this subchapter.

§ 4474c. PROHIBITIONS, RESTRICTIONS, AND LIMITATIONS REGARDING THE USE OF MARIJUANA FOR SYMPTOM RELIEF

(a) This subchapter shall not exempt any person from arrest or prosecution for:

(1) Being under the influence of marijuana while:

(A) operating a motor vehicle, boat, or vessel, or any other vehicle propelled or drawn by power other than muscular power;

(B) in a workplace or place of employment; or

(C) operating heavy machinery or handling a dangerous instrumentality.

(2) The use or possession of marijuana or marijuana-infused products by a registered patient or the possession of marijuana or marijuana-infused products by a registered caregiver:

(A) for purposes other than symptom relief as permitted by this subchapter; or

(B) in a manner that endangers the health or well-being of another person.

(3) The smoking of marijuana in any public place, including:

(A) a school bus, public bus, or other public vehicle;

(B) a workplace or place of employment;

(C) any school grounds;

(D) any correctional facility; or

(E) any public park, public beach, public recreation center, or youth center.

(b) This chapter shall not be construed to require that coverage or reimbursement for the use of marijuana for symptom relief be provided by:

(1) a health insurer as defined by section 9402 of this title, or any insurance company regulated under Title 8;

(2) Medicaid, Vermont health access plan, and any other public health care assistance program;

(3) an employer; or

(4) for purposes of workers' compensation, an employer as defined in 21 V.S.A. § 601(3).

(c) A registered patient or registered caregiver who elects to grow marijuana to be used for symptom relief by the patient may do so only if the marijuana is cultivated in a single, secure indoor facility.

(d) A registered patient or registered caregiver may not transport marijuana in public unless it is secured in a locked container.

(e) Within 72 hours after the death of a registered patient, the patient's

registered caregiver shall return to the department of public safety for disposal any marijuana or marijuana plants in the possession of the patient or registered caregiver at the time of the patient's death. If the patient did not have a registered caregiver, the patient's next of kin shall contact the department of public safety within 72 hours after the patient's death and shall ask the department to retrieve such marijuana and marijuana plants for disposal.

(f) Notwithstanding any law to the contrary, a person who knowingly gives to any law enforcement officer false information to avoid arrest or prosecution, or to assist another in avoiding arrest or prosecution, shall be imprisoned for not more than one year or fined not more than $1,000.00 or both. This penalty shall be in addition to any other penalties that may apply for the possession or use of marijuana.

§ 4474d. LAW ENFORCEMENT VERIFICATION OF INFORMATION; RULEMAKING

(a) The department of public safety shall maintain and keep confidential, except as provided in subsection (b) of this section and except for purposes of a prosecution for false swearing under 13 V.S.A. § 2904, the records of all persons registered under this subchapter or registered caregivers in a secure database accessible by authorized department of public safety ~~employee's~~ employees only.

(b) In response to a person-specific or property-specific inquiry by a law enforcement officer or agency made in the course of a bona fide investigation or prosecution, the department may verify the identities and registered property addresses of the registered patient and the patient's registered caregiver, a dispensary, and the principal officer, the board members, or the employees of a dispensary.

(c) The department shall maintain a separate secure electronic database accessible to law enforcement personnel 24 hours a day that uses a unique identifier system to allow law enforcement to verify that a person or entity is a registered patient, ~~or~~ a registered caregiver, a dispensary, or the principal officer, a board member, or an employee of a dispensary.

(d) The department of public safety shall implement the requirements of this act within 120 days of its effective date. The department may adopt rules under chapter 25 of Title 3 and shall develop forms to implement this act.

§ 4474e. DISPENSARIES; CONDITIONS OF OPERATION

(a) A dispensary registered under this section may:

(1) Acquire, possess, cultivate, manufacture, transfer, transport, supply, sell, and dispense marijuana, marijuana-infused products, and

marijuana-related supplies and educational materials for or to a registered patient who has designated it as his or her dispensary and to his or her registered caregiver for the registered patient's use for symptom relief. For purposes of this section, "transport" shall mean the movement of marijuana or marijuana-infused products from licensed growing locations to their associated dispensaries, between dispensaries, or as otherwise allowed under this subchapter.

(A) Marijuana-infused products shall include tinctures, oils, solvents, and edible or potable goods. Only the portion of any marijuana-infused product that is attributable to marijuana shall count toward the possession limits of the dispensary and the patient. The department of public safety shall establish by rule the appropriate method to establish the weight of marijuana that is attributable to marijuana-infused products.

(B) Marijuana-related supplies shall include pipes, vaporizers, and other items classified as drug paraphernalia under chapter 69 of this title.

(2) Acquire marijuana seeds or parts of the marijuana plant capable of regeneration from or dispense them to registered patients or their caregivers or acquire them from another registered Vermont dispensary, provided that records are kept concerning the amount and the recipient.

(3) Cultivate and possess at any one time up to 28 mature marijuana plants, 98 immature marijuana plants, and 28 ounces of usable marijuana. However, if a dispensary is designated by more than 14 registered patients, the dispensary may cultivate and possess at any one time two mature marijuana plants, seven immature plants, and two ounces of usable marijuana for every registered patient for which the dispensary serves as the designated dispensary.

(b)(1) A dispensary shall be operated on a nonprofit basis for the mutual benefit of its patients but need not be recognized as a tax-exempt organization by the Internal Revenue Service.

(2) A dispensary shall have a sliding-scale fee system that takes into account a registered patient's ability to pay.

(c) A dispensary shall not be located within 1,000 feet of the property line of a preexisting public or private school or licensed or regulated child care facility.

(d)(1) A dispensary shall implement appropriate security measures to deter and prevent the unauthorized entrance into areas containing marijuana and the theft of marijuana and shall ensure that each location has an operational security alarm system. All cultivation of marijuana shall take place in an enclosed, locked facility which is either indoors or otherwise not visible to the

public and which can only be accessed by principal officers and employees of the dispensary who have valid registry identification cards. The department of public safety shall perform an annual on-site assessment of each dispensary and may perform on-site assessments of a dispensary without limitation for the purpose of determining compliance with this subchapter and any rules adopted pursuant to this subchapter and may enter a dispensary at any time for such purpose. During an inspection, the department may review the dispensary's confidential records, including its dispensing records, which shall track transactions according to registered patients' registry identification numbers to protect their confidentiality.

(2) A registered patient or registered caregiver may obtain marijuana from the dispensary facility by appointment only.

(3) The operating documents of a dispensary shall include procedures for the oversight of the dispensary and procedures to ensure accurate record-keeping.

(4) A dispensary shall submit the results of an annual financial audit to the department of public safety no later than 60 days after the end of the dispensary's fiscal year. The annual audit shall be conducted by an independent certified public accountant, and the costs of any such audit shall be borne by the dispensary. The department may also periodically require, within its discretion, the audit of a dispensary's financial records by the department.

(5) A dispensary shall destroy or dispose of marijuana, marijuana-infused products, clones, seeds, parts of marijuana that are not usable for symptom relief or are beyond the possession limits provided by this subchapter, and marijuana-related supplies only in a manner approved by rules adopted by the department of public safety.

(e) A registered patient shall not consume marijuana for symptom relief on dispensary property.

(f) A person may be denied the right to serve as a principal officer, board member, or employee of a dispensary because of the person's criminal history record in accordance with section 4474g of this title and rules adopted by the department of public safety pursuant to that section.

(g)(1) A dispensary shall notify the department of public safety within 10 days of when a principal officer, board member, or employee ceases to be associated with or work at the dispensary. His or her registry identification card shall be deemed null and void, and the person shall be liable for any penalties that may apply.

(2) A dispensary shall notify the department of public safety in writing of the name, address, and date of birth of any proposed new principal officer, board member, or employee and shall submit a fee for a new registry identification card before a new principal officer, board member, or employee begins his or her official duties related to the dispensary and shall submit a complete set of fingerprints for the prospective principal officer, board member, or employee.

(h) A dispensary shall include a label on the packaging of all marijuana that is dispensed. The label shall identify the particular strain of marijuana contained therein. Cannabis strains shall be either pure breeds or hybrid varieties of cannabis and shall reflect properties of the plant. The label also shall contain a statement to the effect that the state of Vermont does not attest to the medicinal value of cannabis.

(i) Each dispensary shall develop, implement, and maintain on the premises employee policies and procedures to address the following requirements:

(1) A job description or employment contract developed for all employees which includes duties, authority, responsibilities, qualification, and supervision;

(2) Training in and adherence to confidentiality laws; and

(3) Training for employees required by subsection (j) of this section.

(j) Each dispensary shall maintain a personnel record for each employee that includes an application for employment and a record of any disciplinary action taken. Each dispensary shall provide each employee, at the time of his or her initial appointment, training in the following:

(1) The proper use of security measures and controls that have been adopted; and

(2) Specific procedural instructions on how to respond to an emergency, including robbery or violent incident.

(k)(1) No dispensary, principal officer, board member, or employee of a dispensary shall:

(A) Acquire, possess, cultivate, manufacture, transfer, transport, supply, sell, or dispense marijuana for any purpose except to assist a registered patient with the use of marijuana for symptom relief directly or through the qualifying patient's designated caregiver.

(B) Acquire usable marijuana or marijuana plants from any source other than registered dispensary principal officers, board members, or employees who cultivate marijuana in accordance with this subchapter.

(C) Dispense more than two ounces of usable marijuana to a registered patient directly or through the qualifying patient's registered caregiver during a 30-day period.

(D) Dispense an amount of usable marijuana to a qualifying patient or a designated caregiver that the principal officer, board member, or employee knows would cause the recipient to possess more marijuana than is permitted under this subchapter.

(E) Dispense marijuana to a person other than a registered patient who has designated the dispensary to provide for his or her needs or other than the patient's registered caregiver.

(2) A person found to have violated subdivision (1) of this subsection may no longer serve as a principal officer, board member, or employee of any dispensary, and such person's registry identification card shall be immediately revoked by the department of public safety.

(3) The board of a dispensary shall be required to report to the department of public safety any information regarding a person who violates this section.

(l)(1) A registered dispensary shall not be subject to the following provided that it is in compliance with this subchapter:

(A) Prosecution for the acquisition, possession, cultivation, manufacture, transfer, transport, supply, sale, or dispensing of marijuana, marijuana-infused products, or marijuana-related supplies for medical purposes in accordance with the provisions of this subchapter and any rule adopted by the department of public safety pursuant to this subchapter.

(B) Inspection and search, except pursuant to this subchapter or upon a search warrant issued by a court or judicial officer.

(C) Seizure of marijuana, marijuana-infused products, and marijuana-related supplies, except upon a valid order issued by a court.

(D) Imposition of any penalty or denied any right or privilege, including imposition of a civil penalty or disciplinary action by an occupational or professional licensing board or entity, solely for acting in accordance with this subchapter to assist registered patients or registered caregivers.

(2) No principal officer, board member, or employee of a dispensary shall be subject to arrest, prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including civil penalty or disciplinary action by a occupational or professional licensing board or entity, solely for working for or with a dispensary to engage in acts permitted by this subchapter.

§ 4474f. DISPENSARY APPLICATION, APPROVAL, AND REGISTRATION

(a)(1) The department of public safety shall adopt rules on the following:

(A) The form and content of dispensary registration and renewal applications.

(B) Minimum oversight requirements for a dispensary.

(C) Minimum record-keeping requirements for a dispensary.

(D) Minimum security requirements for a dispensary, which shall include a fully operational security alarm system. This provision shall apply to each location where marijuana will be grown, cultivated, harvested, or otherwise prepared for distribution by the dispensary or will be distributed by the dispensary.

(E) Procedures for suspending or terminating the registration of a dispensary that violates the provisions of this subchapter or the rules adopted pursuant to this subchapter.

(F) The medium and manner in which a dispensary may notify registered patients of its services.

(G) Procedures to guide reasonable determinations as to whether an applicant would pose a demonstrable threat to public safety if he or she were to be associated with a dispensary.

(H) Procedures for providing notice to applicants regarding federal law with respect to marijuana.

(2) The department of public safety shall adopt such rules with the goal of protecting against diversion and theft without imposing an undue burden on a registered dispensary or compromising the confidentiality of registered patients and their registered caregivers. Any dispensing records that a registered dispensary is required to keep shall track transactions according to registered patients' and registered caregivers' registry identification numbers, rather than their names, to protect confidentiality.

(b) Within 30 days of the adoption of rules, the department shall begin accepting applications for the operation of dispensaries. Within 365 days of the effective date of this section, the department shall grant registration certificates to four dispensaries, provided at least four applicants apply and meet the requirements of this section. No more than four dispensaries shall hold valid registration certificates at one time. The total statewide number of registered patients who have designated a dispensary shall not exceed 1,000 at any one time. Any time a dispensary registration certificate is revoked, is

relinquished, or expires, the department shall accept applications for a new dispensary. If at any time after one year after the effective date of this section fewer than four dispensaries hold valid registration certificates in Vermont, the department of public safety shall accept applications for a new dispensary.

(c) Each application for a dispensary registration certificate shall include all of the following:

(1) A nonrefundable application fee in the amount of $2,500.00 paid to the department of public safety.

(2) The legal name, articles of incorporation, and bylaws of the dispensary.

(3) The proposed physical address of the dispensary, if a precise address has been determined or, if not, the general location where it would be located.

(4) A description of the enclosed, locked facility where marijuana will be grown, cultivated, harvested, or otherwise prepared for distribution by the dispensary.

(5) The name, address, and date of birth of each principal officer and board member of the dispensary and a complete set of fingerprints for each of them.

(6) Proposed security and safety measures, which shall include at least one security alarm system for each location and planned measures to deter and prevent the unauthorized entrance into areas containing marijuana and the theft of marijuana.

(7) Proposed procedures to ensure accurate record-keeping.

(d) Any time one or more dispensary registration applications are being considered, the department of public safety shall solicit input from registered patients and registered caregivers.

(e) Each time a dispensary certificate is granted, the decision shall be based on the overall health needs of qualified patients. The following factors shall weigh heavily in the consideration of an application:

(1) Geographic convenience to patients from throughout the state of Vermont to a dispensary if the applicant were approved.

(2) The entity's ability to provide an adequate supply to the registered patients in the state.

(3) The entity's ability to demonstrate its board members' experience running a nonprofit organization or business.

(4) The comments, if any, of registered patients and registered

caregivers regarding which applicant should be granted a registration certificate.

(5) The sufficiency of the applicant's plans for record-keeping, which records shall be considered confidential health care information under Vermont law and are intended to be deemed protected health care information for purposes of the federal Health Insurance Portability and Accountability Act of 1996, as amended.

(6) The sufficiency of the applicant's plans for safety and security, including the proposed location and security devices employed.

(f) The department of public safety may deny an application for a dispensary if it determines that an applicant's criminal history record indicates that the person's association with a dispensary would pose a demonstrable threat to public safety.

(g) After a dispensary is approved but before it begins operations, it shall submit the following to the department of public safety:

(1) The legal name and articles of incorporation of the dispensary.

(2) The physical address of the dispensary.

(3) The name, address, and date of birth of each principal officer and board member of the dispensary along with a complete set of fingerprints for each.

(4) An annual license fee of not more than $32,000.00.

§ 4474g. DISPENSARY REGISTRY IDENTIFICATION CARD; CRIMINAL BACKGROUND CHECK

(a) Except as provided in subsection (b) of this section, the department of public safety shall issue each principal officer, board member, and employee of a dispensary a registry identification card or renewal card within 30 days of receipt of the person's name, address, and date of birth and a fee of $50.00. A person shall not serve as principal officer, board member, or employee of a dispensary until that person has received a registry identification card issued under this section. Each card shall specify whether the cardholder is a principal officer, board member, or employee of a dispensary and shall contain the following:

(1) The name, address, and date of birth of the person.

(2) The legal name of the dispensary with which the person is affiliated.

(3) A random identification number that is unique to the person.

(4) The date of issuance and the expiration date of the registry identification card.

(5) A photograph of the person.

(b) Prior to acting on an application for a registry identification card, the department of public safety shall obtain with respect to the applicant a Vermont criminal history record, an out-of-state criminal history record, and a criminal history record from the Federal Bureau of Investigation. Each applicant shall consent to the release of criminal history records to the department on forms substantially similar to the release forms developed in accordance with 20 V.S.A. § 2056c.

(c) When the department of public safety obtains a criminal history record, the department shall promptly provide a copy of the record to the applicant and to the principal officer and board of the dispensary if the applicant is to be an employee. The department shall inform the applicant of the right to appeal the accuracy and completeness of the record pursuant to rules adopted by the department.

(d) The department of public safety shall comply with all laws regulating the release of criminal history records and the protection of individual privacy. No person shall confirm the existence or nonexistence of criminal history record information to any person who would not be eligible to receive the information pursuant to this subchapter.

(e) The department of public safety shall not issue a registry identification card to any applicant who has been convicted of a drug-related offense or a violent felony or who has a pending charge for such an offense. For purposes of this subchapter, "violent felony" means a listed crime as defined in 13 V.S.A. § 5301(7) or an offense involving sexual exploitation of children in violation of chapter 64 of Title 13.

(f) The department of public safety shall adopt rules for the issuance of a registry identification card and shall set forth standards for determining whether an applicant should be denied a registry identification card because his or her criminal history record indicates that the person's association with a dispensary would pose a demonstrable threat to public safety. The rules shall consider whether a person who has a conviction for an offense not listed in subsection (e) of this section has been rehabilitated. A conviction for an offense not listed in subsection (e) of this section shall not automatically disqualify a person for a registry identification card. A dispensary may deny a person the opportunity to serve as a board member or an employee based on his or her criminal history record. An applicant who is denied a registry identification card may appeal the department of public safety's determination

in superior court in accordance with Rule 75 of the Vermont Rules of Civil Procedure.

(g) A registration identification card of a principal officer, board member, or employee shall expire one year after its issuance or upon the expiration of the registered organization's registration certificate, whichever occurs first.

§ 4474h. PATIENT DESIGNATION OF DISPENSARY

(a) A registered patient may obtain marijuana only from the patient's designated dispensary and may designate only one dispensary. A registered patient and his or her caregiver may not grow marijuana for symptom relief if the patient designates a dispensary. A registered patient who wishes to change his or her dispensary shall notify the department of public safety in writing on a form issued by the department and shall submit with the form a fee of $25.00. The department shall issue a new identification card to the registered patient within 30 days of receiving the notification of change in dispensary. The registered patient's previous identification card shall expire at the time the new identification card takes effect. A registered patient shall submit his or her expired identification card to the department within 30 days of expiration. A registered patient shall not change his or her designated dispensary more than once in any 90-day period.

(b) The department of public safety shall track the number of registered patients who have designated each dispensary. The department shall issue a monthly written statement to the dispensary identifying the number of registered patients who have designated that dispensary and the registry identification numbers of each patient and each patient's designated caregiver, if any.

(c) In addition to the monthly reports, the department of public safety shall provide written notice to a dispensary whenever any of the following events occurs:

(1) A qualifying patient designates the dispensary to serve his or her needs under this subchapter.

(2) An existing registered patient revokes the designation of the dispensary because he or she has designated a different dispensary.

(3) A registered patient who has designated the dispensary loses his or her status as a registered patient under this subchapter.

§ 4474i. CONFIDENTIALITY OF INFORMATION REGARDING DISPENSARIES AND REGISTERED PATIENTS

The confidentiality provisions in section 4474d of this title shall apply to

records of all registered patients and registered caregivers within dispensary records in the department of public safety.

§ 4474j. ANNUAL REPORT

(a)(1) There is established a marijuana for symptom relief oversight committee. The committee shall be composed of the following members:

(A) one registered patient appointed by each dispensary;

(B) one registered nurse and one registered patient appointed by the governor;

(C) one physician appointed by the Vermont medical society;

(D) one member of a local zoning board appointed by the Vermont League of Cities and Towns;

(E) one representative appointed jointly by the Vermont sheriffs' association and the Vermont association of chiefs of police; and

(F) the commissioner of public safety or his or her designee.

(2) The oversight committee shall meet at least two times per year for the purpose of evaluating and making recommendations to the general assembly regarding:

(A) The ability of qualifying patients and registered caregivers in all areas of the state to obtain timely access to marijuana for symptom relief.

(B) The effectiveness of the registered dispensaries individually and together in serving the needs of qualifying patients and registered caregivers, including the provision of educational and support services.

(C) Sufficiency of the regulatory and security safeguards contained in this subchapter and adopted by the department of public safety to ensure that access to and use of cultivated marijuana is provided only to cardholders authorized for such purposes.

(b) On or before January 1 of each year, beginning in 2013, the oversight committee shall provide a report to the department of public safety, the house committee on human services, the senate committee on health and welfare, the house and senate committees on judiciary, and the house and senate committees on government operations on its findings.

§ 4474k. FEES; DISPOSITION

All fees collected by the department of public safety relating to dispensaries and pursuant to this subchapter shall be deposited in the registration fee fund as referenced in section 4474a of this title.

§ 4474l. REGULATION BY MUNICIPALITIES

Nothing in this subchapter shall be construed to prevent a municipality from prohibiting the establishment of a dispensary within its boundaries or from regulating the time, place, and manner of dispensary operation through zoning or other local ordinances.

Sec. 1a. 18 V.S.A. § 4474h(a) is amended to read:

(a) A registered patient may obtain marijuana only from the patient's designated dispensary and may designate only one dispensary. ~~A registered patient and his or her caregiver may not grow marijuana for symptom relief if the patient designates a dispensary~~ If a registered patient designates a dispensary, the patient and his or her caregiver may not grow marijuana or obtain marijuana or marijuana-infused products for symptom relief from any source other than the designated dispensary. A registered patient who wishes to change his or her dispensary shall notify the department of public safety in writing on a form issued by the department and shall submit with the form a fee of $25.00. The department shall issue a new identification card to the registered patient within 30 days of receiving the notification of change in dispensary. The registered patient's previous identification card shall expire at the time the new identification card takes effect. A registered patient shall submit his or her expired identification card to the department within 30 days of expiration. A registered patient shall not change his or her designated dispensary more than once in any 90-day period.

Sec. 2. DEPARTMENT OF PUBLIC SAFETY; IDENTIFICATION CARDS

The department of public safety shall take measures to improve the quality and security of identification cards required pursuant to chapter 86 of Title 18. The department shall consider the feasibility of a "swipe card" that could be used by law enforcement or a dispensary.

Sec. 2a. REPORT FROM THE DEPARTMENT OF PUBLIC SAFETY

The department of public safety shall report to the general assembly no later than January 1, 2012 on the following:

(1) The actual and projected income and costs for administering this act.

(2) Recommendations for how dispensaries could deliver marijuana to registered patients and their caregivers in a safe manner. Delivery to patients and caregivers is expressly forbidden until the general assembly takes affirmative action to permit delivery.

(3) Whether prohibiting growing marijuana for symptom relief by patients and their caregivers if the patient designates a dispensary interferes with patient access to marijuana for symptom relief and, if so,

recommendations for regulating the ability of a patient and a caregiver to grow marijuana at the same time the patient has designated a dispensary.

Sec. 3. SURVEY

(a) By September 1, 2011, the department of public safety shall develop a survey of patients registered to possess and use marijuana for symptom relief and shall send the survey to such patients. The department shall request that patients return the survey by October 1, 2011.

(b) The survey shall make the following inquiries:

(1) Please describe your medical diagnosis and the "debilitating medical condition" that qualifies you to be a registered patient under Vermont law. Please describe the symptoms that are aided by your use of marijuana for symptom relief.

(2) Please describe how much marijuana you typically use in one month for symptom relief and the strain or strains of marijuana that you use or that are particularly helpful in alleviating symptoms of your medical condition.

(3) Would you purchase marijuana for symptom relief from a state-regulated dispensary if it were available to you at an affordable price? How much do you typically spend in one month on marijuana for symptom relief?

(c) The department of public safety shall clearly state on the survey that the information is being gathered solely for the purpose of assessing the needs of registered medical patients in order to facilitate a safer, more reliable means for patients to obtain marijuana for symptom relief. The completed surveys shall remain confidential and shall not be subject to public inspection; however, summary information shall be available as provided in subsection (d) of this section.

(d) The department of public safety shall summarize the survey responses in a manner that protects the identity of patients, providing information that will assist state decision-makers, the department of public safety, and potential dispensary applicants to better understand the needs of registered patients. This summary shall not be confidential and shall be provided with other information about the medical marijuana registry on the Vermont criminal information website. The department of public safety shall ensure that any patient identifiers are not included in the summary.

Sec. 3a. APPROPRIATION

The amount of $156,500.00 is appropriated from the registry fee fund in fiscal year 2012 to the department of public safety for the performance of the department's responsibilities under this act.

Sec. 4. EFFECTIVE DATE

Sec. 1a of this act shall take effect July on 1, 2014, and the remainder of the act shall take effect on passage.

(Committee vote: 9-1-1)

(For text see Senate Journal 4/14 - 4/15/11)

Rep. Wilson of Manchester, for the Committee on **Ways and Means,** recommends the bill ought to pass when amended as recommended by the Committee on **Human Services** and when further amended as follows:

First: In Sec. 1, 18 V.S.A. § 4474f by striking subdivision (g)(4) in its entirety and inserting in lieu thereof the following:

(4) A license fee of $20,000.00 for the first year of operation, and an annual fee of $30,000.00 in subsequent years.

Second: In Sec. 1, 18 V.S.A. § 4474g(a) after the first sentence by adding "The fee shall be paid by the dispensary and the cost shall not be passed on to a principal officer, board member, or employee."

Third: By adding a Sec. 2b to read as follows:

Sec. 2b. JOINT FISCAL OFFICE REPORT

No later than January 15, 2012, the joint fiscal office shall report to the house committee on ways and means and the senate committee on finance regarding the projected costs of administering this act, the projected fee revenue from this act, the feasibility of a sales tax on marijuana sold through licensed dispensaries, and any other information that would assist the committees in adopting policies that will encourage the viability of the dispensaries while remaining, at a minimum, revenue neutral to the state.

(Committee Vote: 9-1-1)

Rep. O'Brien of Richmond, for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committees on **Human Services** and **Ways and Means** and when further amended as follows:

First: In Sec. 3a, by striking "$156,500.00" and inserting in lieu thereof "$108,500.00"

Second: By adding a Sec. 3b to read as follows:

Sec. 3b. DEPARTMENT OF PUBLIC SAFETY; POSITION

The department of public safety is authorized to establish one new classified position for the administration of the marijuana dispensary program in fiscal

year 2012. The position shall be transferred and converted from existing vacant positions in the executive branch of state government.

(Committee Vote: 7-4-0)

Senate Proposal of Amendment

H. 56

An act relating to the Vermont Energy Act of 2011

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

First: In Sec. 1, 30 V.S.A. § 219a (self-generation and net metering), in subsection (h) (electric company obligations), in subdivision (1)(K)(i), in the first sentence, by striking "paid" and inserting in lieu thereof "charged"

Second: In Sec. 1, 30 V.S.A. § 219a (self-generation and net metering), in subdivision (h)(1)(K), by adding a new subdivision to be numbered subdivision (vii) to read:

(vii) Not later than 30 days after board approval of an electric company's first rate schedule proposed to comply with this subdivision (1)(K), the company shall offer the amount of the credit contained in such rate schedule to each solar net metering system placed into service prior to the date on which the company submitted the proposed schedule to the board. Each system that accepts this offer shall receive the credit for not less than 10 years after the date of such acceptance, provided that the system remains in service, and regardless of any subsequent modification to the credit as contained in the company's rate schedules. Should an additional meter at the premises of the net metering customer be necessary to implement this subdivision (vii), the net metering customer shall bear the cost of the additional meter.

Third: In Sec. 2 (implementation; retroactive application), in subsection (e), in the second sentence, after the words "the board is authorized to" by striking out and shall

Fourth: In Sec. 5, 30 V.S.A. § 248 (new gas and electric purchases, investments, and facilities; certificate of public good), at the end of the section, after the ellipsis, by inserting:

(c)(1) Except as otherwise provided in subdivision (j)(3) of this section, in the case of a municipal plant or department formed under local charter or chapter 79 of this title or a cooperative formed under chapter 81 of this title, any proposed investment, construction or contract which is subject to this section shall be approved by a majority of the voters of a municipality or the members of a cooperative voting upon the question at a duly warned annual or special meeting to be held for that purpose. However, in the case of a

cooperative formed under chapter 81 of this title, an investment in or construction of an in-state electric transmission facility shall not be subject to the requirements of this subsection if the investment or construction is solely for reliability purposes and does not include new construction or upgrades to serve a new generation facility.

(2) The municipal department or cooperative shall provide to the voters or members, as the case may be, written assessment of the risks and benefits of the proposed investment, construction, or contract which were identified by the public service board in the certificate issued under this section. The municipal department or cooperative also may provide to the voters an assessment of any other risks and benefits.

* * *

Fifth: In Sec. 11, 30 V.S.A. § 8009 (baseload renewable power portfolio requirement), in subsection (d), in the fourth sentence, after the words "obtain from a" by striking out the word new

Sixth: In Sec. 11, 30 V.S.A. § 8009, by striking subdivision (f)(1) in its entirety and inserting in lieu thereof the following:

(1) The SPEED facilitator shall purchase the baseload renewable power, and the electricity purchased and any associated costs shall be allocated by the SPEED facilitator to the Vermont retail electricity providers based on their pro rata share of total Vermont retail kWh sales for the previous calendar year, and the Vermont retail electricity providers shall accept and pay those costs.

Seventh: In Sec. 11, 30 V.S.A. § 8009 (baseload renewable power portfolio requirement), by adding a new subsection to be subsection (i) to read:

(i) The state and its instrumentalities shall not be liable to a plant owner or retail electricity provider with respect to any matter related to the baseload renewable power portfolio requirement or a plant used to satisfy such requirement, including costs associated with a contract related to such a plant or any damages arising from the breach of such a contract, the flow of power between a plant and the electric grid, or the interconnection of a plant to that grid. For the purpose of this section, the board and the SPEED facilitator constitute instrumentalities of the state.

Eighth: By adding 10 new sections to be numbered Secs. 18a through 18j to read as follows:

* * * Property Assessed Clean Energy * * *

Sec. 18a. 24 V.S.A. § 3255 is amended to read:

§ 3255. COLLECTION OF ASSESSMENTS; LIENS

(a) Special assessments under this chapter shall constitute a lien on the property against which the assessment is made in the same manner and to the same extent as taxes assessed on the grand list of a municipality, and all procedures and remedies for the collection of taxes shall apply to special assessments.

(b) Notwithstanding subsection (a) of this section, a lien for an assessment under subchapter 2 of this chapter shall be subordinate to all liens on the property in existence at the time the lien for the assessment is filed on the land records, shall be subordinate to a first mortgage on the property recorded after such filing, and shall be superior to any other lien on the property recorded after such filing. In no way shall this subsection affect the status or priority of any municipal lien other than a lien for an assessment under subchapter 2 of this chapter.

Sec. 18b. REDESIGNATION

24 V.S.A. chapter 87, subchapter 2 is redesignated to read:

Subchapter 2. Property-Assessed Clean Energy ~~Assessments~~

Sec. 18c. 24 V.S.A. § 3261 is amended to read:

§ 3261. PROPERTY-ASSESSED CLEAN ENERGY ~~ASSESSMENT~~ DISTRICTS; APPROVAL OF VOTERS

(a)(1) In this subchapter, "district" means a property-assessed clean energy district.

(2) The legislative body of a town, city, or incorporated village may submit to the voters of the municipality the question of whether to designate the municipality as a property-assessed clean energy ~~assessment~~ district. In a ~~clean energy assessment~~ district, only those property owners who have entered into written agreements with the municipality under section 3262 of this title would be subject to a special assessment, as set forth in section 3255 of this title.

(b) Upon a vote of approval by a majority of the qualified voters of the municipality voting at an annual or special meeting duly warned for that purpose, the municipality may incur indebtedness for or otherwise finance projects relating to renewable energy, as defined in 30 V.S.A. § 8002(2), or to eligible projects relating to energy efficiency as defined by section 3267 of this title, undertaken by owners of ~~real property~~ dwellings, as defined in Section 103(v) of the federal Truth in Lending Act, within the boundaries of the town, city, or incorporated village.

Sec. 18d. 24 V.S.A. § 3262 is amended to read:

§ 3262. WRITTEN AGREEMENTS; CONSENT OF PROPERTY OWNERS; ENERGY SAVINGS ANALYSIS

(a) Upon an affirmative vote made pursuant to section 3261 of this title and the performance of an energy savings analysis pursuant to subsection (b) of this section, an owner of ~~real property~~ a dwelling, as defined in Section 103(v) of the federal Truth in Lending Act, within the boundaries of a ~~clean energy assessment~~ district may enter into a written agreement with the municipality that shall constitute the owner's consent to be subject to a special assessment, as set forth in section 3255 of this title. Entry into such an agreement may occur only after January 1, 2012. A participating municipality shall follow underwriting criteria~~, consistent with responsible underwriting and credit standards as~~ established by the department of banking, insurance, securities, and health care administration, and shall establish other qualifying criteria to provide an adequate level of assurance that property owners will have the ability to meet assessment payment obligations. A participating municipality shall refuse to enter into a written agreement with a property owner who fails to meet the underwriting or other qualifying criteria.

* * *

(c) A written agreement shall provide that:

* * *

(2) ~~At~~ Notwithstanding any other provision of law:

(A) At the time of a transfer of property ownership ~~excepting~~ including foreclosure, the past due balances of any special assessment under this subchapter shall be due for payment, but future payments shall continue as a lien on the property.

(B) In the event of a foreclosure action, the past due balances described in subdivision (A) of this subdivision (2) shall include all payments on an assessment under this subchapter that are due and unpaid as of the date the action is filed, and all payments on the assessment that become due after that date and that accrue up to and including the date title to the property is transferred to the mortgage holder, the lien holder, or a third party in the foreclosure action. The person or entity acquiring title to the property in the foreclosure action shall be responsible for payments on the assessment that become due after the date of such acquisition.

(3) A participating municipality shall disclose to participating property owners ~~the~~ each of the following:

(A) The risks associated with participating in the program, including risks related to the failure of participating property owners to make payments

and the risk of foreclosure.

(B) The provisions of subsection (h) of this section that pertain to prepayment of the assessment.

(d) A written agreement or notice of such agreement and the analysis performed pursuant to subsection (b) of this section shall be filed with the clerk of the applicable municipality for recording in the land records of ~~the~~ that municipality and shall be disclosed to potential buyers prior to transfer of property ~~of~~ ownership. Personal financial information provided to a municipality by a participating property owner or potential participating property owner shall not be subject to disclosure as set forth in 1 V.S.A. § 317(c)(7). If a notice of agreement is filed instead of the full written agreement, the notice shall attach the analysis performed pursuant to subsection (b) of this section and shall include at least each of the following:

(1) The name of the property owner as grantor.

(2) The name of the municipality as grantee.

(3) The date of the agreement.

(4) A legal description of the real property against which the assessment is made pursuant to the agreement.

(5) The amount of the assessment and the period during which the assessment will be made on the property.

(6) A statement that the assessment will remain a lien on the property until paid in full or released.

(7) The location at which the original or a true, legible copy of the agreement may be examined.

* * *

(g) ~~In the case of~~ With respect to an agreement ~~with the resident owner of a dwelling, as defined in Section 103(v) of the federal Truth in Lending Act~~ under this section:

(1) the assessments to be repaid under the agreement, when calculated as if they were the repayment of a loan, shall not violate ~~chapter 4 of Title 9~~ 9 V.S.A. §§ 41a, 43, 44, and 46–50.

(2) the maximum length of time for the owner to repay the ~~loan~~ assessment shall not exceed 20 years; and

(3) the maximum amount to be repaid for the project, including the participating property owner's contribution to the reserve fund under subsection 3269(c) of this title, shall not exceed $30,000.00 or 15 percent of

the assessed value of the property, whichever is less.

(h) There shall be no penalty or premium for prepayment of the outstanding balance of an assessment under this subchapter if the balance is prepaid in full.

Sec. 18e. 24 V.S.A. § 3267 is amended to read:

§ 3267. ELIGIBLE ENERGY EFFICIENCY PROJECTS; ASSISTANCE TO MUNICIPALITIES

Those entities appointed as energy efficiency utilities under 30 V.S.A. § 209(d) ~~shall~~:

(1) Shall develop a list of eligible energy efficiency projects and shall make the list available to the public on or before July 1 of each year; and

(2) Shall provide information concerning implementation of this subchapter to each municipality, within the area in which the entity delivers efficiency services, that requests such information, and shall contact each such municipality that votes to establish a district to offer this information.

Sec. 18f. 24 V.S.A. § 3268 is amended to read:

§ 3268. RELEASE OF LIEN

(a) A municipality shall release a participating property owner of the lien on the property against which the assessment under this subchapter is made upon~~:~~

~~(1) Full~~ full payment of the value of the assessment~~; or~~

~~(2) Demand from a party who has filed an action for foreclosure on a participating property~~.

(b) ~~If a municipality releases a participating property owner of a lien upon demand from a party who has filed an action for foreclosure and the participating property owner redeems the property, the municipality shall reinstate the lien on the property against which the assessment under this subchapter is made.~~

~~(c)~~ Notice of ~~the~~ a release ~~or reinstatement~~ of ~~the~~ a lien for an assessment under this subchapter shall be filed with the clerk of the applicable municipality for recording in the land records of ~~the~~ that municipality.

Sec. 18g. 24 V.S.A. § 3269 is amended to read:

§ 3269. RESERVE FUND

(a) A ~~participating municipality may create a~~ reserve fund is created for use in paying the past due balances of an assessment under this subchapter in the event ~~of~~ that there is a foreclosure upon ~~an assessed~~ the property subject to the

assessment and the proceeds resulting from the foreclosure are, after all superior liens have been satisfied, insufficient to pay those past due balances. The reserve fund shall comply with the provisions of subsections (b) through (e) of this section and shall be administered by and in the custody of the entity described in subsection (f) of this section. Each municipality that establishes a district under this subchapter shall participate in the reserve fund created by this subsection.

(b) The reserve fund shall be funded by participating property owners at a level sufficient to provide for the payment of ~~any~~ past due balances ~~on assessments under this subchapter and any remaining principal balances on those assessments~~ described in subdivision 3262(c)(2) of this title in the event of a foreclosure upon a participating property and the costs of administering the reserve fund and shall only be used to provide for such payment and administration.

(c) The contribution of each participating property owner to the reserve fund shall be included in the special assessment applicable to the property and shall be subject to section 3255 of this title. From time to time, the commissioner of banking, insurance, securities, and health care administration shall determine the appropriate contribution to the fund in accordance with subsection (d) of this section. A determination by the commissioner under this subsection shall apply to the reserve fund contribution for an assessment concerning which a written agreement under section 3262 is signed after the date of the commissioner's determination and shall not affect the reserve fund contribution for an assessment concerning which such an agreement was signed on or before the date of the commissioner's determination.

~~(b)~~(d) The reserve fund shall be capitalized in accordance with standards and procedures approved by the commissioner of banking, insurance, securities, and health care administration to cover expected foreclosures and fund administration costs based on good lending practice experience. Interest earned shall remain in the fund. The administrator of the reserve fund shall invest and reinvest the moneys in the fund and hold, purchase, sell, assign, transfer, and dispose of the investments in accordance with the standard of care established by the prudent investor rule under chapter 147 of Title 9. The administrator shall apply the same investment objectives and policies adopted by the Vermont state employees' retirement system, where appropriate, to the investment of moneys in the fund.

~~(c)~~(e) The municipality shall disclose in advance to each interested property owner the amount of that property owner's required payment into the reserve fund. Once disclosed, the amount of the reserve fund payment shall not change over the life of the assessment.

(f) An entity appointed under 30 V.S.A. § 209(d)(2) to deliver energy efficiency programs to multiple service territories shall administer the reserve fund created under subdivision (a)(1) of this section.

(1) The entity's costs of administering the reserve fund shall be considered costs of operating the districts under section 3263 of this title.

(2) In the event of foreclosure on a property that is subject to a special assessment and is in a district that participates in the reserve fund administered by the entity, the entity's obligation shall be to disburse, at the direction of the municipality, moneys from the reserve fund to apply to the past due balances of the assessment. In no event shall other moneys received or held by the entity be available to meet this obligation or the payment of balances on an assessment.

(3) The entity shall keep an accurate account of all activities and receipts and expenditures under this subsection. An independent audit of the reserve fund shall be conducted annually. The cost of such an audit shall be considered a cost of administering the reserve fund. Where feasible, the entity shall cause this audit to be conducted in conjunction with other independent audits of its accounts, receipts, and expenditures. An audit conducted under this subdivision shall be available, on request, to the auditor of accounts and the commissioners of banking, insurance, securities, and health care administration and of public service.

Sec. 18h. 24 V.S.A. § 3270 is added to read:

§ 3270. STATE PACE RESERVE FUND

(a) The state PACE reserve fund is established to be held in the custody of and administered by the state treasurer. The purpose of the state PACE reserve fund shall be to reduce, for those districts for which the entity described in subsection 3269(f) of this title administers the loss reserve fund, the risk faced by an investor making an agreement with a municipality to finance such a district.

(b) The treasurer may invest monies in the fund in accordance with 32 V.S.A. § 434. All balances in the fund at the end of the fiscal year shall be carried forward and shall not revert to the general fund. Interest earned shall remain in the fund. The treasurer's annual financial report to the general assembly under 32 V.S.A. § 434 shall contain an accounting of receipts, disbursements, and earnings of the fund.

(c) At the direction of the treasurer, a sum shall be transferred to the fund from moneys deposited into the energy efficiency fund pursuant to 30 V.S.A. § 209(d)(7) (net capacity savings payments) and (8) (net revenues from the

sale of carbon credits).

(1)(A) For a given year, the sum transferred under this subsection shall be:

(i) Five percent of the total amount of those assessments concerning which owners of real property, in the districts described in subsection (a) of this section, are expected to enter into written agreements pursuant to section 3262 of this title during the year; and

(ii) Such additional amount, if any, that is necessary to meet the full amount of payments reasonably expected to be made from the state PACE reserve fund during that year.

(B) In no event shall the sum transferred under this subsection exceed the limits on the total amount of funding from the state PACE reserve fund set forth under subsection (f) of this section.

(2) When directing a transfer under this subsection, the treasurer shall notify the commissioners of finance and management and of public service, the chair of the public service board, and the entity described in subsection 3269(f) of this title. Monies shall not be disbursed from the state PACE reserve fund until necessary resources are transferred to the fund.

(d) Moneys deposited to the state PACE reserve fund and any interest on moneys in that fund shall be used for the sole purpose of paying claims as described in subsections (e) and (f) of this section. In no event shall any moneys received or held by the state of Vermont, other than moneys deposited into the state PACE reserve fund or interest on moneys in that fund, be available to meet this obligation or the payment of a remaining past due balance or any other obligation under this subchapter.

(e) In this section, "remaining past due balance" means that amount, if any, of a past due balance on an assessment under this subchapter that exists:

(1) Immediately following foreclosure on a property in a district that participates in the loss reserve fund administered by the entity described in subsection 3269(f) of this title; and

(2) After the application, to the past due balances of the assessment on that property, of the proceeds available from the foreclosure, net of superior liens, and of the assets of that loss reserve fund.

(f) The obligation of the state PACE reserve fund shall be to fund 90 percent of a remaining past due balance, upon presentation of a claim and application acceptable to the treasurer and the entity described in subsection 3269(f) of this title, provided that the total amount of all such funding from the state PACE reserve fund shall not exceed the smallest of the following:

(1) $1,000,000.00.

(2) The funds available pursuant to subsection (d) of this section.

(3) Five percent of the total of all assessments under this subchapter in the districts that participate in the loss reserve fund administered by the entity described in subsection 3269(f) of this title.

Sec. 18i. 24 V.S.A. § 3271 is added to read:

§ 3271. MONITORING; COMPLIANCE; UNDERWRITING CRITERIA

The department of public service created under 30 V.S.A. § 1 shall monitor and evaluate, for compliance with the underwriting criteria, standards, and procedures established under subsections 3262(a) (underwriting criteria for assessments) and 3269(c) and (d) (underwriting standards and procedures; loss reserve fund) of this title, all activities to which those criteria, standards, and procedures apply that are undertaken by an entity appointed under 30 V.S.A. § 209(d)(2) to deliver energy efficiency programs. The department shall consult with the department of banking, insurance, securities, and health care administration in performing these tasks. The department of public service may combine its tasks under this section with monitoring and evaluation of an energy efficiency entity conducted pursuant to 30 V.S.A. § 209(d) or (e).

Sec. 18j. UNDERWRITING CRITERIA; ADOPTION

On or before December 31, 2011, the commissioner of banking, insurance, securities, and health care administration shall adopt criteria and standards pursuant to Sec. 18d of this act, 24 V.S.A. § 3262(a), and determine the participating property owner's contribution to the loss reserve fund and adopt standards and procedures pursuant to Sec. 18g of this act, 24 V.S.A. § 3269(c) and (d). Prior to adoption, the commissioner of banking, insurance, securities, and health care administration shall consult with the commissioner of public service concerning the development of such criteria, standards, and procedures.

Ninth: By adding a new section to be numbered Sec. 19a to read as follows:

* * * Propane Regulation * * *

Sec. 19a. 9 V.S.A. § 2461b is amended to read:

§ 2461b. REGULATION OF ~~LIQUIFIED PETROLEUM GAS~~ PROPANE

(a)(1) In this section:

(A) "Consumer" means any person who purchases propane for consumption and not for resale, through a meter or has propane delivered to one or more storage tanks of 2000 gallons or less.

(B) "Seller" means a person who sells or offers to sell propane to a consumer.

(2) The attorney general shall investigate irregularities, complaints, and unfair or deceptive acts in commerce by sellers ~~of liquefied petroleum gas~~.

(b) For the purpose of promoting business practices which are uniformly fair to sellers and which protect consumers, the attorney general shall promulgate necessary rules and regulations, including~~, but not limited to,~~ notice prior to disconnection, repayment agreements, minimum delivery, discrimination, security deposits and the assessment of fees and charges.

(c)(1) A violation of this section, or a rule or regulation promulgated under this section not inconsistent with this section, shall constitute an unfair and deceptive act in commerce in violation of section 2453 of this title.

(2) No contract for propane services shall contain any provision which conflicts with the obligations and remedies established by this section or by any rule or regulation promulgated under this section, and any conflicting provision shall be unenforceable and void.

(d) A seller shall not:

(1) assess a minimum usage fee;

(2) assess a fee for propane that is not actually delivered to a consumer; or

(3) require a consumer to purchase a minimum number of gallons of propane per year, except as part of a guaranteed price plan that meets the requirements of section 2461e of this title.

(e) When terminating service to a consumer, a seller shall comply with the following requirements.

(1)(A) If the propane storage tank has been located on the consumer's premises, regardless of ownership of the premises, for 12 months or more, the seller may not assess a fee related to termination of propane service, including a fee

(i) to remove the seller's storage tank from the premises;

(ii) to pump out or restock propane; or

(iii) to terminate service.

(B) If a consumer has received propane service from the seller for less than 12 months, any fee related to termination of service may not exceed the disclosed price of labor and materials.

(2)(A) Within 20 days of the date when the seller disconnects propane service or is notified by the consumer in writing that service has been disconnected, whichever is earlier, the seller shall refund to the consumer the amount paid by the consumer for any propane remaining in the storage tank, less any payments due the seller from the consumer.

(B) If the quantity of propane remaining in the storage tank cannot be determined with certainty, the seller shall, within the 20 days described in subdivision (2)(A) of this subsection, refund to the consumer the amount paid by the consumer for 80 percent of the seller's best reasonable estimate of the quantity of propane remaining in the tank, less any payments due from the consumer. The seller shall refund the remainder of the amount due as soon as the quantity of propane left in the tank can be determined with certainty, but no later than 14 days after the removal of the tank or restocking of the tank at the time of reconnection.

(3)(A) Any refund to the consumer shall be by cash, check, direct deposit, credit to a credit card account, or in the same method or manner of payment that the consumer, or a third party on the consumer's behalf, used to make payments to the seller.

(B) Unless requested by the consumer, a seller shall not provide a refund in the form of a reimbursement or credit to any account with the seller.

(4) If the seller fails to mail or deliver a refund to the consumer in accordance with this subsection, the seller shall within one business day make a penalty payment to the consumer, in addition to the refund, of $250.00 on the first day after the refund was due, and $75.00 per day for each day thereafter until the refund and penalty payment have been mailed or delivered.

(5) Termination of service does not void any guaranteed price plan that meets the requirements of section 2461e of this title that has not expired by its own terms.

(f)(1) A seller of propane shall not refuse to deliver propane to a storage tank owned by a consumer if the consumer provides proof of ownership of the tank and the seller has conducted a safety check of the tank in accordance with NFPA 54 (National Fuel Gas Code) and NFPA 58 (Storage and Handling of Liquefied Petroleum Gas Code) of the National Fire Protection Association and complies with rules adopted by the attorney general governing propane.

(2) If a seller of propane chooses to finance a consumer's purchase of a storage tank, the financing shall be a retail installment sale as provided in chapter 61 of this title.

(g) Nonpayment of the following charges may be the only basis for an

interruption or disconnection of service: propane, leak or pressure test, safety check, restart of equipment, after-hours delivery, special trip for delivery, and meter read.

Tenth: By striking out Sec. 20 (utility payment; credit or debit card; report) and inserting in lieu thereof a new Sec. 20 to read:

Sec. 20. UTILITY BILL PAYMENT; CREDIT OR DEBIT CARD; REPORT

On or before January 15, 2012, the commissioner of public service shall submit to the general assembly a report on whether, in the commissioner's opinion, it is in the public interest for the cost of service of a company subject to jurisdiction under 30 V.S.A. § 203 to include fees and expenses incurred by the company in accepting payments from customers of retail charges by credit or debit card. In the report, the commissioner shall consider and discuss the advantages and disadvantages of including these fees and expenses in a company's cost of service, including the extent to which allowing inclusion of such fees and expenses may avoid or reduce costs that would otherwise be incurred by the company; shall quantify on a statewide basis the expected cost impacts of requiring all ratepayers to bear the cost of these fees and expenses, including the amount, if any, of cross-subsidy that would occur from customers who do not pay utility bills by credit or debit card to customers who do pay utility bills by credit or debit card; and shall propose a draft statute or a statutory amendment to effect the commissioner's recommendation.

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

* * * Woody Biomass Heating; Energy Efficiency * * *

Sec. 20a. FINDINGS; INTENT; WOODY BIOMASS HEATING

(a) The general assembly finds that:

(1) Installation of woody biomass heating systems will provide multiple benefits to Vermont homes, businesses, and the Vermont economy.

(2) These benefits will include reducing Vermont's dependence on foreign oil and other fossil fuels, supporting locally harvested fuel resources, reducing emissions of greenhouse gases, and supporting local biomass equipment and fuel manufacturers and distributors.

(3) These benefits also will include the retention and potential expansion of significant in-state economic resources that would otherwise flow out of the state and the nation.

(b) The general assembly intends to clarify that an energy efficiency entity appointed pursuant to 30 V.S.A. § 209(d)(2) that delivers energy efficiency services to heating and fuel process consumers in Vermont is fully authorized

to offer incentives for installation of woody biomass heating systems in a manner that promotes deployment of such systems.

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

Sec. 20b. 30 V.S.A. § 209(d)(7) and (8) are amended to read:

(7) Net revenues above costs associated with payments from the New England Independent System Operator (ISO-NE) for capacity savings resulting from the activities of the energy efficiency utility designated under subdivision (2) of this subsection shall be deposited into the electric efficiency fund established by this section ~~and~~. Any such net revenues not transferred to the state PACE reserve fund under 24 V.S.A. § 3270(c) shall be used by the entity appointed under subdivision (2) of this subsection to deliver ~~fossil fuel~~ heating and process-fuel energy efficiency services to Vermont ~~heating and process fuel~~ consumers of such fuel on a whole-buildings basis to help meet the state's building efficiency goals established by 10 V.S.A. § 581. In delivering such services with respect to heating systems, the entity shall give priority to incentives for the installation of woody biomass heating systems and shall have a goal of offering an incentive that is equal to 25 percent of the installed cost of such a system. For the purpose of this subdivision (7), "woody biomass" means organic nonfossil material from trees or woody plants constituting a source of renewable energy within the meaning of subdivision 8002(2) of this title. Provision of an incentive under this subdivision (7) for a woody biomass heating system shall not be contingent on the making of other energy efficiency improvements at the property on which the system will be installed.

(8) Effective January 1, 2010, such net revenues above costs from the sale of carbon credits under the cap and trade program as provided for in section 255 of this title shall be deposited into the electric efficiency fund established by this section. Such revenues shall be used by the entity appointed under subdivision (2) of this subsection to support delivery of the services described in subdivision (7) of this subsection.

Thirteenth: By adding a new section to be numbered Sec. 20c to read:

Sec. 20c. 30 V.S.A. § 255 is amended to read:

§ 255. REGIONAL COORDINATION TO REDUCE GREENHOUSE GASES

* * *

(d) Appointment of consumer trustees. The public service board, by rule, order, or competitive solicitation, may appoint one or more consumer trustees

to receive, hold, bank, and sell tradable carbon credits created under this program. Trustees may include Vermont electric distribution utilities, the fiscal agent collecting and disbursing funds to support the statewide efficiency utility, or a financial institution or other entity with the expertise and financial resources to manage a portfolio of carbon credits for the long-term benefit of Vermont energy consumers. Fifty percent of the net proceeds above costs from the sale of carbon credits shall be deposited into the fuel efficiency fund established under section 203a of this title. These funds shall be used to provide expanded fossil fuel energy efficiency services to residential consumers who have incomes up to and including 80 percent of the median income in the state. The remaining 50 percent of the net proceeds above costs shall be deposited into the electric efficiency fund established under subdivision 209(d)(3) of this title. These funds shall be used by the entity or entities appointed under subdivision 209(d)(2) of this title to help meet the building efficiency goals established under 10 V.S.A. § 581 by delivering ~~fossil fuel~~ heating and process-fuel energy efficiency services to Vermont ~~heating and process fuel~~ consumers who use such fuel and are businesses or are residential consumers whose incomes exceed 80 percent of the median income in the state.

Fourteenth: By adding a new section to be numbered Sec. 20d to read:

* * * Building Energy Disclosure; Working Group * * *

Sec. 20d. WORKING GROUP ON BUILDING ENERGY DISCLOSURE

(a) Creation of working group. There is created a working group on building energy disclosure to study whether and how to require disclosure of the energy efficiency of commercial and residential buildings in order to make data on building energy performance visible in the marketplace for real property and inform the choices of those who may purchase or rent such property.

(b) Membership. The building energy disclosure working group (the working group) shall be composed of the following members:

(1) A member of the senate appointed by the committee on committees.

(2) A member of the house appointed by the speaker of the house.

(3) The commissioner of public service or designee.

(4) The secretary of commerce and community development or designee.

(5) A real estate broker licensed in Vermont appointed by the governor from a list of three names recommended by the Vermont association of realtors.

(6) A representative of an entity appointed pursuant to 30 V.S.A. § 209(d)(2) to deliver energy efficiency services to multiple utility service territories, designated by the entity.

(7) A real estate appraiser licensed in Vermont appointed by the governor.

(8) A building construction contractor appointed by the governor.

(9) A representative of the Vermont homebuilders and remodelers association designated by the association.

(10) A person who is an accredited provider of energy rating services under the process adopted by the department of public service pursuant to 21 V.S.A. § 267, appointed by the governor.

(11) A person with expertise in energy policy appointed by the governor.

(12) A person who is an active member of a local energy committee that is part of the Vermont energy and climate action network, appointed by the governor from a list of three names recommended by that network.

(13) A representative of a financial institution appointed by the governor from a list of three names submitted by the Vermont bankers association and the association of Vermont credit unions.

(14) A representative of the Vermont housing finance agency designated by the agency.

(15) A member of the Vermont Bar Association with experience in the conveyance of real property designated by the association.

(16) A representative of the heating service industry designated by the Vermont Fuel Dealers Association.

(c) Structure; decision-making. The working group shall elect two co-chairs from its membership, one of whom shall be a legislative member. The provisions of 1 V.S.A. § 172 (joint authority to three or more) shall apply to the meetings and decision-making of the working group.

(d) Issues. The working group shall consider the following:

(1) Whether there should be requirements to disclose building energy performance, that is, to disclose the energy use of buildings in a standardized manner that allows comparison and assessment of energy use among multiple buildings.

(2) Requirements for disclosure of building energy performance that have been adopted in other jurisdictions and model codes or statutes that have

been published relating to such disclosure.

(3) If requirements to disclose building energy performance as described in subdivision (1) of this subsection were to be adopted:

(A) To whom should such disclosure be made (e.g., prospective buyers, prospective renters, the general public, the state).

(B) When such disclosure, if any, should be required (e.g., time of offer for sale, execution of contract for sale, at regular intervals).

(C) Which properties, if any, should be exempt from such requirements.

(D) For which markets (e.g., residential property, commercial property, purchase of property, rental of property) such disclosure, if any, should be required, and whether there should be a phase-in of any requirements for disclosure.

(E) What type or types of building energy ratings and audits should be employed.

(F) Whether the state should subsidize the cost of energy audits (e.g., for low income housing) and what sources of funding would be used to support the subsidy.

(4) Any other issue relevant to the question of disclosing building energy performance as described in subdivision (1) of this subsection.

(e) Report. On or before December 15, 2011, the working group shall submit to the general assembly its recommendation on whether the state of Vermont should adopt requirements on disclosure of building energy performance and recommended legislation on such disclosure if the general assembly were to choose to adopt such requirements.

(f) Assistance. For the purpose of its study of the issues identified in subsection (d) of this section and the preparation of its recommendation pursuant to subsection (e) of this section on whether the state should adopt requirements on building energy performance, the working group shall have the administrative, technical, and legal assistance of the department of public service and of the agency of commerce and community development. For the purpose of scheduling meetings and preparing its recommended legislation pursuant to subsection (e) of this section, the working group shall have the assistance of the office of legislative council.

(g) Meetings; term of working group; reimbursement. The working group may meet no more than four times during adjournment of the general assembly, and shall cease to exist on July 1, 2012.

(h) Reimbursement. For attendance at meetings during adjournment of the general assembly, legislative members of the working group shall be entitled to compensation and reimbursement for expenses as provided in 2 V.S.A. § 406; and other members of the working group who are not employees of the state of Vermont and whose participation is not supported by their employment or association shall be reimbursed at the per diem rate set in 32 V.S.A. § 1010. The costs of reimbursement of members of the working group who are not legislative members shall be allocated among the budgets of the department of public service and the agency of commerce and community development.

(i) Appointments. Within 30 days of this section's effective date, each entity required to submit a list of names to the governor pursuant to subsection (b) of this section shall make such submission. Within 60 days of this section's effective date, the appointing or designating authority shall appoint or designate each member of the working group under subsection (b) of this section and shall report the member so appointed or designated to the office of legislative council.

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

* * * Energy Planning * * *

Sec. 20e. ENERGY PLAN

(a) The general assembly finds that the department of public service is presently in the process of updating the electrical energy and comprehensive energy plans issued pursuant to 30 V.S.A. §§ 202 and 202b, with an intent to reissue such plans in October 2011.

(b) In the first update immediately following the effective date of this section by the department of public service of the plans described in subsection (a) of this section, the department shall consider each of the following:

(1) After considering the report of the public service board required by Sec. 13 of No. 159 of the Acts of the 2009 Adj. Sess. (2010), whether the best interests of the state are served by implementing a renewable portfolio standard (RPS) or by continued use and potential expansion of the Sustainably Priced Energy Enterprise Development (SPEED) Program under 30 V.S.A. § 8005; whether, should an RPS come into effect in the state, energy efficiency should be a resource that could be used to satisfy an RPS; and whether there should be tiers of resources used to satisfy an RPS based on the characteristics and qualities of the resources, such as the environmental impacts of their procurement, siting, or use. In the event that, due to the timing of the public service board's report, the department is unable to consider the matters in this subdivision (1) in the energy plan it intends to issue in October 2011, the department may propose any relevant recommendations in an addendum to the

energy plan issued on or before January 15, 2012.

(2) The relationship of energy use and land use, including land devoted now or in the future to cultivating biomass energy resources and the interrelationship among modes of transportation (such as single-occupancy or low efficiency vehicles), energy consumption, and settlement patterns.

(3) The work of the agency of agriculture, food and markets on 25 x 25, which may include:

(A) The cultivation of land for biomass energy resources in a manner that is carbon-neutral or carbon-negative, that is, a net reduction in carbon emissions over the life cycle of the cultivation, harvesting, and use of such resources.

(B) The use of buffer zones on properties to counter the carbon impacts of fossil fuel use or to cultivate land for biomass energy resources and on potential incentives to encourage landowners to set aside such buffer zones.

(C) The use of grass as a source of energy.

(D) Energy end uses of biomass in the state, including residential heating and transportation.

(4) The appropriate energy conversion efficiency requirements that should be applicable to woody biomass energy plants, with particular emphasis on encouraging woody biomass for combined heat and power applications.

(5) The potential development of a land capability map for the purpose of guiding and accomplishing coordinated, efficient, and environmentally and economically sound development of renewable energy plants in the state, including particularly wind and woody biomass energy generation plants and any recommendations concerning the siting of wind energy plants to assure adequate protection of ridgeline environments.

(6) Obtaining additional funds from available sources to be used within the clean energy development fund (CEDF) established under 10 V.S.A. § 6523 to establish one or more revolving loan funds to support the purposes of the CEDF and of increasing the use of existing CEDF moneys to support such revolving loan funds.

(7) Citizen participation in decision-making on energy generation projects, including mechanisms in other states for so-called "intervenor funding" with respect to participation in permit processes for proposed electric generation plants and of the advantages and disadvantages of adopting in Vermont a system for funding intervenor participation in permit processes for such plants.

(8) Mechanisms to assure that electric energy consumers receive the benefits of so-called "smart grid" technology, also known as advanced metering infrastructure, taking into consideration the reports and orders previously issued by the public service board on such technology.

(9) The residential building and commercial building energy standards required to be adopted pursuant to 21 V.S.A. §§ 266 and 268, including their adequacy in advancing the efficient use of energy and in reducing carbon impacts, including consideration of incentives or other means to encourage energy-efficient upgrades of rental property.

(10) Measures to control or mitigate the effects of fuel price volatility on Vermonters, including heating, process, and transportation fuel, including the role of entities appointed pursuant to Title 30 to deliver energy efficiency services to heating and process-fuel consumers and to consumers of electric energy.

(11) Development of a timeline for full implementation of the recommendations issued in October 2007 by the Governor's Commission on Climate Change pursuant to executive order no. 10-33 dated December 5, 2005.

(c) In making any recommendations concerning woody biomass, the department of public service shall consider the 2011 interim report of the biomass energy development working group filed pursuant to No. 37 of the Acts of 2009.

(d) In this section:

(1) "Biomass" means organic nonfossil material of biological origin constituting a source of renewable energy.

(2) "Renewable energy" shall have the same meaning as under 30 V.S.A. § 8002(2).

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

* * * Energy Efficiency; Street Lighting * * *

Sec. 20f. 30 V.S.A. § 218(g) is added to read:

(g) Each company subject to the public service board's jurisdiction that distributes electrical energy shall have in place a rate schedule for street lighting that provides an option under which efficient streetlights, including light-emitting diode (LED) lights, are installed on company-owned fixtures. These rate schedules also shall include a separate option under which customers may own street lighting and install efficient streetlights, including

LED lights, on customer-owned fixtures.

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

Sec. 20g. RATE SCHEDULES; STREET LIGHTING; IMPLEMENTATION

No later than 60 days after the effective date of this section, each company subject to the public service board's jurisdiction that distributes electrical energy shall file with the public service board a proposed modification to its rate schedules that complies with Sec. 20f of this act, 30 V.S.A. § 218(g). However, a company shall not be required to file such a proposed modification if its rate schedules, as of the date on which such filing is due, include an approved street lighting rate schedule that complies with Sec. 20f of this act, 30 V.S.A. § 218(g).

Eighteenth: By adding a new section to be numbered Sec. 20h to read:

* * * Clean Energy Development Fund; Solar Tax Credits * * *

Sec. 20h. 32 V.S.A. § 5930z is amended to read:

§ 5930z. SOLAR ENERGY TAX CREDIT

* * *

(f) In lieu of a solar energy tax credit certified by the board under this section, a taxpayer may in accordance with this subsection convert such a credit into a grant to the taxpayer from the clean energy development fund established under 10 V.S.A. § 6523.

(1) To qualify for a grant-in-lieu-of-credit under this subsection, the taxpayer shall comply with the provisions of this subsection and subdivision (c)(1) (solar plant of 2.2 MW or less) or (2) (solar plant of 150 kW or less) of this section. However, in the case of a taxpayer who complies with the provisions of this subsection and of subdivision (c)(1) of this section except for subdivision (c)(1)(C) (commissioning by Sep. 1, 2011), the taxpayer may qualify for such a grant if, by September 1, 2011, construction begins on the plant in accordance with Sec. IV.C (beginning of construction) of "Payments for Specified Energy Property in Lieu of Tax Credits under the American Recovery and Reinvestment Act of 2009" issued by the U.S. Department of the Treasury, Office of the Fiscal Assistant Secretary, as revised April 2011.

(2) The dollar amount of a grant-in-lieu-of-credit under this subsection shall be the lesser of the following:

(A) 50 percent of the dollar amount of the credit as contained in the certification issued by the board to the taxpayer.

(B) 15 percent of the actual costs of the plant.

(3) No later than 30 days after the effective date of this subdivision (2), the clean energy development fund shall provide notice of this option to obtain a grant-in-lieu-of-credit to all taxpayers for which the clean energy development board has certified tax credits under this section.

(4) On or before August 1, 2011, a taxpayer to which the board has issued a certification of a solar energy tax credit under this section shall submit to the fund the taxpayer's request, if any, to obtain a grant-in-lieu-of-credit under this subsection.

(5) To a taxpayer making a timely request under subdivision (4) of this subsection, a grant-in-lieu-of-credit shall be paid from the clean energy development fund within 30 days of:

(A) The date on which the taxpayer provides proof to the clean energy development fund that the plant for which the taxpayer seeks a grant-in-lieu-of-credit under this subsection has received from the U.S. Department of the Treasury, pursuant to 26 U.S.C. §§ 46 and 48, a grant in lieu of the federal investment tax credit and proof of the dollar amount of such federal grant; or

(B) If the taxpayer has not received a grant from the U.S Department of the Treasury described in subdivision (5)(A) of this subsection, the date on which the taxpayer provides to the clean energy development fund proof that the solar energy plant for which the taxpayer seeks a grant-in-lieu-of-credit under this subsection has been commissioned and proof of the plant's actual costs.

(g) On a regular basis, the department shall notify the treasurer and the clean energy development board of solar energy tax credits claimed pursuant to this section, and the board shall cause to be transferred from the clean energy development fund to the general fund an amount equal to the amount of solar energy tax credits as and when the credits are claimed.

~~(g)~~(h) The clean energy development board and the department shall collaborate in implementing the certification of credits under this section.

Nineteenth: By adding a new section to be numbered Sec. 20i to read:

Sec. 20i. GRANT IN LIEU OF CREDIT; TAX TREATMENT

The amount of a clean energy development fund grant made pursuant to 32 V.S.A. § 5930z(f) in lieu of a solar energy tax credit certified under 32 V.S.A. § 5930z(c) shall not be included as Vermont net income under 32 V.S.A. § 5811(18) and shall not be included as taxable income under 32 V.S.A. § 5811(21). This section shall apply to tax years 2010, 2011, and

2012.

Twentieth: By adding a new section to be numbered Sec. 20j to read:

Sec. 20j. 10 V.S.A § 6523 is amended to read:

§ 6523. VERMONT CLEAN ENERGY DEVELOPMENT FUND

* * *

(c) Purposes of fund. The purposes of the fund shall be to promote the development and deployment of cost-effective and environmentally sustainable electric power and thermal energy or geothermal resources~~, and emerging energy efficient technologies,~~ for the long-term benefit of Vermont consumers, primarily with respect to renewable energy resources, and the use of combined heat and power technologies. The fund also may be used to support natural gas vehicles in accordance with subdivision (d)(1)(K) of this section. The general assembly expects and intends that the public service board, public service department, and the state's power and efficiency utilities will actively implement the authority granted in Title 30 to acquire all reasonably available cost-effective energy efficiency resources for the benefit of Vermont ratepayers and the power system.

(d) Expenditures authorized.

* * *

(2) If during a particular year, the ~~clean energy development board~~ commissioner of public service determines that there is a lack of high value projects eligible for funding, as identified in the five-year plan, or as otherwise identified, the ~~clean energy development board may~~ commissioner shall consult with the ~~public service~~ clean energy development board, and shall consider transferring funds to the energy efficiency fund established under the provisions of 30 V.S.A. § 209(d). Such a transfer may take place only in response to an opportunity for a particularly cost-effective investment in energy efficiency, and only as a temporary supplement to funds collected under that subsection, not as replacement funding.

(3) A grant in lieu of a solar energy tax credit in accordance with 32 V.S.A. § 5930z(f). Of any fund moneys unencumbered by such grants, the first $2.3 million shall fund the small-scale renewable energy incentive program described in subdivision (1)(E)(ii) of this subsection.

(4) A sum equal to the cost for the 2010 and preceding tax years of the business solar energy income tax credits authorized in 32 V.S.A. ~~§~~ §§ 5822(d) and 5930z(a), net of any such costs for which a transfer has already been made under this subdivision and of the cost of any credits in lieu of which the taxpayer elects to receive a grant, shall be transferred ~~annually~~ from the clean

energy development fund to the general fund.

(e) Management of fund.

(1) ~~There is created the clean energy development board, which shall consist of the following nine directors:~~

~~(A) Three at-large directors appointed by the speaker of the house;~~

~~(B) Three at-large directors appointed by the president pro tempore of the senate.~~

~~(C) Two at-large directors appointed by the governor.~~

~~(D) The state treasurer, ex officio.~~ This fund shall be administered by the department of public service to facilitate the development and implementation of clean energy resources. The department is authorized to expend moneys from the clean energy development fund in accordance with this section. The commissioner of the department shall make all decisions necessary to implement this section and administer the fund except those decisions committed to the clean energy development board under this subsection. The department shall assure an open public process in the administration of the fund for the purposes established in this subchapter.

(2) During fiscal years after FY 2006, up to five percent of amounts appropriated to the public service department from the fund may be used for administrative costs related to the clean energy development fund ~~and after FY 2007, another five percent of amounts appropriated to the public service department from the fund not to exceed $300,000.00 in any fiscal year shall be transferred to the secretary of the agency of agriculture, food and markets for agricultural and farm-based energy project development activities~~.

(3) ~~A quorum of the clean energy development board shall consist of five directors. The directors of the board shall select a chair and vice chair.~~ There is created the clean energy development board, which shall consist of seven persons appointed in accordance with subdivision (4) of this subsection.

(A) The clean energy development board shall have decision-making and approval authority with respect to the plans, budget, and program designs described in subdivisions (7)(B)–(D) of this subsection. The clean energy development board shall function in an advisory capacity to the commissioner on all other aspects of this section's implementation.

(B) During a board member's term and for a period of one year after the member leaves the board, the clean energy development fund shall not make any award of funds to and shall confer no financial benefit on a company or corporation of which the member is an employee, officer, partner, proprietor, or board member or of which the member owns more than

10 percent of the outstanding voting securities. This prohibition shall not apply to a financial benefit that is available to any person and is not awarded on a competitive basis or offered only to a limited number of persons.

(4) ~~In making appointments of at-large directors to the clean energy development board, the appointing authorities shall give consideration to citizens of the state with knowledge of relevant technology, regulatory law, infrastructure, finance, and environmental permitting. A director shall recuse himself or herself from all matters and decisions pertaining to a company or corporation of which the director is an employee, officer, partner, proprietor, or board member. The at-large directors of the board shall serve terms of four years beginning July 1 of the year of appointment. However, one at-large director appointed by the speaker and one at-large director appointed by the president pro tempore shall serve an initial term of two years. Any vacancy occurring among the at-large directors shall be filled by the respective appointing authority and shall be filled for the balance of the unexpired term. A director may be reappointed.~~ The commissioner of public service shall appoint three members of the clean energy development board, and the chairs of the house and senate committees on natural resources and energy each shall appoint two members of the clean energy development board. The terms of the members of the clean energy development board shall be four years, except that when appointments to this board are made for the first time after the effective date of this act, each appointing authority shall appoint one member for a two-year term and the remaining members for four-year terms. When a vacancy occurs in the board during the term of a member, the authority who appointed that member shall appoint a new member for the balance of the departing member's term.

(5) Except for those ~~directors~~ members of the clean energy development board otherwise regularly employed by the state, the compensation of the ~~directors~~ members shall be the same as that provided by ~~subsection~~ 32 V.S.A. § 1010(a) ~~of Title 32. All directors of the clean energy development board, including those directors otherwise regularly employed by the state, shall receive their actual and necessary expenses when away from home or office upon their official duties~~.

(6) ~~At least every three years, the clean energy development board shall commission a detailed financial audit by an independent third party of the fund and the activities of the fund manager, which shall make available to the auditor its books, records, and any other information reasonably requested by the board or the auditor for the purpose of the audit.~~

~~(7)~~ In performing its duties, the clean energy development board may utilize the legal and technical resources of the department of public service ~~or,~~

~~alternatively, may utilize reasonable amounts from the clean energy development fund to retain qualified private legal and technical service providers~~. The department of public service shall provide the clean energy development board ~~and its fund manager~~ with administrative services.

~~(8)~~(7) The ~~clean energy development board~~ department shall perform each of the following:

(A) By January 15 of each year, ~~commencing in 2010,~~ provide to the house and senate committees on natural resources and energy, the senate committee on finance, and the house committee on commerce and economic development a report for the fiscal year ending the preceding June 30 detailing the activities undertaken, the revenues collected, and the expenditures made under this subchapter.

(B) Develop, and submit to the clean energy development board for review and approval, a five-year strategic plan and an annual program plan, both of which shall be developed with input from a public stakeholder process and shall be consistent with state energy planning principles.

(C) Develop, and submit to the clean energy development board for review and approval, an annual operating budget.

(D) Develop, and submit to the clean energy development board for review and approval, proposed program designs to facilitate clean energy market and project development (including use of financial assistance, investments, competitive solicitations, technical assistance, and other incentive programs and strategies). Prior to any approval of a new program or of a substantial modification to a previously approved program of the clean energy development fund, the department of public service shall publish online the proposed program or modification, shall provide an opportunity for public comment of no less than 30 days, and shall provide to the clean energy development board copies of all comments received on the proposed program or modification. For the purpose of this subdivision (D), "substantial modification" shall include a change to a program's application criteria or application deadlines and shall include any change to a program if advance knowledge of the change could unfairly benefit one applicant over another applicant. For the purpose of 3 V.S.A. § 831(b) (initiating rulemaking on request), a new program or substantial modification of a previously approved program shall be treated as if it were an existing practice or procedure.

~~(9)~~(8) At least ~~quarterly~~ annually, the clean energy development board and the commissioner or designee jointly shall hold a public meeting to review and discuss the status of the fund, fund projects, the performance of the fund manager, any reports, information, or inquiries submitted by the fund manager

or the public, and any additional matters ~~the clean energy development board deems~~ they deem necessary to fulfill ~~its~~ their obligations under this section.

~~(10) The clean energy development board shall administer and is authorized to expend monies from the clean energy development fund in accordance with this section.~~

(f) Clean energy development fund manager. The clean energy development fund shall have a fund manager who shall be ~~a state~~ an employee ~~retained and supervised by the board and housed within and assigned for administrative purposes to~~ of the department of public service.

(g) Bonds. The commissioner of public service, in consultation with the clean energy development board, may explore use of the fund to establish one or more loan-loss reserve funds to back issuance of bonds by the state treasurer otherwise authorized by law, including clean renewable energy bonds, that support the purposes of the fund.

(h) ARRA funds. All American Recovery and Reinvestment Act (ARRA) funds described in section 6524 of this title shall be disbursed, administered, and accounted for in a manner that ensures rapid deployment of the funds and is consistent with all applicable requirements of ARRA, including requirements for administration of funds received and for timeliness, energy savings, matching, transparency, and accountability. These funds shall be expended for the following categories listed in this subsection, provided that no single project directly or indirectly receives a grant in more than one of these categories. ~~The~~ After consultation with the clean energy development board, the commissioner of public service shall have discretion to use non-ARRA moneys within the fund to support all or a portion of these categories and shall direct any ARRA moneys for which non-ARRA moneys have been substituted to the support of other eligible projects, programs, or activities under ARRA and this section.

* * *

(4) $2 million for a public-serving institution efficiency and renewable energy program that may include grants and loans and create a revolving loan fund. For the purpose of this subsection, "public-serving institution" means government buildings and nonprofit public and private universities, colleges, and hospitals. In this program, awards shall be made through a competitive bid process. ~~On or before January 15, 2011, the clean energy development board shall report to the general assembly on the status of this program, including each award made and, for each such award, the expected energy savings or generation and the actual energy savings or generation achieved.~~

* * *

(8) Concerning the funds authorized for use in subdivisions (4)–(7) of this subsection:

(A) To the extent permissible under ARRA, up to five percent may be spent for administration of the funds received.

(B) In the event that the ~~clean energy development board~~ commissioner of public service determines that a recipient of such funds has insufficient eligible projects, programs, or activities to fully utilize the authorized funds, then after consultation with the clean energy development board, the commissioner shall have discretion to reallocate the balance to other eligible projects, programs, or activities under this section.

(9) The ~~clean energy development board~~ commissioner of public service is authorized, to the extent allowable under ARRA, to utilize up to 10 percent of ARRA funds received for the purpose of administration. The ~~board~~ commissioner shall allocate a portion of the amount utilized for administration to retain permanent, temporary, or limited service positions or contractors and the remaining portion to the oversight of specific projects receiving ARRA funding ~~through the board~~ pursuant to section 6524 of this title.

(i) Rules. The department and the clean energy development board each may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out its functions under this section~~. The board~~ and shall consult with ~~the commissioner of public service~~ each other either before or during the rulemaking process.

~~(j) Governor disapproval. The governor shall have the authority within 30 days of approval or adoption to disapprove a project, program, or other activity approved by the clean energy development board if the source of the funds is ARRA; and any rules adopted under subsection (i) of this section. The governor may at any time waive his or her authority to disapprove any project, program, or other activity or rule under this subsection.~~

Twenty-first: By adding a new section to be numbered Sec. 20k to read:

Sec. 20k. CLEAN ENERGY DEVELOPMENT BOARD; TRANSITION; TERM EXPIRATION; NEW APPOINTMENTS

(a) The terms of all members of the clean energy development board under 10 V.S.A. § 6523 appointed prior to the effective date of this section shall expire 44 days after such effective date.

(b) No later than 30 days after the effective date of this section, the appointing authorities under Sec. 20j of this act, 10 V.S.A. § 6523(e)(4), shall appoint the members of the clean energy development board created by Sec. 20j, 10 V.S.A. § 6523(e)(3). The terms of the members so appointed shall commence on the 45th day following the effective date of this section. The

appointing authorities may appoint members of the clean energy development board as it existed prior to the effective date of this section. The provisions of 10 V.S.A. § 6523(e)(3)(B) (board members; prohibition; financial benefits) shall apply only to members of the clean energy development board appointed to terms commencing on the 45th day after such effective date.

(c) With respect to the clean energy development fund established under 10 V.S.A. § 6523, as of the 45th day following the effective date of this section:

(1) The department of public service shall be the successor to the clean energy development board as it existed on the 44th day after the effective date of this act, and any legal obligations incurred by the clean energy development board as of such 44th day shall become legal obligations of the department of public service.

(2) The clean energy development board shall exercise prospectively such functions and authority as this act confers on that board.

Twenty-second: By adding a new section to be numbered Sec. 20l to read:

Sec. 20l. 10 V.S.A. § 6524 is amended to read:

§ 6524. ARRA ENERGY MONEYS

The expenditure of each of the following shall be subject to the direction and approval of the commissioner of public service, after consultation with the clean energy development board established under subdivision ~~6523(e)(1)~~ 6523(e)(4) of this title, and shall be made in accordance with subdivisions 6523(d)(1)(expenditures authorized), ~~(e)(3)(quorum), (e)(4)(appointments; recusal), (e)(5)(compensation), (e)(7)(assistance, administrative support),~~ and (e)(8)(A)(reporting) and subsections 6523(f)(fund manager), (h)(ARRA funds), and (i)(rules)~~, and (j)(governor disapproval)~~ of this title and applicable federal law and regulations:

(1) The amount of $21,999,000.00 in funds received by the state under the appropriation contained in the American Recovery and Reinvestment Act (ARRA) of 2009, Pub.L. No. 111-5, to the state energy program authorized under 42 U.S.C. § 6321 et seq.

(2) The amount of $9,593,500.00 received by the state under ARRA from the United States Department of Energy through the energy efficiency and conservation block grant program.

Twenty-third: By adding a new section to be numbered Sec. 20m to read:

Sec. 20m. RECODIFICATION; REDESIGNATION

(a) 10 V.S.A. §§ 6523 and 6524 are recodified respectively as 30 V.S.A.

§§ 8015 and 8016. The office of legislative council shall revise accordingly any references to these statutes contained in the Vermont Statutes Annotated. Any references in session law to these statutes as previously codified shall be deemed to refer to the statutes as recodified by this act.

(b) Within 30 V.S.A. chapter 89 (renewable energy programs):

(1) §§ 8001–8014 shall be within subchapter 1 and designated to read:

Subchapter 1. General Provisions

(2) §§ 8015–8016 shall be within subchapter 2 and designated to read:

Subchapter 2. Clean Energy Development Fund

Twenty-fourth: By adding a new section to be numbered Sec. 20n to read:

* * * Cost Allocation * * *

Sec. 20n. 30 V.S.A. § 20 is amended to read:

§ 20. PARTICULAR PROCEEDINGS; PERSONNEL

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

(i) to assist the board or department in any proceeding listed in subsection (b) of this section; ~~and~~

(ii) to monitor compliance with any formal opinion or order of the board; ~~and~~

(iii) in proceedings under section 248 of this title, to assist other state agencies that are named parties to the proceeding where the board or department determines that they are essential to a full consideration of the petition, or for the purpose of monitoring compliance with an order resulting from such a petition; ~~and~~

(iv) in addition to the above, in proceedings under subsection 248(h) of this title, by contract with the regional planning commission of the region or regions affected by a proposed facility, to assist in determining conformance with local and regional plans and to obtain the commissions data, analysis and recommendations on the economic, environmental, historic, or other impact of the proposed facility in the region; and

(v) to assist in monitoring the ongoing and future reliability and the postclosure activities of any nuclear generating plant within the state. For the purpose of this subdivision, "postclosure activities" includes planning for and implementation of any action within the state's jurisdiction that shall or

will occur when the plant permanently ceases generating electricity.

* * *

(b) Proceedings, including appeals therefrom, for which additional personnel may be retained are:

* * *

(12) proceedings at the United States Bankruptcy Court which involve Vermont utilities or which may affect the interests of the state of Vermont. Costs under this subdivision shall be charged to the involved ~~electric companies~~ utilities pursuant to subsection 21(a) of this title. In cases where the proceeding is generic in nature, the costs shall be allocated to ~~electric companies~~ utilities in proportion to the benefits sought for the customers of such companies from such advocacy;

* * *

(14) proceedings before the Federal Communications Commission or related forums which involve a company that owns a cable television system holding a certificate of public good and delivering services in Vermont or which may affect the interests of the state of Vermont. Costs under this subdivision shall be charged to the company pursuant to subsection 21(a) of this title. In cases where the proceeding is generic in nature, the costs shall be allocated to companies in proportion to the benefits sought for their customers from such advocacy;

(15) proceedings before any state or federal court concerning a company holding or a facility subject to a certificate issued under this title if the proceedings may affect the interests of the state of Vermont. Costs under this subdivision (15) shall be charged to the involved company pursuant to subsection 21(a) of this title. In cases where the proceeding is generic in nature, the costs shall be allocated to companies in proportion to the benefits sought for their customers from such advocacy.

Twenty-fifth: By adding a new section to be numbered Sec. 20o to read:

Sec. 20o. 30 V.S.A. § 21 is amended to read:

§ 21. PARTICULAR PROCEEDINGS; ASSESSMENT OF COSTS

(a) The board, the department, or the agency of natural resources may allocate the portion of the expense incurred or authorized by it in retaining additional personnel for the particular proceedings authorized in section 20 of this title to the applicant or the public service company or companies involved in those proceedings. The board shall upon petition of an applicant or public service company to which costs are proposed to be allocated, review and

determine, after opportunity for hearing, having due regard for the size and complexity of the project, the necessity and reasonableness of such costs, and may amend or revise such allocations. Nothing in this section shall confer authority on the board to select or decide the personnel, the expenses of whom are being allocated, unless such personnel are retained by the board. Prior to allocating costs, the board shall make a determination of the purpose and use of the funds to be raised hereunder, identify the recipient of the funds, provide for allocation of costs among companies to be assessed, indicate an estimated duration of the proceedings, and estimate the total costs to be imposed. With the approval of the board, such estimates may be revised as necessary. From time to time during the progress of the work of such additional personnel, the board, the department, or the agency of natural resources shall render to the company detailed statements showing the amount of money expended or contracted for in the work of such personnel, which statements shall be paid by the applicant or the public service company into the state treasury at such time and in such manner as the board, the department, or the agency of natural resources may reasonably direct.

* * *

(f) With the approval of the governor, the department of public service may allocate the expense incurred under 10 V.S.A. § 7063 in compensating members and alternate members of the commission among the generators of low-level radioactive waste in the state. Any such allocation shall be in proportion to the volume of waste generated by each such generator.

(g) The board, or the department with the approval of the governor, may allocate such portion of expense incurred or authorized by it in compensating persons retained pursuant to subdivision 20(a)(1)(v) of this title to the nuclear generating plant whose activities are being monitored.

(h) Under subsections (f) and (g) of this section, the manner of assessment and making payments shall be as provided in subsection (a) of this section. A generator or plant to which expense is allocated under subsection (f) or (g) of this section may petition the board in accordance with the procedures of subsection (a) of this section.

Twenty-sixth: By adding a new section to be numbered Sec. 20p to read:

Sec. 20p. Sec. 5.012.2 of No. 192 of the Acts of the 2007 Adj. Sess. (2008), as amended by Sec. E.127.1 of No. 156 of the Acts of the 2009 Adj. Sess. (2010), is amended to read:

Sec. 5.012.2. JOINT FISCAL COMMITTEE – NUCLEAR ENERGY ANALYSIS (Sec. 2.031)

(a) The joint fiscal committee may authorize or retain ~~consultant~~ services or resources to assist the general assembly:

(1) ~~in~~ In any legislative proceeding under or related to 30 V.S.A. § 248(e) or chapter 157 of Title 10; or

(2) With respect to any proceedings before any state or federal court concerning a nuclear generating plant in the state and related issues.

(b) ~~Consultants~~ Persons retained pursuant to subsection (a) of this section shall work under the direction of a special committee consisting of the chairs of the house and senate committees on natural resources and energy and the joint fiscal committee.

(c) The public service board shall allocate expenses incurred pursuant to subsection (a) of this section to the applicant or the ~~public service~~ company or companies involved ~~in those proceedings~~ and such allocation and expense may be reviewed by the public service board pursuant to 30 V.S.A. § 21.

Twenty-seventh: By adding a new section to be numbered Sec. 20q to read:

Sec. 20q. CODIFICATION

The office of legislative council shall codify, as 30 V.S.A. § 254a, the catchline and provisions of Sec. 5.012.2 of No. 192 of the Acts of the 2007 Adj. Sess. (2008), as amended by Sec. E.127.1 of No. 156 of the Acts of the 2009 Adj. Sess. (2010) and this act.

Twenty-eighth: By adding a new section to be numbered Sec. 20r to read:

* * * Texas–Vermont Compact * * *

Sec. 20r. 10 V.S.A. § 7062 is amended to read:

§ 7062. ~~MEMBER OF THE~~ COMMISSION MEMBERSHIP

The governor shall appoint ~~a person~~ one or more persons with relevant knowledge and experience to represent the state on the commission established by Article III of the compact. The governor may appoint an alternate for ~~the~~ each commission member appointed under this section. ~~The~~ Each commission member and alternate, if appointed, shall serve at the pleasure of the governor.

Twenty-ninth: By adding a new section to be numbered Sec. 20s to read:

Sec. 20s. 10 V.S.A. § 7063 is amended to read:

§ 7063. COMPENSATION OF ~~THE~~ COMMISSION ~~MEMBER~~ MEMBERS; REPORT

~~The~~ Each commission member and alternate ~~are~~ is entitled to compensation at ~~the~~ a rate established ~~under 32 V.S.A. § 1010~~ by the governor, and for

reimbursement for actual and necessary expenses incurred in the performance of their duties. If a state employee is appointed as a commission member or an alternate, that state employee is not entitled to ~~per diem~~ compensation in addition to such employee's regular pay. At least annually by December 31, commission members and alternates appointed under this section shall report to the governor and the commissioner of public service on their activities conducted in representing the state on the commission. The report shall include an itemization of compensation paid and expenses incurred. Compensation and expenses of commission members and alternates shall be included in the annual budget of the department of public service and shall be specifically identified in the budget report filed pursuant to 32 V.S.A. §§ 306 and 307.

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

Sec. 20t. 21 V.S.A. § 266(c) is amended to read:

(c) Revision and interpretation of energy standards. The commissioner of public service shall amend and update the RBES, by means of administrative rules adopted in accordance with chapter 25 of Title 3. No later than January 1, 2011, the commissioner shall complete rulemaking to amend the energy standards to ensure that, to comply with the standards, residential construction must be designed and constructed in a manner that complies with the 2009 edition of the IECC. These amendments shall be effective ~~on~~ three months after final adoption and shall apply to construction commenced on and after the date they become effective. After January 1, 2011, the commissioner shall ensure that appropriate revisions are made promptly after the issuance of updated standards for residential construction under the IECC. The department of public service shall provide technical assistance and expert advice to the commissioner in the interpretation of the RBES and in the formulation of specific proposals for amending the RBES. Prior to final adoption of each required revision of the RBES, the department of public service shall convene an advisory committee to include one or more mortgage lenders, builders, building designers, utility representatives, and other persons with experience and expertise, such as consumer advocates and energy conservation experts. The advisory committee may provide the commissioner with additional recommendations for revision of the RBES.

* * *

Thirty-first: By adding a new section to be numbered Sec. 20u to read as follows:

Sec. 20u. 21 V.S.A. § 268(c) is amended to read:

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

* * *

Thirty-second: In Sec. 21 (effective dates), in subsection (b) (sections effective on passage), at the end of the subsection, by inserting:

(4) Secs. 20a through 20g of this act.

(5) Secs. 20h (business solar energy tax credits), 20i (grant in lieu of credit; tax treatment), and 20k (clean energy development; transition; term expiration; new appointments) of this act.

(6) In Sec. 20j (clean energy development fund) of this act: 10 V.S.A. § 6523(d)(3) and (4) (solar tax credit; grant in lieu of and general fund reimbursement) and, for the purpose of Sec. 20k of this act, 10 V.S.A. § 6523(e)(3) (clean energy development board) and (4) (appointments to clean energy development board).

(7) Secs. 20n–20s of this act.

(8) Secs. 20t (revision and interpretation of residential building energy standards) and 20u (revision and interpretation of commercial building energy standards) of this act.

Thirty-third: In Sec. 21 (effective dates), by striking out subsection (c) in its entirety and inserting in lieu thereof a new subsection (c) to read:

(c) The following shall take effect on July 1, 2011: Secs. 5 (new gas and electric purchases); 11 (baseload renewable power portfolio requirement); 18 (statutory revision); 19 (heating oil), except for 10 V.S.A. § 585(c) (heating oil; biodiesel requirement); and 20m (recodification; redesignation) of this act.

Thirty-fourth: In Sec. 21 (effective dates), at the end of the section, by inserting:

(e)(1) Secs. 18c (property-assessed clean energy districts) and 18j (underwriting criteria; adoption) of this act shall take effect on passage.

(2) Secs. 18a, 18b, and 18d–18i of this act shall take effect on January 1, 2012, except that in Sec. 18d, 24 V.S.A. § 3262(a) (written agreements) shall take effect on passage.

(f)(1) Sec. 19a (regulation of propane) of this act shall take effect on passage.

(2) A provision of an existing contract that specifies an amount for any fee that would otherwise be prohibited by Sec. 19a this act shall remain valid and enforceable until:

(A) the date the contract expires or April 1, 2012, whichever is sooner; or,

(B) in the case of the termination of service to an underground storage tank, the earlier of:

(i) 30 days after the date the contract expires, or as soon thereafter as weather and access to the tank allow; or

(ii) April 1, 2014.

(For text see House Journal 4/5 - 4/6/11)

H. 73

An act relating to establishing a government transparency office to enforce the public records act

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

Sec. 1. 1 V.S.A. § 315 is amended to read:

§ 315. STATEMENT OF POLICY

It is the policy of this subchapter to provide for free and open examination

of records consistent with Chapter I, Article 6 of the Vermont Constitution. Officers of government are trustees and servants of the people and it is in the public interest to enable any person to review and criticize their decisions even though such examination may cause inconvenience or embarrassment. All people, however, have a right to privacy in their personal and economic pursuits, which ought to be protected unless specific information is needed to review the action of a governmental officer. Consistent with these principles, the general assembly hereby declares that certain public records shall be made available to any person as hereinafter provided. To that end, the provisions of this subchapter shall be liberally construed ~~with the view towards carrying out the above declaration of public policy~~ to implement this policy, and the burden of proof shall be on the public agency to sustain its action.

Sec. 2. 1 V.S.A. § 316 is amended to read:

§ 316. ACCESS TO PUBLIC RECORDS AND DOCUMENTS

(a) Any person may inspect or copy any public record ~~or document~~ of a public agency, as follows:

(1) For any agency, board, department, commission, committee, branch, instrumentality, or authority of the state, a person may inspect a public record on any day other than a Saturday, Sunday, or a legal holiday, between the hours of nine o'clock and 12 o'clock in the forenoon and between one o'clock and four o'clock in the afternoon; ~~provided, however, if the public agency is not regularly open to the public during those hours, inspection or copying may be made~~

(2) For any agency, board, committee, department, instrumentality, commission, or authority of a political subdivision of the state, a person may inspect a public record during customary ~~office~~ business hours.

(b) If copying equipment maintained for use by a public agency is used by the agency to copy the public record or document requested, the agency may charge and collect from the person requesting the copy the actual cost of providing the copy. The agency may also charge and collect from the person making the request, the costs associated with mailing or transmitting the record by facsimile or other electronic means. Nothing in this section shall exempt any person from paying fees otherwise established by law for obtaining copies of public records or documents, but if such fee is established for the copy, no additional costs or fees shall be charged.

(c) In the following instances an agency may also charge and collect the cost of staff time associated with complying with a request for a copy of a public record: (1) the time directly involved in complying with the request exceeds 30 minutes; (2) the agency agrees to create a public record; or (3) the

agency agrees to provide the public record in a nonstandard format and the time directly involved in complying with the request exceeds 30 minutes. The agency may require that requests subject to staff time charges under this subsection be made in writing and that all charges be paid, in whole or in part, prior to delivery of the copies. Upon request, the agency shall provide an estimate of the charge.

(d) The secretary of state, after consultation with the secretary of administration, shall establish the actual cost of providing a copy of a public record that may be charged by state agencies. The secretary shall also establish the amount that may be charged for staff time, when such a charge is authorized under this section. To determine "actual cost" the secretary shall consider the following only: the cost of the paper or the electronic media onto which a public record is copied, a prorated amount for maintenance and replacement of the machine or equipment used to copy the record and any utility charges directly associated with copying a record. The secretary of state shall adopt, by rule, a uniform schedule of public record charges for state agencies.

(e) After public hearing, the legislative body of a political subdivision shall establish actual cost charges for copies of public records. The legislative body shall also establish the amount that may be charged for staff time, when such a charge is authorized under this section. To determine actual cost charges, the legislative body shall use the same factors used by the secretary of state. If a legislative body fails to establish a uniform schedule of charges, the charges for that political subdivision shall be the uniform schedule of charges established by the secretary of state until the local legislative body establishes such a schedule. A schedule of public records charges shall be posted in prominent locations in the town offices.

* * *

Sec. 3. 1 V.S.A. § 317 is amended to read:

§ 317. DEFINITIONS; PUBLIC AGENCY; PUBLIC RECORDS AND DOCUMENTS

(a) As used in this subchapter~~,~~:

(1) "Business day" means a day that a public agency is open to provide services.

(2) "~~public~~ Public agency" or "agency" means any agency, board, department, commission, committee, branch, instrumentality, or authority of the state or any agency, board, committee, department, branch, instrumentality, commission, or authority of any political subdivision of the state.

(b) As used in this subchapter, "public record" or "public document" means any written or recorded information, regardless of physical form or characteristics, which is produced or acquired in the course of public agency business. Individual salaries and benefits of and salary schedules relating to elected or appointed officials and employees of public agencies shall not be exempt from public inspection and copying.

(c) The following public records are exempt from public inspection and copying:

* * *

(5) records dealing with the detection and investigation of crime, including those maintained on any individual or compiled in the course of a criminal or disciplinary investigation by any police or professional licensing agency; provided, however, that records relating to management and direction of a law enforcement agency ~~and~~; records reflecting the initial arrest of a person, including any ticket, citation, or complaint issued for a traffic violation, as that term is defined in 23 V.S.A. § 2301; and records reflecting the charge of a person shall be public;

* * *

Sec. 4. 1 V.S.A. § 318 is amended to read:

§ 318. PROCEDURE

(a) Upon request, the custodian of a public record shall promptly produce the record for inspection, except that:

(1) if the record is in active use or in storage and therefore not available for use at the time the person asks to examine it, the custodian shall so certify this fact in writing to the applicant and set a date and hour within one calendar week of the request when the record will be available for examination;

(2) if the custodian considers the record to be exempt from inspection under the provisions of this subchapter, the custodian shall so certify in writing. Such certification shall identify the records withheld and the basis for the denial. ~~The~~ A record shall be produced for inspection or a certification shall be made that a record is exempt within ~~two~~ three business days of receipt of the request, unless otherwise provided in subdivision (5) of this subsection. The certification shall include the asserted statutory basis for denial and a brief statement of the reasons and supporting facts for denial. The custodian shall also notify the person of his or her right to appeal to the head of the agency any adverse determination;

(3) if appealed to the head of the agency, the head of the agency shall make a determination with respect to any appeal within five business days~~,~~

~~excepting Saturdays, Sundays, and legal public holidays,~~ after the receipt of such appeal. If an appeal of the denial of the request for records is in whole or in part upheld, the agency shall notify the person making such request of the provisions for judicial review of that determination under section 319 of this title;

(4) if a record does not exist, the custodian shall certify in writing that the record does not exist under the name given to the custodian by the applicant or by any other name known to the custodian;

(5) in unusual circumstances as herein specified the time limits prescribed in this subsection may be extended by written notice to the person making such request setting forth the reasons for such extension and the date on which a determination is expected to be dispatched. No such notice shall specify a date that would result in an extension for more than ten ~~working~~ business days from receipt of the request. As used in this subdivision, "unusual circumstances" means to the extent reasonably necessary to the proper processing of the particular request:

(A) the need to search for and collect the requested records from field facilities or other establishments that are separate from the office processing the request;

(B) the need to search for, collect, and appropriately examine a voluminous amount of separate and distinct records which are demanded in a single request; or

(C) the need for consultation, which shall be conducted with all practicable speed, with another agency having a substantial interest in the determination of the request or among two or more components of the agency having substantial subject matter interest therein, or with the attorney general.

(b) Any person making a request to any agency for records under subsection (a) of this section shall be deemed to have exhausted the person's administrative remedies with respect to each request if the agency fails to comply within the applicable time limit provisions of this section. Upon any determination by an agency to comply with a request for records, the records shall be made available promptly to the person making such request. Any notification of denial of any request for records under this section shall set forth the names and titles or positions of each person responsible for the denial of such request.

(c)(1) Any denial of access by the custodian of a public record may be appealed to the head of the agency. The head of the agency shall make a written determination on an appeal within five business days after the receipt of the appeal. A written determination shall include the asserted statutory basis

for denial and a brief statement of the reasons and supporting facts for denial.

(2) If the head of the agency reverses the denial of a request for records, the records shall be promptly made available to the person making the request. A failure by the agency to comply with any of the time limit provisions of this section shall be deemed a final denial of the request for records by the agency.

(d) In responding to a request to inspect or copy a record under this subchapter, a public agency shall consult with the person making the request in order to clarify the request or to obtain additional information that will assist the public agency in responding to the request and, when authorized by this subchapter, in facilitating production of the requested record for inspection or copying. In unusual circumstances, as that term is defined in subdivision (a)(5) of this section, a public agency may request that a person seeking a voluminous amount of separate and distinct records narrow the scope of a public records request.

(e) A public agency shall not withhold any record in its entirety on the basis that it contains some exempt content if the record is otherwise subject to disclosure; instead, the public agency shall redact the information it considers to be exempt and produce the record accompanied by an explanation of the basis for denial of the redacted information.

(f) If a person making the request has a disability which requires accommodation to gain equal access to the public record sought, the person shall notify the public agency of the type of accommodation requested. The public agency shall give primary consideration to the accommodation choice expressed by the requestor, but may propose an alternative accommodation so long as it achieves equal access. The public agency shall provide accommodation to the person making the request unless the agency can demonstrate that accommodation would result in a fundamental alteration in the nature of its service, programs, activities, or in undue financial and administrative burden.

(g) The secretary of state may provide municipal public agencies and members of the public information and advice regarding the requirements of the public records act and may utilize informational websites, toll-free telephone numbers, or other methods to provide such information and advice.

Sec. 5. 1 V.S.A. § 319 is amended to read:

§ 319. ENFORCEMENT

(a) Any person aggrieved by the denial of a request for public records under this subchapter may apply to the civil division of the superior court in the county in which the complainant resides, or has his or her personal place of

business, or in which the public records are situated, or in the civil division of the superior court of Washington County, to enjoin the public agency from withholding agency records and to order the production of any agency records improperly withheld from the complainant. In such a case, the court shall determine the matter de novo, and may examine the contents of such agency records in camera to determine whether such records or any part thereof shall be withheld under any of the exemptions set forth in section 317 of this title, and the burden ~~is~~ of proof shall be on the public agency to sustain its action.

(b) Except as to cases the court considers of greater importance, proceedings before the civil division of the superior court, as authorized by this section, and appeals there from, take precedence on the docket over all cases and shall be assigned for hearing and trial or for argument at the earliest practicable date and expedited in every way.

(c) If the public agency can show the court that exceptional circumstances exist and that the agency is exercising due diligence in responding to the request, the court may retain jurisdiction and allow the agency additional time to complete its review of the records.

(d)(1) ~~The~~ Except as provided in subdivision (2) of this section, the court ~~may~~ shall assess against the public agency reasonable attorney fees and other litigation costs reasonably incurred in any case under this section in which the complainant has substantially prevailed.

(2) The court may, in its discretion, assess against a public agency reasonable attorney fees and other litigation costs reasonably incurred in a case under this section in which the complainant has substantially prevailed provided that the public agency, within the time allowed for service of an answer under Rule 12(a)(1) of the Vermont Rules of Civil Procedure:

(A) concedes that a contested record or contested records are public; and

(B) provides the record or records to the complainant.

(3) The court may assesses against the complainant reasonable attorney fees and other litigation costs reasonably incurred in any case under this section when the court finds that the complainant has violated Rule 11 of the Vermont Rules of Civil Procedure.

Sec. 6. 1 V.S.A. § 320(b) is amended to read:

(b) In the event of noncompliance with the order of the court, the civil division of the superior court may punish for contempt the responsible employee or official, and in the case of a uniformed service, the responsible member.

Sec. 7. 1 V.S.A. § 313(a)(6) is amended to read:

(6) Discussion or consideration of records or documents excepted from the access to public records provisions of ~~subsection~~ section 317~~(b)~~ of this title. Discussion or consideration of the excepted record or document shall not itself permit an extension of the executive session to the general subject to which the record or document pertains;

Sec. 8. 3 V.S.A. § 218(d) is amended to read:

(d) The head of each state agency or department shall designate a member of his or her staff as the records officer for his or her agency or department, and shall notify the Vermont state archives and records administration in writing of the name and title of the person designated, and shall post the name and contact information of the person on the agency or department website, if one exists.

Sec. 9. 9 V.S.A. § 4113(b) is amended to read:

(b) Reports filed pursuant to this section shall be an exempt record and confidential pursuant to ~~subdivision 317(b)(1) of Title 1~~ 1 V.S.A. § 317(c)(1) and shall be maintained for the sole and confidential use of the commissioner, except that the reports may be disclosed to the federal government or to the appropriate energy agency or department of another state with substantially similar confidentiality statutes for regulations with respect to such reports. However, the commissioner shall make available to appropriate committees of the general assembly statistical information derived from the reports required by this section, provided that this may be done in a manner which preserves the confidentiality of the reports submitted by particular persons.

Sec. 10. 32 V.S.A. § 3755(e) is amended to read:

(e) Any applicant for appraisal under this subchapter bears the burden of proof as to his or her qualification. Any documents submitted by an applicant as evidence of income shall be held in confidence by any person accepting or reviewing them pursuant to provisions of this subchapter, and shall not be made available for public examination, whether or not such person is subject to the provisions of ~~subdivision 317(a)(6) of Title 1~~ 1 V.S.A. § 317(c)(6).

Sec. 11. PUBLIC RECORDS LEGISLATIVE STUDY COMMITTEE

(a) There is established a legislative study committee to review the requirements of the public records act and the numerous exemptions to that act in order to assure the integrity, viability, and the ultimate purposes of the act. The review committee shall consist of:

(1) Three members of the house of representatives, appointed by the speaker of the house; and

(2) Three members of the senate, appointed by the committee on committees.

(b) The review committee shall review the exemptions set forth in 1 V.S.A. § 317 or elsewhere in the Vermont Statutes Annotated to the inspection and copying of public records under the public records act, 1 V.S.A. chapter 5, subchapter 3. Prior to each legislative session, the committee shall submit to the house and senate committees on government operations and the house and senate committees on judiciary recommendations concerning whether the public records act and exemptions under the act from inspection and copying of a public record should be repealed, amended, or remain unchanged. The report of the committee may take the form of draft legislation.

(c) In reviewing and making a recommendation under subsection (b) of this section, the study committee may review:

(1) Whether the public records act requires revision;

(2) Whether an exemption to inspection or copying under the public records act is necessary, antiquated, or in need of revision;

(3) Whether an exemption to inspection or copying under the public records act is as narrowly tailored as possible, including the need to clarify the term "personal documents" referenced in 1 V.S.A. § 317(c)(7) in order to ensure that it does not unintentionally limit access to public records that are not personnel records; and

(4) Whether the public records act should be amended to clarify application of the act to contracts between a public agency and a private entity for the performance of a governmental function;

(5) Whether or not to authorize a public agency to charge for staff time associated with responding to a request to inspect or copy a public record, including whether an agency should be authorized to charge for the staff time incurred in locating, reviewing, or redacting a public record; and

(6) Any other criteria that assist the review committee in determining the value of an exemption as compared to the public's interest in the public record protected by the exemption.

(d) In developing recommendations authorized under subsection (a) of this section, the study committee shall consult with the secretary of administration, the secretary of state, the office of the attorney general, representatives of municipal interests, representatives of school or education interests, representatives of the media, and advocates for access to public records.

(e) The study committee shall elect co-chairs from among its members. For attendance at a meeting when the general assembly is not in session,

legislative members of the commission shall be entitled to the same per diem compensation and reimbursement for actual and necessary expenses as provided members of standing committees under 2 V.S.A. § 406. The study committee is authorized to meet no more than three times each year during the interim between sessions of the general assembly.

(f) Legislative council shall provide legal and administrative services to the study committee. The study committee may utilize the legal, research, and administrative services of other entities, such as educational institutions and, when necessary for the performance of its duties, the Vermont state archives and records administration.

Sec. 12. LEGISLATIVE COUNCIL; LIST OF PUBLIC RECORDS ACT EXEMPTIONS

The legislative council, under its statutory revision authority set forth in 2 V.S.A. § 421, shall compile a list of all known Vermont statutory exemptions to the inspection and copying of public records under the public records act, 1 V.S.A. chapter 5, subchapter 3. Legislative council shall publish the list of exemptions compiled under this section as a statutory revision note to 1 V.S.A. § 317 and shall update the list as necessary.

Sec. 13. STATE AGENCY PUBLIC RECORDS REQUEST SYSTEM

(a) Beginning July 1, 2011, all state agencies that receive a request to inspect or copy a public record shall catalogue the request in the public records request system that the secretary of administration established in response to the requirements of Sec. 3 of No. 132 of the Acts of the 2005 Adj. Sess. (2006).

(b) The secretary of administration shall revise and update the public records request system so that it includes: the date a public records request is received; the state agency that received the request; the organization or individual that made the request, including a contact name; the status of the request, including whether the request was fulfilled in whole, fulfilled in part, or denied; if the request was fulfilled in part or denied, the exemption or other grounds asserted as the basis for partial fulfillment or denial; the estimated hours necessary to respond to the request; the date the state agency closed the request; and the elapsed time between receipt of the request and the date the agency closed the request.

(c) On or before January 15, 2012, and annually thereafter, the secretary of administration shall submit to the senate and house committees on government operations a copy of the records requests catalogued in the public records request system in the preceding calendar year.

(d)(1) As a part of the report issued on or before January 15, 2012 to the senate and house committees on government operations under subsection (c) of this section, the secretary of administration, after consultation with the department of information and innovation and the Vermont state archives and records administration, shall submit a report regarding implementation by state agencies of an electronic documents management system for the creation, management, archiving, redaction, and confidential designation of records produced or acquired by state agencies. The report shall include a recommendation as to whether a documents management system should be implemented by state agencies.

(2) If the secretary recommends implementation of a document management system, the recommendation shall:

(A) identify a specific document management system for implementation by state agencies. The report shall summarize the operation or application of the system, provide a short explanation of the basis for selection of the system, and describe how the system will improve efficiency of state agencies in managing public records;

(B) estimate the cost of implementation by state agencies of the recommended document system;

(C) propose a schedule for implementation of the recommended document management system by all state agencies.

Sec. 14. PUBLIC RECORDS REQUESTS; MUNICIPALITIES

(a) The secretary of state, after consultation with the Vermont League of Cities and Towns, annually shall survey municipalities in the state regarding whether municipalities are receiving an increased number of requests to inspect records, whether requests for inspection of public records are being used to circumvent copying of a record by a municipality, and whether requests to inspect records pose any administrative burdens on municipalities. For purposes of this subsection, "municipality" shall mean a city, town, village, or school district of the state. On or before January 15, 2012 and annually thereafter, the secretary of state shall submit the results of the survey to the senate and house committees on government operations.

(b) As part of the report required under subsection (a) of this section to be submitted to the senate and house committees on government operations on January 15, 2012, the secretary of state, after consultation with the Vermont League of Cities and Towns and other interested parties, shall submit a recommendation for increasing municipal understanding and compliance with the requirements of the Public Records Act, as set forth in 1 V.S.A. chapter 5, subchapter 4.

Sec. 15. COURT ADMINISTRATOR REPORT ON PUBLIC RECORDS CASES

On or before January 15, 2012 and annually thereafter, the Vermont court administrator's office shall report to the senate and house committees on government operations regarding contested cases filed in the civil division of the superior court involving disputes under the Public Records Act, as set forth in 1 V.S.A. chapter 5, subchapter 4. The report shall include the number of Public Records Act contested cases filed annually in the civil division of the superior court, the disposition of such cases, and whether attorney's fees were awarded in any of the cases. The court administrator shall submit a copy of a report required under this section to the secretary of state at the same time the report is submitted to the senate and house committees on government operations.

Sec. 16. REPEAL

Sec. 11 of this act (public records legislative study committee) is repealed on January 15, 2015.

Sec. 17. EFFECTIVE DATE

This act shall take effect on July 1, 2011.

(For text see House Journal 4/6 - 4/7/11)

Amendment to be offered by Rep. Hubert of Milton to H. 73

First: In Sec. 2, 1 V.S.A. § 316, in subsection (c), in the first sentence, by striking out "In" where it appears before "the following instances" and inserting in lieu thereof "Unless otherwise provided by law, in"

Second: In Sec. 4, 1 V.S.A. § 318, in subsection (g), by striking out "may" where it occurs the first time and inserting in lieu thereof "shall"

Third: In Sec. 11, in subsection (c), at the end of subdivisions (3) and (5), by striking out "and" where it appears and by inserting "; and" at the end of subdivision (6) and by adding subdivision (7) to read as follows:

(7) Whether a municipality and how a municipality shall appoint or designate an official, officer, or employee responsible for advising municipal employees and any agency, board, committee, department, instrumentality, commission, or authority of the municipality regarding the requirements of the public records act and proper management of public records. As used in this subdivision, "municipality" shall mean a city, town, village, or school district.

Fourth: In Sec. 11, in subsection (e), by striking out the last sentence and inserting in lieu thereof the following:

The study committee is authorized to meet three times each year during the interim between sessions of the general assembly, provided that the speaker of the house and the committee on committees may authorize the study committee to hold additional meetings during the interim between sessions so that the committee may accomplish its charge.

Fifth: In Sec. 14, by striking out the designation (a) where it appears and by striking out subsection (b) in its entirety

H. 369

An act relating to health professionals regulated by the board of medical practice

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

Sec. 1. 26 V.S.A. chapter 7 is amended to read:

CHAPTER 7. PODIATRY

Subchapter 1. General Provisions

§ 321. DEFINITIONS

In this chapter, unless the context requires another meaning:

(1) "Board" means the state board of medical practice established by chapter 23 of this title.

(2) "Disciplinary action" means any action taken against a licensee or an applicant by the board~~, the appellate officer~~, or on appeal ~~therefrom~~ from that action, when that action suspends, revokes, limits, or conditions licensure in any way, ~~and~~ or when it includes reprimands or an administrative penalty.

* * *

§ 324. PROHIBITIONS; PENALTIES

* * *

(c) A person who violates a provision of this ~~chapter~~ section shall be imprisoned not more than two years or fined not more than ~~$100.00 for the first offense and not more than $500.00 for each subsequent offense~~ $10,000.00.

* * *

§ 371. ELIGIBILITY

To be eligible for licensure as a podiatrist, an applicant must:

* * *

(3) have received a diploma or certificate of graduation from an accredited school of podiatric medicine approved by the board; ~~and~~

(4) successfully complete the examinations given by the National Board of Podiatry Examiners; and

(5) if the applicant has not engaged in practice as a podiatrist within the last three years, comply with the requirements for updating knowledge and skills as defined by board rules.

* * *

§ 373. RENEWAL OF LICENSURE

(a) ~~Licenses shall be renewable every two years without examination and on payment of the required fee~~ A person licensed by the board to practice podiatry shall apply biennially for the renewal of his or her license. At least one month prior to the date on which renewal is required, the board shall send to each licensee a license renewal application form and notice of the date on which the existing license will expire. On or before the renewal date, the licensee shall file an application for license renewal and pay the required fee; however, any podiatrist while on extended active duty in the uniformed services of the United States or as a member of the national guard, state guard, or reserve component who is licensed as a podiatrist at the time of an activation or deployment shall receive an extension of licensure up to 90 days following the podiatrist's return from activation or deployment, provided the podiatrist notifies the board of his or her activation or deployment prior to the expiration of the current license and certifies that the circumstances of the activation or deployment impede good faith efforts to make timely application for renewal of the license. The board shall register the applicant and issue the renewal license. Within one month following the date by which renewal is required, the board shall pay the license renewal fees into the medical practice board special fund.

(b) A license which has lapsed may be reinstated on payment of a renewal fee and a late renewal penalty. The applicant shall not be required to pay renewal fees during periods when the license was lapsed. However, if such license remains lapsed for a period of three years, the board may~~, after notice and an opportunity for hearing,~~ require ~~reexamination as a condition of renewal~~ the licensee to update his or her knowledge and skills as defined by board rules.

* * *

(d) All applicants shall demonstrate that the requirements for licensure are met.

§ 374. FEES; LICENSES

Applicants and persons regulated under this chapter shall pay the following fees:

(1) Application for licensure ~~$565.00, in fiscal year 2009 $600.00, and in fiscal year 2010 and thereafter,~~ $625.00; the board shall use at least $25.00 of this fee to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

(2) Biennial renewal ~~$450.00 and in fiscal year 2009 and thereafter,~~ $500.00; the board shall use at least $25.00 of this fee to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

§ 375. UNPROFESSIONAL CONDUCT

(a) ~~The term "unprofessional conduct" as used in this chapter shall mean the conduct prohibited by this chapter.~~

(b) The following conduct and the conduct described in section 1354 of this title by a licensed podiatrist constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of licensure:

(1) ~~fraudulent procuring~~ fraud or ~~use of a license~~ misrepresentation in applying for or procuring a podiatry license or in connection with applying for or procuring a periodic renewal of a podiatry license;

* * *

(c) Unprofessional conduct includes the following actions by a licensee:

* * *

(3) ~~professional negligence~~ failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct. Failure to practice competently includes as determined by the board:

(A) performance of unsafe or unacceptable patient care; and

(B) failure to conform to the essential standards of acceptable and prevailing practice;

* * *

(7) administering, dispensing or prescribing any controlled substance other than as authorized by law;

(8) habitual or excessive use or abuse of drugs, alcohol, or other substances that impair the podiatrist's ability to practice.

* * *

§ 376. DISPOSITION OF COMPLAINTS

* * *

(b) ~~The board shall accept complaints from any person including a state or federal agency and the attorney general~~ Any person, firm, corporation, or public officer may submit a written complaint to the board charging any podiatrist practicing in the state with unprofessional conduct, specifying the grounds. The board ~~may~~ shall initiate ~~disciplinary action in any complaint against~~ an investigation of a podiatrist ~~and~~ when a complaint is received or may act without having received a complaint.

(c) After giving an opportunity for a hearing ~~and upon a finding of unprofessional conduct~~, the board ~~may suspend or revoke a license, refuse to issue or renew a license, issue a warning, or limit or condition a license~~ shall take disciplinary action described in subsection 1361(b) of this title against a podiatrist or applicant found guilty of unprofessional conduct.

(d) The board may approve a negotiated agreement between the parties when it is in the best interest of the public health, safety, or welfare to do so. Such an agreement may include~~, without limitation,~~ any of the following conditions or restrictions which may be in addition to, or in lieu of, suspension:

* * *

(4) a requirement that the scope of practice permitted be restricted to a specified extent;

(5) an administrative penalty not to exceed $1,000.00 for each act that constitutes an unprofessional conduct violation. Any money received from the imposition of an administrative penalty imposed under this subdivision shall be deposited into the board of medical practice regulatory fee fund for the purpose of providing education and training for board members and the professions regulated by the board. The commissioner shall detail in the annual report receipts and expenses from money received under this subsection.

* * *

Sec. 2. 26 V.S.A. chapter 23 is amended to read:

CHAPTER 23. MEDICINE ~~AND SURGERY~~

Subchapter 1. General Provisions

§ 1311. DEFINITIONS

For the purposes of this chapter:

(1) ~~A person who advertises or holds himself or herself out to the public as a physician or surgeon, or who assumes the title or uses the words or letters "Dr.," "Doctor," "Professor," "M.D.," or "M.B.," in connection with his or her name, or any other title implying or designating that he or she is a practitioner of medicine or surgery in any of its branches, or shall advertise or hold himself or herself out to the public as one skilled in the art of curing or alleviating disease, pain, bodily injuries or physical or nervous ailments, or shall prescribe, direct, recommend, or advise, give or sell for the use of any person, any drug, medicine or other agency or application for the treatment, cure or relief of any bodily injury, pain, infirmity or disease, or who follows the occupation of treating diseases by any system or method, shall be deemed a physician, or practitioner of medicine or surgery.~~ Practice of medicine means:

(A) using the designation "Doctor," "Doctor of Medicine," "Physician," "Dr.," "M.D.," or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless the designation additionally contains the description of another branch of the healing arts for which one holds a valid license in Vermont;

(B) advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;

(C) offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person;

(D) offering or undertaking to prevent, diagnose, correct, or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;

(E) offering or undertaking to perform any surgical operation upon any person;

(F) rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within the state by a physician located outside the state as a result of the transmission of individual patient data by electronic or other means from within the state to the physician or his or her agent; or

(G) rendering a determination of medical necessity or a decision affecting the diagnosis or treatment of a patient.

* * *

§ 1313. EXEMPTIONS

(a) ~~Except as to the provisions of sections 1398 and 1399 of this title, this chapter shall not apply to persons licensed to practice osteopathy under chapter 33 of this title; or to persons licensed to practice chiropractic under the laws of the state; or to persons licensed under the laws in force prior to December 9, 1904, or to commissioned officers~~ The provisions of this chapter shall not apply to the following:

(1) a health care professional licensed or certified by the office of professional regulation when that person is practicing within the scope of his or her profession;

(2) a member of the United States ~~army, navy or marine hospital service~~ military or national guard, including a national guard member in state status, or to any person ~~or persons~~ giving aid, assistance, or relief in emergency or accident cases pending the arrival of a regularly licensed physician ~~or surgeon.~~;

~~(b)~~(3) ~~This chapter shall not apply to a nonresident physician or surgeon who is called to treat a particular case in this state and who does not otherwise practice in this state, provided that such nonresident physician or surgeon is duly licensed where he resides and that the state of his residence grants the same privilege to duly licensed practitioners of this state. This chapter shall not prevent~~ a nonresident physician ~~or surgeon from~~ coming into this state ~~for consultation~~ to consult or using telecommunications to consult with a duly licensed practitioner herein ~~nor shall it prevent,~~; or

(4) a duly licensed physician ~~or surgeon of an adjoining~~ in another state, ~~or of the Dominion of~~ in Canada ~~from coming into a town bordering thereon, in this state for the purpose of treating a sick or disabled person therein~~, or in another nation as approved by the board who is visiting a medical school or a teaching hospital in this state to receive or conduct medical instruction for a period not to exceed three months, provided the practice is limited to that instruction and is under the supervision of a physician licensed by the board.

~~(c)~~(b) The provisions of sections 1311 and 1312 of this title shall not apply to a person, firm or corporation that manufactures or sells patent, compound or proprietary medicines, that are compounded according to the prescription of a physician who has been duly authorized to practice medicine, or to the domestic administration of family remedies.

* * *

(e) ~~Notwithstanding the provisions of subsection 1313(d) of this title, no physician's assistant shall engage in the practice of optometry as defined in~~

~~section 1601 of this title.~~

* * *

§ 1314. ILLEGAL PRACTICE

(a) A person who, not being licensed, advertises or holds himself or herself out to the public as described in section 1311 of this title, or who, not being licensed, practices medicine ~~or surgery~~ as defined in section 1311 of this title, or who practices medicine ~~or surgery~~ under a fictitious or assumed name, or who impersonates another practitioner or who is not a licensed health care provider as defined in 18 V.S.A. § 5202 and signs a certificate of death for the purpose of burial or removal, shall be imprisoned not more than ~~three months~~ two years or fined not more than ~~$200.00 nor less than $50.00~~ $10,000.00, or both.

* * *

§ 1317. UNPROFESSIONAL CONDUCT TO BE REPORTED TO BOARD

(a) Any hospital, clinic, community mental health center, or other health care institution in which a licensee performs professional services shall report to the ~~commissioner of health~~ board, along with supporting information and evidence, any disciplinary action taken by it or its staff which significantly limits the licensee's privilege to practice or leads to suspension or expulsion from the institution, a nonrenewal of medical staff membership, or the restrictions of privileges at a hospital taken in lieu of, or in settlement of, a pending disciplinary case related to unprofessional conduct as defined in sections 1354 and 1398 of this title. The commissioner of health shall forward any such information or evidence he or she receives immediately to the board. The report shall be made within 10 days of the date such disciplinary action was taken, and, in the case of disciplinary action taken against a licensee based on the provision of mental health services, a copy of the report shall also be sent to the commissioner of mental health and the commissioner of disabilities, aging, and independent living. This section shall not apply to cases of resignation or separation from service for reasons unrelated to disciplinary action.

* * *

(e) A person who violates this section shall be subject to a civil penalty of not more than ~~$1,000.00~~ $10,000.00.

§ 1318. ACCESSIBILITY AND CONFIDENTIALITY OF DISCIPLINARY MATTERS

* * *

(c) The commissioner of health shall prepare and maintain a register of all complaints, which shall be a public record, and which shall show:

* * *

(2) only with respect to complaints resulting in filing of disciplinary charges or stipulations or the taking of disciplinary action, the following additional information, except for medical and other protected health information contained therein pertaining to any identifiable person that is otherwise confidential by state or federal law:

* * *

(E) stipulations ~~filed with~~ presented to the board at a public meeting; and

* * *

(f) For the purposes of this section, "disciplinary action" means action that suspends, revokes, limits, or conditions licensure or certification in any way, and includes reprimands and administrative penalties.

(g) Nothing in this section shall prohibit the disclosure of information by the commissioner regarding disciplinary complaints to Vermont or other state or federal law enforcement or regulatory agencies in the execution of its duties authorized by statute or regulation, including the department of disabilities, aging, and independent living or the department of banking, insurance, securities, and health care administration in the course of its investigations about an identified licensee, provided the agency or department agrees to maintain the confidentiality and privileged status of the information as provided in subsection (d) of this section.

(h) Nothing in this section shall prohibit the board, at its discretion, from sharing investigative and adjudicatory files of an identified licensee with another state, territorial, or international medical board at any time during the investigational or adjudicative process.

(i) Neither the commissioner nor any person who received documents, material, or information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, material, or information.

Subchapter 2. Board of Medical Practice

§ 1351. BOARD OF MEDICAL PRACTICE

(a) A state board of medical practice is created. The board shall be composed of 17 members, nine of whom shall be licensed physicians, one of whom shall be a ~~physician's~~ physician assistant ~~certified~~ licensed pursuant to

chapter 31 of this title, one of whom shall be a podiatrist ~~as described in section 322~~ licensed pursuant to chapter 7 of this title, and six of whom shall be persons not associated with the medical field. The governor, with the advice and consent of the senate, shall appoint the members of the board. Appointments shall be for a term of five years, except that a vacancy occurring during a term shall be filled by an appointment by the governor for the unexpired term. No member shall be appointed to more than two consecutive full terms, but a member appointed for less than a full term (originally or to fill a vacancy) may serve two full terms in addition to such part of a full term, and a former member shall again be eligible for appointment after a lapse of one or more years. Any member of the board may be removed by the governor at any time. The board shall elect from its members a chair, vice chair, and secretary who shall serve for one year and until their successors are appointed and qualified. The board shall meet upon the call of the chair or the commissioner of health, or at such other times and places as the board may determine. Except as provided in section 1360 of this title, nine members of the board shall constitute a quorum for the transaction of business. The affirmative vote of the majority of the members present shall be required to carry any motion or resolution, to adopt any rule, to pass any measure or to authorize any decision or order of the board.

(b) In the performance of their duties, members of the board shall be paid ~~$30.00~~ a per diem and their actual and necessary expenses as provided by 32 V.S.A. § 1010(b).

(c) The board of medical practice is established as an office within the department of health. With respect to the board, the commissioner shall have the following powers and duties to:

* * *

(4) act as custodian of the records of the board; ~~and~~

(5) prepare an annual budget and administer money appropriated to the board by the general assembly. The budget of the board shall be part of the budget of the department. A board of medical practice regulatory fee fund is created. All board regulatory fees received by the department shall be deposited into this fund and used to offset up to two years of the costs incurred by the board, and shall not be used for any purpose other than professional regulation and responsibilities of the board, as determined by the commissioner of health. To ensure that revenues derived by the department are adequate to offset the cost of regulation, the commissioner shall review fees from time to time, and present proposed fee changes to the general assembly;

(6) prepare and maintain a registry of all physicians licensed by the

board; and

(7) make available an accounting of all fees and fines received by the board and all expenditures and costs of the board annually.

* * *

§ 1353. POWERS AND DUTIES OF THE BOARD

The board shall have the following powers and duties to:

(1) License and certify health professionals pursuant to this title.

(2) Investigate all complaints and charges of unprofessional conduct against any holder of a license or certificate, or any medical practitioner practicing pursuant to section 1313 of this title, and to hold hearings to determine whether such charges are substantiated or unsubstantiated.

~~(2)~~(3) Issue subpoenas and administer oaths in connection with any investigations, hearings, or disciplinary proceedings held under this chapter.

~~(3)~~(4) Take or cause depositions to be taken as needed in any investigation, hearing or proceeding.

~~(4)~~(5) Undertake any such other actions and procedures specified in, or required or appropriate to carry out, the provisions of this chapter and chapters 7, 29, 31, and 52 of this title.

~~(5)~~(6) Require a licensee or applicant to submit to a mental or physical examination, and an evaluation of medical knowledge and skill by individuals or entities designated by the board if the board has a reasonable basis to believe a licensee or applicant may be incompetent or unable to practice medicine with reasonable skill and safety. The results of the examination or evaluation shall be admissible in any hearing before the board. The results of an examination or evaluation obtained under this subsection and any information directly or indirectly derived from such examination or evaluation shall not be used for any purpose, including impeachment or cross-examination against the licensee or applicant in any criminal or civil case, except a prosecution for perjury or giving a false statement. The board shall bear the cost of any examination or evaluation ordered and conducted pursuant to this subdivision in whole or in part if the licensee demonstrates financial hardship or other good cause. The licensee or applicant, at his or her expense, shall have the right to present the results or reports of independent examinations and evaluations for the board's due consideration. An order by the board that a licensee or applicant submit to an examination, test or evaluation shall be treated as a discovery order for the purposes of enforcement under ~~sections~~ 3 V.S.A. §§ 809a and 809b ~~of Title 3~~. The results of an examination or evaluation obtained under this subdivision shall be confidential except as

provided in this subdivision.

(7) Investigate all complaints of illegal practice of medicine and refer any substantiated illegal practice of medicine to the office of the attorney general or the state's attorney in the county in which the violation occurred.

(8) Obtain, at the board's discretion, from the Vermont criminal information center a Vermont criminal history record, an out-of-state criminal history record, and a criminal history record from the Federal Bureau of Investigation, for any applicant, licensee, or holder of certification. The board may also inquire of Interpol for any information on criminal history records of an applicant, licensee, or holder of certification. Each applicant, licensee, or holder of certification shall consent to the release of criminal history records to the board on forms substantially similar to the release forms developed in accordance with 20 V.S.A. § 2056c. When the board obtains a criminal history record, it shall promptly provide a copy of the record to the applicant, licensee, or holder of certification and inform him or her of the right to appeal the accuracy and completeness of the record pursuant to rules adopted by the Vermont criminal information center. When fingerprinting is required pursuant to this subdivision, the applicant, licensee, or holder of certification shall bear all costs associated with fingerprinting. The board shall comply with all laws regulating the release of criminal history records and the protection of individual privacy. No person shall confirm the existence or nonexistence of criminal history record information to any person who would not be eligible to receive the information pursuant to this chapter. For purposes of this subdivision, "criminal history record" is as defined in 20 V.S.A. § 2056a.

(9) Inquire, at the board's discretion, of the Vermont department for children and families or of the Vermont department of disabilities, aging, and independent living to determine whether any applicant, licensee, or holder of certification who may provide care or treatment to a child or a vulnerable adult is listed on the child protection registry or the vulnerable adult abuse, neglect, and exploitation registry.

§ 1354. UNPROFESSIONAL CONDUCT

(a) The board shall find that any one of the following, or any combination of the following, whether or not the conduct at issue was committed within or outside the state, constitutes unprofessional conduct:

(1) ~~fraudulent~~ fraud or ~~deceptive procuring or use of a license~~ misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;

* * *

(5) ~~addiction to narcotics,~~ habitual ~~drunkenness~~ or ~~rendering professional services to a patient if the physician is intoxicated or under the influence of drugs~~ excessive use or abuse of drugs, alcohol, or other substances that impair the licensee's ability to practice medicine;

* * *

(15) practicing medicine with a physician who is not legally practicing within the state, or aiding or abetting such physician in the practice of medicine; except that it shall be legal to practice in an accredited preceptorship or residency training program or pursuant to section 1313 of this title;

* * *

(23) revocation of a license to practice medicine or surgery in another jurisdiction on one or more of the grounds specified in ~~subdivisions (1) (25) of~~ this section;

* * *

(30) conviction of a crime related to the practice of the profession or conviction of a felony, whether or not related to the practice of the profession, or failure to report to the board a conviction of any crime related to the practice of the profession or any felony in any court within 30 days of the conviction;

* * *

(32) use of the services of a radiologist assistant by a radiologist in a manner that is inconsistent with the provisions of chapter 52 of this title;

(33)(A) providing, prescribing, dispensing or furnishing medical services or prescription medication or prescription-only devices to a person in response to any communication transmitted or received by computer or other electronic means, when the licensee fails to take the following actions to establish and maintain a proper physician-patient relationship:

(i) a reasonable effort to verify that the person requesting medication is in fact the patient, and is in fact who the person claims to be;

(ii) establishment of documented diagnosis through the use of accepted medical practices; and

(iii) maintenance of a current medical record.

(B) For the purposes of this subdivision (33), an electronic, on-line, or telephonic evaluation by questionnaire is inadequate for the initial evaluation of the patient.

(C) The following would not be in violation of this subdivision (33) if transmitted or received by computer or other electronic means:

(i) initial admission orders for newly hospitalized patients;

(ii) prescribing for a patient of another physician for whom the prescriber has taken the call;

(iii) prescribing for a patient examined by a licensed advanced practice registered nurse, physician assistant, or other advanced practitioner authorized by law and supported by the physician;

(iv) continuing medication on a short-term basis for a new patient, prior to the patient's first appointment; or

(v) emergency situations where life or health of the patient is in imminent danger;

(34) failure to provide to the board such information it may reasonably request in furtherance of its statutory duties. The patient privilege set forth in 12 V.S.A. § 1612 shall not bar the licensee's obligations under this subsection (a) and no confidentiality agreement entered into in concluding a settlement of a malpractice claim shall exempt the licensee from fulfilling his or her obligations under this subdivision;

(35) disruptive behavior which involves interaction with physicians, hospital personnel, office staff, patients, or support persons of the patient or others that interferes with patient care or could reasonably be expected to adversely affect the quality of care rendered to a patient;

(36) commission of any sexual misconduct which exploits the physician-patient relationship, including sexual contact with a patient, surrogates, or key third parties;

(37) prescribing, selling, administering, distributing, ordering, or dispensing any drug legally classified as a controlled substance for the licensee's own use or to an immediate family member as defined by rule;

(38) signing a blank or undated prescription form;

(39) use of the services of a physician assistant by a physician in a manner which is inconsistent with the provisions of chapter 31 of this title.

* * *

§ 1355. COMPLAINTS; HEARING COMMITTEE

(a) Any person, firm, corporation, or public officer may submit a written complaint to the ~~secretary charging~~ board alleging any person practicing medicine ~~or surgery~~ in the state ~~with~~ committed unprofessional conduct, specifying the grounds therefor. ~~If the board determines that such complaint merits consideration, or~~ i~~f the board shall have reason to believe, without a~~

~~formal complaint, that any person practicing medicine or surgery in the state has been guilty of unprofessional conduct, and in the case of every formal complaint received, the chairman~~ The board shall initiate an investigation of the physician when a complaint is received or may act on its own initiative without having received a complaint. The chairperson shall designate four members, including one public member to serve as a committee to hear or investigate and report upon such charges.

* * *

(c) A person or organization shall not be liable in a civil action for damages resulting from the good faith reporting of information to the board about alleged incompetent, unprofessional, or unlawful conduct of a licensee.

(d) The hearing committee may close portions of hearings to the public if the hearing committee deems it appropriate in order to protect the confidentiality of an individual or for medical and other protected health information pertaining to any identifiable person that is otherwise confidential by state or federal law.

(e) In any proceeding under this section which addresses an applicant's or licensee's alleged sexual misconduct, evidence of the sexual history of the victim of the alleged sexual misconduct shall neither be subject to discovery nor be admitted into evidence. Neither opinion evidence nor evidence of the reputation of the victim's sexual conduct shall be admitted. At the request of the victim, the hearing committee may close portions of hearings to the public if the board deems it appropriate in order to protect the identity of the victim and the confidentiality of his or her medical records.

* * *

§ 1357. TIME AND NOTICE OF HEARING

The time of hearing shall be fixed by the secretary as soon as convenient, but not earlier than 30 days after service of the charge upon the person complained against. The secretary shall issue a notice of hearing of the charges, which notice shall specify the time and place of hearing and shall notify the person complained against that he or she may file with the secretary a written response within 20 days of the date of service. ~~Such~~ The notice shall also notify the person complained against that a stenographic record of the proceeding will be kept, that he or she will have the opportunity to appear personally and to have counsel present, with the right to produce witnesses and evidence in his or her own behalf, to cross-examine witnesses testifying against him or her and to examine such documentary evidence as may be produced against him or her.

* * *

§ 1359. REPORT OF HEARING

Within 30 days after holding a hearing under the provisions of section 1357 ~~and section 1358~~ of this title, the committee shall make a written report of its findings of fact and its recommendations, and the same shall be forthwith transmitted to the secretary, with a transcript of the evidence.

§ 1360. HEARING BEFORE BOARD

* * *

(d) The board may close portions of hearings to the public if the board deems it appropriate in order to protect the confidentiality of an individual or for medical and other protected health information pertaining to any identifiable person that is otherwise confidential by state or federal law.

§ 1361. DECISION AND ORDER

* * *

(b) In such order, the board may reprimand the person complained against, as it deems appropriate; condition, limit, suspend or revoke the license, certificate, or practice of the person complained against; or take such other action relating to discipline or practice as the board determines is proper, including imposing an administrative penalty not to exceed $1,000.00 for each act that constitutes an unprofessional conduct violation. Any money received from the imposition of an administrative penalty imposed under this subsection shall be deposited into the board of medical practice regulatory fee fund for the purpose of providing education and training for board members and licensees. The commissioner shall detail in the annual report receipts and expenses from money received under this subsection.

(c) If the person complained against is found not guilty, or the proceedings against him or her are dismissed, the board shall forthwith order a dismissal of the charges and the exoneration of the person complained against.

* * *

§ 1365. NOTICE OF CONVICTION OF CRIME; INTERIM SUSPENSION OF LICENSE

(a) The board shall treat a certified copy of the judgment of conviction of a crime for which a licensee may be disciplined under ~~subdivision~~ section 1354~~(a)(3)~~ of this title as an unprofessional conduct complaint. The record of conviction shall be conclusive evidence of the fact that the conviction occurred. If a person licensed under this chapter is convicted of a crime by a court in this state, the clerk of the court shall within 10 days of such conviction

transmit a certified copy of the judgment of conviction to the board.

* * *

§ 1368. DATA REPOSITORY; LICENSEE PROFILES

(a) A data repository is created within the department of health which will be responsible for the compilation of all data required under this section and any other law or rule which requires the reporting of such information. Notwithstanding any provision of law to the contrary, licensees shall promptly report and the department shall collect the following information to create individual profiles on all health care professionals licensed, certified, or registered by the department, pursuant to the provisions of this title, in a format created that shall be available for dissemination to the public:

* * *

(6)(A) All medical malpractice court judgments and all medical malpractice arbitration awards in which a payment is awarded to a complaining party during the last 10 years, and all settlements of medical malpractice claims in which a payment is made to a complaining party within the last 10 years. Dispositions of paid claims shall be reported in a minimum of three graduated categories, indicating the level of significance of the award or settlement, if valid comparison data are available for the profession or specialty. Information concerning paid medical malpractice claims shall be put in context by comparing an individual health care professional's medical malpractice judgment awards and settlements to the experience of other health care professionals within the same specialty within the New England region or nationally. The commissioner may, in consultation with the Vermont medical society, report comparisons of individual health care professionals covered under this section to all similar health care professionals within the New England region or nationally.

(B) Comparisons of malpractice payment data shall be accompanied by:

(i) an explanation of the fact that ~~physicians~~ professionals treating certain patients and performing certain procedures are more likely to be the subject of litigation than others;

(ii) a statement that the report reflects data for the last 10 years, and the recipient should take into account the number of years the ~~physicians~~ professional has been in practice when considering the data;

* * *

(iv) an explanation of the possible effect of treating high-risk patients on a ~~physician's~~ professional's malpractice history; and

* * *

(C) Information concerning all settlements shall be accompanied by the following statement: "Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the health care professional. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred." Nothing herein shall be construed to limit or prevent the licensing authority from providing further explanatory information regarding the significance of categories in which settlements are reported. Pending malpractice claims and actual amounts paid by or on behalf of a ~~physician~~ professional in connection with a malpractice judgment, award or settlement shall not be disclosed by the commissioner of health or by the licensing authority to the public. Nothing herein shall be construed to prevent the licensing authority from investigating and disciplining a health care professional on the basis of medical malpractice claims that are pending.

* * *

(c) The profile shall include the following conspicuous statement: "This profile contains information which may be used as a starting point in evaluating the ~~physician~~ professional. This profile should not, however, be your sole basis for selecting a ~~physician~~ professional."

Subchapter 3. Licenses

§ 1391. ~~GENERAL PROVISIONS~~ QUALIFICATIONS FOR MEDICAL LICENSURE

* * *

(b) If a person successfully completes the examination, he or she may then apply for licensure to practice medicine ~~and surgery~~ in the state of Vermont. In addition, each applicant ~~must appear for a personal interview with one or more members of the~~ may be interviewed by a board member.

* * *

(e) An applicant for limited temporary license, who shall furnish the board with satisfactory proof that he or she has attained the age of majority, ~~and~~ is of good moral character, ~~that he or she~~ is a graduate of a legally chartered medical school of this country or of a foreign country ~~having~~ that is recognized by the board and which has power to grant degrees in medicine, that all other eligibility requirements for house officer status have been met, and that he or she has been appointed an intern, resident, fellow or medical officer in a licensed hospital or in a clinic which is affiliated with a licensed hospital, or in

any hospital or institution maintained by the state, or in any clinic or outpatient clinic affiliated with or maintained by the state, may upon the payment of the required fee, be granted a limited temporary license by the board as a hospital medical officer for a period of up to 54 weeks and such license may be renewed or reissued, upon payment of the fee, for the period of the applicant's postgraduate training, internship, or fellowship program. Such limited temporary license shall entitle the said applicant to practice medicine only in the hospital or other institution designated on his or her certificate of limited temporary license and in clinics or outpatient clinics operated by or affiliated with such designated hospital or institution and only if such applicant is under the direct supervision and control of a licensed physician. Such licensed physician shall be legally responsible and liable for all negligent or wrongful acts or omissions of the limited temporary licensee and shall file with the board the name and address both of himself or herself and the limited temporary licensee and the name of such hospital or other institution. Such limited temporary license shall be revoked upon the death or legal incompetency of the licensed physician or, upon ten days written notice, by withdrawal of his or her filing by such licensed physician. The limited temporary licensee shall at all times exercise the same standard of care and skill as a licensed physician, practicing in the same specialty, in the state of Vermont. Termination of appointment as intern, resident, fellow or medical officer of such designated hospital or institution shall operate as a revocation of such limited temporary license. An application for limited temporary license shall not be subject to ~~section~~ subsection 1391(d) of this title.

§ 1392. [Repealed.]

§ 1393. EXAMINATIONS

The examinations shall be wholly or partly in writing, in the English language, and shall be of a practical character, sufficiently strict to test the qualifications of the applicant. In its discretion the board may use multiple choice style examinations provided by the National Board of Medical Examiners or by the Federation of State Medical Boards ~~(The Federation Licensing Examination or FLEX)~~, or as determined by rule. The ~~examinations~~ examination shall embrace the general subjects of anatomy, physiology, chemistry, pathology, bacteriology, hygiene, practice of medicine, surgery, obstetrics, gynecology, materia medica, therapeutics, and legal medicine. The subjects covered by the National Board ~~or FLEX~~ of Medical Examiners examination shall be considered to have met the requirements of this section. If the applicant passes the ~~National Board of Examiners test or FLEX~~ examination approved by the board and meets the other standards for licensure, he or she will qualify for licensure.

* * *

§ 1395. LICENSE WITHOUT EXAMINATION

(a) Without examination the board may, upon payment of the required fee, issue a license to a reputable physician ~~or surgeon~~ who personally appears and presents a certified copy of a certificate of registration or a license issued to him or her in a jurisdiction whose requirements for registration are deemed by the board as equivalent to those of this state, providing that such jurisdiction grants the same reciprocity to a Vermont physician or by the national board of medical examiners.

(b) Without examination the board may issue a license to a reputable physician ~~or surgeon~~ who is a resident of a foreign country and who shall furnish the board with satisfactory proof that he or she has been appointed to the faculty of a medical college accredited by the Liaison Committee on Medical Education (LCME) and located within the state of Vermont. An applicant for a license under this subsection shall furnish the board with satisfactory proof that he or she has attained the age of majority, is of good moral character, is licensed to practice medicine in his or her country of residence, and that he or she has been appointed to the faculty of an LCME accredited medical college located within the state of Vermont. The information submitted to the board concerning the applicant's faculty appointment shall include detailed information concerning the nature and term of the appointment and the method by which the performance of the applicant will be monitored and evaluated. A license issued under this subsection shall be for a period no longer than the term of the applicant's faculty appointment and may, in the discretion of the board, be for a shorter period. A license issued under this subsection shall expire automatically upon termination for any reason of the licensee's faculty appointment.

(c) Notwithstanding the provisions of subsection (a) of this section and any other provision of law, a physician who holds an unrestricted license in all jurisdictions where the physician is currently licensed, and who certifies to the Vermont board of medical practice that he or she will limit his or her practice in Vermont to providing pro bono services at a free or reduced fee health care clinic in Vermont and who meets the criteria of the board, shall be licensed by the board within 60 days of the licensee's certification without further examination, interview, fee, or any other requirement for board licensure. The physician shall file with the board, on forms provided by the board and based on criteria developed by the board, information on medical qualifications, professional discipline, criminal record, malpractice claims, or any other such information as the board may require. A license granted under this subsection shall authorize the licensee to practice medicine ~~or surgery~~ on a voluntary basis

in Vermont.

§ 1396. REQUIREMENTS FOR ADMISSION TO PRACTICE

(a) The standard of requirements for admission to practice in this state, under section 1395 of this title, shall be as follows:

* * *

(4) Moral: Applicant shall present letters of reference as to moral character and professional competence from the chief of service and two other active physician staff members at the hospital where he or she was last affiliated. In the discretion of the board, letters from different sources may be presented.

* * *

(7) Practice: Applicant shall have practiced medicine within the last three years as defined in section 1311 of this title or shall comply with the requirements for updating knowledge and skills as defined by board rules.

* * *

§ 1398. REFUSAL OR REVOCATION OF LICENSES

1. The board may refuse to issue the licenses provided for in section 1391 of this title to persons who ~~have been convicted of the practice of criminal abortion, or who~~, by false or fraudulent representations, have obtained or sought to obtain practice in their profession, or by false or fraudulent representations of their profession, have obtained or sought to obtain money or any other thing of value, or who assume names other than their own, or for any other immoral, unprofessional or dishonorable conduct. ~~For like cause, or when a licensee has been admitted to a mental hospital or has become incompetent by reason of senility, the board may suspend or revoke any certificate issued by it.~~ However, a certificate shall not be suspended, revoked, or refused until the holder or applicant is given a hearing before the board. In the event of revocation, the holder of any certificate so revoked shall forthwith relinquish the same to the secretary of the board.

§ 1399. [Repealed.]

§ 1400. RENEWAL OF LICENSE; CONTINUING MEDICAL EDUCATION

(a) Every person licensed to practice medicine ~~and surgery~~ by the board shall apply biennially for the renewal of his or her license. ~~One~~ At least one month prior to the date on which renewal is required, the board shall send to

each licensee a license renewal application form and notice of the date on which the existing license will expire. On or before the renewal date, the licensee shall file an application for license renewal and pay the required fee. The board shall register the applicant and issue the renewal license. Within one month following the date renewal is required, the board shall pay the license renewal fees into the medical practice board special fund ~~and shall file a list of licensees with the department of health~~.

(b) A licensee for renewal of an active license to practice medicine shall have completed continuing medical education which shall meet minimum criteria as established by rule, by the board, by August 31, 2012 and which shall be in effect for the renewal of licenses to practice medicine expiring after August 31, 2014. The board shall require a minimum of ten hours of continuing medical education by rule. The training provided by the continuing medical education shall be designed to assure that the licensee has updated his or her knowledge and skills in his or her own specialties and also has kept abreast of advances in other fields for which patient referrals may be appropriate. The board shall require evidence of current professional competence in recognizing the need for timely appropriate consultations and referrals to assure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

(c) A licensee for renewal of an active license to practice medicine shall have practiced medicine within the last three years as defined in section 1311 of this title or have complied with the requirements for updating knowledge and skills as defined by board rules.

(d) All licensees shall demonstrate that the requirements for licensure are met.

(e) A licensee shall promptly provide the board with new or changed information pertinent to the information in his or her license and license renewal applications at the time he or she becomes aware of the new or changed information.

(f) A person who practices medicine ~~and surgery~~ and who fails to renew his or her license in accordance with the provisions of this section shall be deemed an illegal practitioner and shall forfeit the right to so practice or to hold himself or herself out as a person licensed to practice medicine ~~and surgery~~ in the state until reinstated by the board, but nevertheless a ~~person who was licensed to practice medicine and surgery at the time of his induction, call on reserve commission or enlistment into the armed forces of the United States, shall be entitled to practice medicine and surgery during the time of his service with the armed forces of the United States and for 60 days after separation from such~~

~~service~~ physician while on extended active duty in the uniformed services of the United States or as a member of the national guard, state guard, or reserve component who is licensed as a physician at the time of an activation or deployment shall receive an extension of licensure up to 90 days following the physician's return from activation or deployment, provided the physician notifies the board of his or her activation or deployment prior to the expiration of the current license and certifies that the circumstances of the activation or deployment impede good faith efforts to make timely application for renewal of the license.

~~(c)~~(g) Any person who allows a license to lapse by failing to renew the same in accordance with the provisions of this section may be reinstated by the board by payment of the renewal fee ~~and~~, the late renewal penalty, and if applicable, by completion of the required continuing medical education requirement as established in subsection (b) of this section and any other requirements for licensure as required by this section and board rule.

§ 1401. [Expired.]

§ 1401a. FEES

(a) The department of health shall collect the following fees:

(1) Application for licensure ~~$565.00, in fiscal year 2009 $600.00, and in fiscal year 2010 and thereafter,~~ $625.00; the board shall use at least $25.00 of this fee to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

(2) Biennial renewal ~~$450.00 and in fiscal year 2009 and thereafter,~~ $500.00; the board shall use at least $25.00 of this fee to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

* * *

§ 1403. PROFESSIONAL CORPORATIONS; MEDICINE ~~AND SURGERY~~

A person licensed to practice medicine ~~and surgery~~ under this chapter may own shares in a professional corporation created under chapter 4 of Title 11 which provides professional services in the medical and nursing professions.

* * *

Subchapter 5. Quality Assurance Data

* * *

§ 1446. DIRECTORS OF CORPORATION

The board of directors of the Vermont Program for Quality in Health Care, Inc. shall include ~~without limitation~~ the commissioner of the department of health~~, the chair of the hospital data council~~ and two directors, each of whom represents at least one of the following populations: elderly, ~~handicapped~~ people with disabilities, or low income individuals.

* * *

Sec. 3. 26 V.S.A. chapter 29 is amended to read:

CHAPTER 29. ANESTHESIOLOGIST ASSISTANTS

* * *

§ 1654. ELIGIBILITY

To be eligible for certification as an anesthesiologist assistant, an applicant shall have:

(1) obtained a master's degree from a board-approved anesthesiologist assistant program at an institution of higher education accredited by the Committee on Allied Health Education and Accreditation, the Commission on Accreditation of Allied Health Education Programs, or their successor agencies, or graduated from a board-approved anesthesiologist assistant program at an institution of higher education accredited by the Committee on Allied Health Education and Accreditation or the Commission of Accreditation of Allied Health Education Programs, prior to January 1, 1984; ~~and~~

(2) satisfactorily completed the certification examination given by the NCCAA and be currently certified by the NCCAA; and

(3) if the applicant has not engaged in practice as an anesthesiologist assistant within the last three years, complied with the requirements for updating knowledge and skills as defined by board rules.

* * *

§ 1656. RENEWAL OF CERTIFICATION

(a) Certifications shall be ~~renewable~~ renewed every two years ~~on payment of the required fee and submission of proof of current, active NCCAA certification~~. At least one month prior to the date on which renewal is required, the board shall send to each anesthesiologist assistant a renewal application form and notice of the date on which the existing certification will expire. On or before the renewal date, the anesthesiologist assistant shall file an application for renewal, pay the required fee and submit proof of current active NCCAA certification. The board shall register the applicant and issue

the renewal certification. Within one month following the date renewal is required, the board shall pay the certification renewal fees into the medical practice board special fund.

(b) A certification that has lapsed may be reinstated on payment of a renewal fee and a late renewal fee. The applicant shall not be required to pay back renewal fees for the periods when certification was lapsed. However, if such certification remains lapsed for a period of three years, the board may~~, after notice and an opportunity for hearing,~~ require ~~reexamination as a condition of renewal~~ the applicant to update his or her knowledge and skills as defined by board rules.

* * *

§ 1658. UNPROFESSIONAL CONDUCT

(a) The following conduct and the conduct described in section 1354 of this title by a certified anesthesiologist assistant constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of certification:

(1) ~~fraudulent procuring~~ fraud or ~~use of certification~~ misrepresentation in applying for or procuring an anesthesiologist assistant certificate or in connection with applying for or procuring a periodic renewal of an anesthesiologist assistant certificate;

* * *

(9) ~~professional negligence~~ failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct. Failure to practice competently includes as determined by the board:

(A) performance of unsafe or unacceptable patient care; or

(B) failure to conform to the essential standards of acceptable and prevailing practice;

* * *

(18) in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred; ~~or~~

(19) habitual or excessive use or abuse of drugs, alcohol, or other substances that impair the anesthesiologist assistant's ability to provide

medical services; or

~~(19)~~(20) revocation of certification to practice as an anesthesiologist assistant in another jurisdiction on one or more of the grounds specified in subdivisions ~~(1) (18)~~(1)–(19) of this subsection.

* * *

§ 1659. DISPOSITION OF COMPLAINTS

* * *

(b) ~~The board shall accept complaints from a member of the public, a physician, a hospital, an anesthesiologist assistant, a state or federal agency, or the attorney general~~ Any person, firm, corporation, or public officer may submit a written complaint to the board alleging any anesthesiologist assistant practicing in the state is engaged in unprofessional conduct, specifying the grounds. The board shall initiate an investigation of an anesthesiologist assistant when a complaint is received or may act on its own initiative without having received a complaint.

(c) After giving opportunity for hearing, the board shall take disciplinary action described in subsection 1361(b) of this title against an anesthesiologist assistant or applicant found guilty of unprofessional conduct.

(d) The board may approve a negotiated agreement between the parties when it is in the best interest of the public health, safety, or welfare to do so. That agreement may include any of the following conditions or restrictions which may be in addition to, or in lieu of, suspension:

* * *

(4) a requirement that the scope of practice permitted be restricted to a specified extent;

(5) an administrative penalty not to exceed $1,000.00 for each act that constitutes an unprofessional conduct violation. Any money received from the imposition of an administrative penalty imposed under this subsection shall be deposited into the board of medical practice regulatory fee fund and shall not be used for any other purpose other than professional regulation and other responsibilities of the board, as determined by the commissioner of health.

* * *

§ 1662. FEES

Applicants and persons regulated under this chapter shall pay the following fees:

(1)(A)(i) Original application for certification, $115.00;

(ii) Each additional application, $50.00;

(B) The board shall use at least $10.00 of these fees to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

(2)(A)(i) Biennial renewal, $115.00;

(ii) Each additional renewal, $50.00;

(B) The board shall use at least $10.00 of these fees to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network ~~that will monitor~~ which monitors recovering chemically dependent licensees for the protection of the public. In addition to the fee, an applicant for certification renewal shall submit evidence in a manner acceptable to the board that he or she continues to meet the certification requirements of the NCCAA.

* * *

§ 1664. PENALTY

(a) A person who, not being certified, holds himself or herself out to the public as being certified under this chapter shall be liable for a fine of not more than ~~$1,000.00~~ $10,000.00.

* * *

Sec. 4. 26 V.S.A. chapter 31 is amended to read:

CHAPTER 31. ~~PHYSICIAN'S~~ PHYSICIAN ASSISTANTS

* * *

§ 1732. DEFINITIONS

2. As used in this chapter:

(1) "Accredited physician assistant program" means a physician assistant educational program that has been accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), or, prior to 2001, by either the Committee on Allied Health Education and Accreditation (CAHEA), or the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

(2) "Board" means the state board of medical practice established by chapter 23 of this title.

~~(2)~~(3) ~~"Contract" means a legally binding agreement, expressed in writing, containing the terms of employment of a physician's assistant.~~

"Delegation agreement" means a detailed description of the duties and scope of practice delegated by a primary supervising physician to a physician assistant that is signed by both the physician assistant and the supervising physicians.

~~(3)~~(4) "Physician" means an individual licensed to practice medicine pursuant to ~~chapters~~ chapter 23 ~~and~~ or 33 of this title.

~~(4)~~(5) "~~Physician's~~ Physician assistant" means an individual ~~certified~~ licensed by the state of Vermont who is qualified by education, training, experience, and personal character to provide medical ~~services under~~ care with the direction and supervision of a Vermont licensed physician.

~~(5) "Physician's assistant trainee" means a person who is not certified as a "physician's assistant" under this chapter but who assists a physician under the physician's direct supervision for the purpose of acquiring the basic knowledge and skills of a physician's assistant by the apprentice-preceptor mode of education.~~

(6) ~~"Protocol" means a detailed description of the duties and scope of practice delegated by a physician to a physician's assistant~~ "Supervising physician" means an M.D. or D.O. licensed by the state of Vermont who oversees and accepts responsibility for the medical care provided by a physician assistant.

(7) "Supervision" means the direction and review by the supervising physician~~, as determined to be appropriate by the board,~~ of the medical ~~services~~ care provided by the ~~physician's~~ physician assistant. The constant physical presence of the supervising physician is not required as long as the supervising physician and physician assistant are or easily can be in contact with each other by telecommunication.

(8) "Disciplinary action" means any action taken against a ~~certified physician's~~ physician assistant~~, a registered physician's assistant trainee~~ or an applicant by the board~~, the appellate officer,~~ or on appeal therefrom, when that action suspends, revokes, limits, or conditions ~~certification or registration~~ licensure in any way, and includes reprimands and administrative penalties.

§ 1733. ~~CERTIFICATION AND REGISTRATION~~ LICENSURE

(a) The state board of medical practice is responsible for the ~~certification~~ licensure of ~~physician's~~ physician assistants ~~and the registration of physician's assistant trainees~~, and the commissioner of health shall adopt, amend, or repeal rules regarding the training, practice ~~and~~, qualification, and discipline of ~~physician's~~ physician assistants.

(b) ~~All applications for certification shall be accompanied by an application by the proposed supervising physician which shall contain a statement that the~~

~~physician shall be responsible for all medical activities of the physician's assistant~~ In order to practice, a licensed physician assistant shall have completed a delegation agreement as described in section 1735a of this title with a Vermont licensed physician signed by both the physician assistant and the supervising physician or physicians. The original shall be filed with the board and copies shall be kept on file at each of the physician assistant's practice sites.

~~(c) All applications for certification shall be accompanied by a protocol signed by the supervising physician and a copy of the physician's assistant employment contract~~ All applicants and licensees shall demonstrate that the requirements for licensure are met.

~~(d) All physician's assistant trainees shall register biennially with the board. Registrants shall provide the board with such information as it may require, including a copy of an employment contract and description of the apprenticeship program involved~~

§ 1734. ELIGIBILITY

(a) ~~To be eligible for certification as a physician's assistant, an applicant shall:~~

~~(1) have graduated from a board-approved physician's assistant program sponsored by an institution of higher education and have satisfactorily completed the certification examination given by the National Commission on the Certification of Physicians' Assistants (NCCPA); or~~

~~(2) have completed a board-approved apprenticeship program, including an evaluation conducted by the board. The requirements of apprenticeship programs shall be set by the board to ensure continuing opportunity for nonuniversity trained persons to practice as physician's assistants consistent with ensuring the highest standards of professional medical care~~ The board may grant a license to practice as a physician assistant to an applicant who:

(1) submits a completed application form provided by the board;

(2) pays the required application fee;

(3) has graduated from an accredited physician assistant program or has passed and maintained the certification examination by the National Commission on the Certification of Physician Assistants (NCCPA) prior to 1988;

(4) has passed the certification examination given by the NCCPA;

(5) is mentally and physically able to engage safely in practice as a physician assistant;

(6) does not hold any license, certification, or registration as a physician assistant in another state or jurisdiction which is under current disciplinary action, or has been revoked, suspended, or placed on probation for cause resulting from the applicant's practice as a physician assistant, unless the board has considered the applicant's circumstances and determines that licensure is appropriate;

(7) is of good moral character;

(8) submits to the board any other information that the board deems necessary to evaluate the applicant's qualifications; and

(9) has engaged in practice as a physician assistant within the last three years or has complied with the requirements for updating knowledge and skills as defined by board rules. This requirement shall not apply to applicants who have graduated from an accredited physician assistant program within the last three years.

(b) ~~A person intending to practice as a physician's assistant and his or her supervising physician shall be responsible for designing and presenting an apprenticeship program to the board for approval. The program shall be approved in a timely fashion unless there is good reason to believe that the program would be inconsistent with the public health, safety and welfare.~~

(c) ~~Evaluation procedures followed by the board shall be fair and reasonable and shall be designed and implemented to demonstrate competence in the skills required of a physician's assistant and to reasonably ensure that all applicants are certified unless there is good reason to believe that certification of a particular applicant would be inconsistent with the public health, safety and welfare. An evaluation shall include reviewing statements of the supervising physician who has observed the applicant conduct a physical examination, render a diagnosis, give certain tests to patients, prepare and maintain medical records and charts, render treatment, provide patient education and prescribe medication. The evaluation shall be of activities appropriate to the applicant's approved training program. They shall not be designed or implemented for the purpose of limiting the number of certified physician's assistants.~~

(d) When the board intends to deny an application for ~~certification~~ licensure, it shall send the applicant written notice of its decision by certified mail. The notice shall include a statement of the reasons for the action. Within 30 days of the date that an applicant receives such notice, the applicant may file a petition with the board for review of its preliminary decision. At the hearing, the burden shall be on the applicant to show that ~~certification~~ licensure should be granted. After the hearing, the board shall affirm or reverse its

preliminary denial.

(e) Failure to maintain competence in the knowledge and skills of a ~~physician's~~ physician assistant, as determined by the board, shall be cause for revocation of ~~certification~~ licensure. ~~Any person whose certification has been revoked for failure to maintain competence may practice for one year as a registered physician's assistant trainee, but shall be examined at the end of that period in the manner provided in subsection (a) of this section. Should the person fail upon reexamination, the person shall be enjoined from practice until meeting all requirements for certification under this chapter.~~

* * *

§ 1734b. RENEWAL OF ~~CERTIFICATION~~ LICENSE

(a) ~~Certifications~~ Licenses shall be ~~renewable~~ renewed every two years ~~without examination and~~ on payment of the required fee. At least one month prior to the date on which renewal is required, the board shall send to each licensee a license renewal application form and notice of the date on which the existing license will expire. On or before the renewal date, the licensee shall file an application for license renewal and pay the required fee. The board shall register the applicant and issue the renewal license. Within one month following the date renewal is required, the board shall pay the license renewal fees into the medical practice board special fund. Any physician assistant while on extended active duty in the uniformed services of the United States or member of the national guard, state guard, or reserve component who is licensed as a physician assistant at the time of an activation or deployment shall receive an extension of licensure up to 90 days following the physician assistant's return from activation or deployment, provided the physician assistant notifies the board of his or her activation or deployment prior to the expiration of the current license, and certifies that the circumstances of the activation or deployment impede good faith efforts to make timely application for renewal of the license.

(b) A licensee shall demonstrate that the requirements for licensure are met.

(c) A licensee for renewal of an active license to practice shall have practiced as a physician assistant within the last three years or have complied with the requirements for updating knowledge and skills as defined by board rules.

(d) A licensee shall promptly provide the board with new or changed information pertinent to the information in his or her license and license renewal applications at the time he or she becomes aware of the new or changed information.

(e) A ~~certification~~ license which has lapsed may be reinstated on payment of a renewal fee and a late renewal fee. The applicant shall not be required to pay renewal fees during periods when ~~certification~~ the license was lapsed. However, if ~~such certification~~ a license remains lapsed for a period of three years, the board may~~, after notice and an opportunity for hearing,~~ require ~~reexamination as a condition of renewal~~ the licensee to update his or her knowledge and skills as defined by board rules.

§ 1734c. EXEMPTIONS

Nothing herein shall be construed to require licensure under this chapter of:

(1) a physician assistant student enrolled in a physician assistant educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant;

(2) a physician assistant employed in the service of the U.S. military or national guard, including national guard in-state status, while performing duties incident to that employment; or

(3) a technician or other assistant or employee of a physician who performs physician-delegated tasks but who is not rendering services as a physician assistant or identifying himself or herself as a physician assistant.

* * *

§ 1735a. SUPERVISION AND SCOPE OF PRACTICE

(a) It is the obligation of each team of physician and physician assistant to ensure that the physician assistant's scope of practice is identified; that delegation of medical care is appropriate to the physician assistant's level of competence; that the supervision, monitoring, documentation, and access to the supervising physician is defined; and that a process for evaluation of the physician assistant's performance is established.

(b) The information required in subsection (a) of this section shall be included in a delegation agreement as required by the commissioner by rule. The delegation agreement shall be signed by both the physician assistant and the supervising physician or physicians, and a copy shall be kept on file at each of the physician assistant's practice sites and the original filed with the board.

(c) The physician assistant's scope of practice shall be limited to medical care which is delegated to the physician assistant by the supervising physician and performed with the supervision of the supervising physician. The medical care shall be within the supervising physician's scope of practice and shall be care which the supervising physician has determined that the physician assistant is qualified by education, training, and experience to provide.

(d) A physician assistant may prescribe, dispense, and administer drugs and medical devices to the extent delegated by a supervising physician. A physician assistant who is authorized by a supervising physician to prescribe controlled substances must register with the federal Drug Enforcement Administration.

(e) A supervising physician and physician assistant shall report to the board immediately upon an alteration or the termination of the delegation agreement.

§ 1736. UNPROFESSIONAL CONDUCT

(a) The following conduct and the conduct described in section 1354 of this title by a ~~certified physician's~~ licensed physician assistant ~~or registered physician's assistant trainee constitutes~~ shall constitute unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of ~~certification or registration~~ licensure:

(1) ~~fraudulent procuring~~ fraud or ~~use of certification or registration~~ misrepresentation in applying for or procuring a license or in applying for or procuring a periodic renewal of a license;

* * *

(b) Unprofessional conduct includes the following actions by a ~~certified physician's~~ licensed physician assistant ~~or a registered physician's assistant trainee~~:

* * *

(3) ~~professional negligence~~ practicing the profession without having a delegation agreement meeting the requirements of this chapter on file at the primary location of the physician assistant's practice and the board;

* * *

(7) performing otherwise than at the direction and under the supervision of a physician licensed by the board or an osteopath licensed by the Vermont board of osteopathic physicians and surgeons;

(8) ~~accepting the delegation of, or~~ performing or offering to perform a task or tasks beyond the individual's delegated scope ~~as defined by the board~~ of practice;

(9) administering, dispensing, or prescribing any controlled substance otherwise than as authorized by law;

(10) habitual or excessive use or abuse of drugs, alcohol, or other substances that impair the ability to provide medical services;

(11) failure to practice competently by reason of any cause on a single occasion or on multiple occasions. Failure to practice competently includes as determined by the board:

(A) performance of unsafe or unacceptable patient care; or

(B) failure to conform to the essential standards of acceptable and prevailing practice.

* * *

§ 1737. DISPOSITION OF COMPLAINTS

* * *

(b) ~~The board shall accept complaints from any member of the public, any physician, and any physician's assistant, any state or federal agency or the attorney general~~ Any person, firm, corporation, or public officer may submit a written complaint to the board alleging a physician assistant practicing in the state committed unprofessional conduct, specifying the grounds. The board may initiate disciplinary action in any complaint against a ~~physician's~~ physician assistant and may act without having received a complaint.

(c) After giving opportunity for hearing, the board shall take disciplinary action described in subsection 1361(b) of this title against a ~~physician's~~ physician assistant~~, physician's assistant trainee,~~ or applicant found guilty of unprofessional conduct.

(d) The board may approve a negotiated agreement between the parties when it is in the best interest of the public health, safety, or welfare to do so. Such an agreement may include~~, without limitation,~~ any of the following conditions or restrictions which may be in addition to, or in lieu of, suspension:

(1) a requirement that the individual submit to care or counseling;

(2) a restriction that the individual practice only under supervision of a named person or a person with specified credentials;

(3) a requirement that the individual participate in continuing education in order to overcome specified practical deficiencies;

(4) a requirement that the scope of practice permitted be restricted to a specified extent;

(5) an administrative penalty not to exceed $1,000.00 for each act that constitutes an unprofessional conduct violation. Any money received from the imposition of an administrative penalty imposed under this subdivision shall be deposited into the board of medical practice regulatory fee fund for the purpose of providing education and training for board members and the professions

regulated by the board. The commissioner shall detail in the annual report receipts and expenses from money received under this subsection.

(e) Upon application, the board may modify the terms of an order under this section and, if ~~certification or registration~~ licensure has been revoked or suspended, order reinstatement on terms and conditions it deems proper.

§ 1738. USE OF TITLE

Any person who is ~~certified~~ licensed to practice as a ~~physician's~~ physician assistant in this state shall have the right to use the title "~~physician's~~ physician assistant" and the abbreviation "P.A." and "PA-C". No other person may assume that title or use that abbreviation, or any other words, letters, signs, or devices to indicate that the person using them is a ~~physician's~~ physician assistant. ~~A physician's assistant shall not so represent himself or herself unless there is currently in existence, a valid contract between the physician's assistant and his or her employer supervising physician, and unless the protocol under which the physician's assistant's duties are delegated is on file with, and has been approved by, the board.~~

§ 1739. LEGAL LIABILITY

(a) The supervising physician delegating activities to a ~~physician's~~ physician assistant shall be legally liable for such activities of the ~~physician's~~ physician assistant, and the ~~physician's~~ physician assistant shall in this relationship be the physician's agent.

* * *

§ 1739a. INAPPROPRIATE USE OF SERVICES BY PHYSICIAN; UNPROFESSIONAL CONDUCT

Use of the services of a ~~physician's~~ physician assistant ~~or a physician's assistant-trainee~~ by a physician in a manner which is inconsistent with the provisions of this chapter constitutes unprofessional conduct by the physician and such physician shall be subject to disciplinary action by the board in accordance with the provisions of chapter 23 or 33 of this title, as appropriate.

§ 1740. FEES

Applicants and persons regulated under this chapter shall pay the following fees:

(1) Original application for ~~certification and registration $115.00 with each additional application at $50.00~~ licensure, $170.00; the board shall use at least $10.00 of this fee to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the

protection of the public.

(2) Biennial renewal ~~$115.00 with each additional renewal at $50.00,~~ $170.00; the board shall use at least $10.00 of this fee to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

~~(3) Transfer of certification or registration, $15.00.~~

§ 1741. NOTICE OF USE OF ~~PHYSICIAN'S~~ PHYSICIAN ASSISTANT TO BE POSTED

A physician, clinic, or hospital that utilizes the services of a ~~physician's~~ physician assistant shall post a notice to that effect in a prominent place.

§ 1742. PENALTY

(a) Any person who, not being ~~certified or registered~~ licensed, holds himself or herself out to the public as being ~~so certified or registered~~ licensed under this chapter shall be liable for a fine of not more than ~~$1,000.00~~ $10,000.00.

* * *

§ 1743. MEDICAID REIMBURSEMENT

The secretary of the agency of human services shall, pursuant to the Administrative Procedure Act, promulgate rules providing for a fee schedule for reimbursement under Title XIX of the Social Security Act and chapter ~~36~~ 19 of Title 33, relating to medical assistance which recognizes reasonable cost differences between services provided by physicians and those provided by ~~physician's~~ physician assistants under this chapter.

§ 1744. CERTIFIED PHYSICIAN ASSISTANTS

Any person who is certified by the board as a physician assistant prior to the enactment of this section shall be considered to be licensed as a physician assistant under this chapter immediately upon enactment of this section, and shall be eligible for licensure renewal pursuant to section 1734 of this title.

Sec. 5. 26 V.S.A. chapter 52 is amended to read:

CHAPTER 52. RADIOLOGIST ASSISTANTS

* * *

§ 2854. ELIGIBILITY

To be eligible for certification as a radiologist assistant, an applicant shall:

* * *

(3) be certified as a radiologic technologist in radiography by the ARRT; ~~and~~

(4) be licensed as a radiologic technologist in radiography in this state under chapter 51 of this title; and

(5) if the applicant has not engaged in practice as a radiologist assistant within the last three years, comply with the requirements for updating knowledge and skills as defined by board rules.

* * *

§ 2856. RENEWAL OF CERTIFICATION

(a) ~~Certifications shall be renewable every two years upon payment of the required fee and submission of proof of current, active ARRT certification, including compliance with continuing education requirements~~ At least one month prior to the date on which renewal is required, the board shall send to each radiology assistant a renewal application form and notice of the date on which the existing certification will expire. On or before the renewal date, the radiologist assistant shall file an application for renewal, pay the required fee and submit proof of current active ARRT certification, including compliance with continuing education requirements. The board shall register the applicant and issue the renewal certification. Within one month following the date renewal is required, the board shall pay the certification renewal fees into the medical practice board special fund.

(b) A certification that has lapsed may be reinstated on payment of a renewal fee and a late renewal fee. The applicant shall not be required to pay back renewal fees for the periods when certification was lapsed. However, if certification remains lapsed for a period of three years, the board may~~, after notice and an opportunity for hearing,~~ require ~~reexamination as a condition of renewal~~ the applicant to update his or her knowledge and skills as defined by board rules.

* * *

§ 2858. UNPROFESSIONAL CONDUCT

(a) The following conduct and the conduct described in section 1354 of this title by a certified radiologist assistant constitutes unprofessional conduct. When that conduct is by an applicant or person who later becomes an applicant, it may constitute grounds for denial of certification:

(1) ~~fraudulent procuring~~ fraud or ~~use of certification~~ misrepresentation in applying for or procuring a certificate or in connection with applying for or

procuring a periodic recertification as a radiologist assistant;

* * *

(5) conviction of a crime related to the profession or conviction of a felony, whether or not related to the practice of the profession or failure to report to the board of medical practice a conviction of any crime related to the practice of the profession or any felony in any court within 30 days of the conviction;

* * *

(9) ~~professional negligence~~ failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct. Failure to practice competently includes as determined by the board:

(A) performance of unsafe or unacceptable patient care; or

(B) failure to conform to the essential standards of acceptable and prevailing practice;

* * *

(18) in the course of practice, gross failure to use and exercise on a particular occasion or the failure to use and exercise on repeated occasions that degree of care, skill, and proficiency that is commonly exercised by the ordinary skillful, careful, and prudent professional engaged in similar practice under the same or similar conditions, whether or not actual injury to a patient has occurred; ~~or~~

(19) habitual or excessive use or abuse of drugs, alcohol, or other substances that impair the radiologist assistant's ability to provide medical services; or

(20) revocation of certification to practice as a radiologist assistant in another jurisdiction on one or more of the grounds specified in subdivisions ~~(1)–(18)~~(1)–(19) of this subsection.

* * *

§ 2859. DISPOSITION OF COMPLAINTS

* * *

(b) ~~The board shall accept complaints from a member of the public, a physician, a hospital, a radiologist assistant, a state or federal agency, or the attorney general~~ Any person, firm, corporation, or public officer may submit a written complaint to the board alleging a radiologist assistant practicing in the state engaged in unprofessional conduct, specifying the grounds. The board

shall initiate an investigation of a radiologist assistant when a complaint is received or may act on its own initiative without having received a complaint.

* * *

(d) After giving an opportunity for hearing, the board shall take disciplinary action described in subsection 1361(b) of this title against a radiologist assistant or applicant found guilty of unprofessional conduct.

(e) The board may approve a negotiated agreement between the parties when it is in the best interest of the public health, safety, or welfare to do so. That agreement may include any of the following conditions or restrictions which may be in addition to or in lieu of suspension:

* * *

(4) a requirement that the scope of practice permitted be restricted to a specified extent;

(5) an administrative penalty not to exceed $1,000.00 for each act that constitutes an unprofessional conduct violation. Any money received from the imposition of an administrative penalty imposed under this subdivision shall be deposited into the board of medical practice regulatory fee fund for the purpose of providing education and training for board members. The commissioner shall detail in the annual report receipts and expenses from money received under this subsection.

* * *

§ 2862. FEES

Applicants and persons regulated under this chapter shall pay the following fees:

(1)(A)(i) Original application for certification	$115.00;
(ii) Each additional application	$ 50.00;

(B) The board shall use at least $10.00 of these fees to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network which ~~will monitor~~ monitors recovering chemically dependent licensees for the protection of the public.

(2)(A)(i) Biennial renewal	$115.00;
(ii) Each additional renewal	$ 50.00;

(B) The board shall use at least $10.00 of these fees to support the ~~costs~~ cost of ~~the creation and maintenance of a~~ maintaining the Vermont practitioner recovery network ~~that will monitor~~ which monitors recovering

chemically dependent licensees for the protection of the public. In addition to the fee, an applicant for certification renewal shall submit evidence in a manner acceptable to the board that he or she continues to meet the certification requirements of the ARRT and is licensed as a radiologic technologist under chapter 51 of this title.

* * *

§ 2864. PENALTY

(a) A person who, not being certified, holds himself or herself out to the public as being certified under this chapter shall be liable for a fine of not more than ~~$1,000.00~~ $10,000.00.

* * *

Sec. 6. 20 V.S.A. § 2060 is amended to read:

§ 2060. RELEASE OF RECORDS

The center is authorized to release records or information requested under ~~section 309 or 6914 of Title~~ 33 V.S.A. §§ 309 or 6914, 26 V.S.A. § 1353, ~~section 4010 of Title~~ 24 V.S.A. § 4010, or chapter 5, subchapter 4 of Title 16.

Sec. 7. 33 V.S.A. § 4919 is amended to read:

§ 4919. DISCLOSURE OF REGISTRY RECORDS

(a) The commissioner may disclose a registry record only as follows:

* * *

(10) To the board of medical practice for the purpose of evaluating an applicant, licensee, or holder of certification pursuant to 26 V.S.A. § 1353.

* * *

Sec. 8. 33 V.S.A. § 6911 is amended to read:

§ 6911. RECORDS OF ABUSE, NEGLECT, AND EXPLOITATION

* * *

(c) The commissioner or the commissioner's designee may disclose registry information only to:

* * *

(6) the commissioner of health, or the commissioner's designee, for purposes related to oversight and monitoring of persons who are served by or compensated with funds provided by the department of health, including persons to whom a conditional offer of employment has been made; ~~and~~

(7) upon request or when relevant to other states' adult protective services offices; and

(8) the board of medical practice for the purpose of evaluating an applicant, licensee, or holder of certification pursuant to 26 V.S.A. § 1353.

Sec. 9. REPEAL

The following sections of Title 26 are repealed:

(1) § 322 (podiatrist as member of board of medical practice);

(2) § 1352 (reports);

(3) § 1397 (recording license);

(4) § 1734a (temporary certification); and

(5) § 1735 (supervision and scope of practice).

Sec. 10. ADOPTION OF RULES

The state board of medical practice shall adopt maintenance of licensure rules for podiatrists, physicians, and physician assistants by September 1, 2012.

Sec. 11. REPORT

By January 15, 2012, the Vermont board of medical practice shall review the process for licensing physicians who seek to provide only pro bono services pursuant to 26 V.S.A. § 1395(c) and report to the house committee on health care regarding any changes to the criteria developed by the board for licensing those physicians pursuant to that subsection or, if no changes are made to the criteria, the reasons therefor.

Sec. 12. EFFECTIVE DATES

This act shall take effect on passage, except that, in Title 26:

(1) §§ 371(5)and 373(b) shall take effect 60 days after the adoption of the maintenance of licensure rule for podiatrists;

(2) §§ 1396(7) and 1400(c) shall take effect 60 days after the adoption of the maintenance of licensure rule for physicians;

(3) §§ 1654(3) and 1656(b) shall take effect 60 days after the adoption of the rule referenced in 26 V.S.A. § 1654(3);

(4) § 1734b(c) shall take effect 60 days after the adoption of the maintenance of licensure rule for physician assistants; and

(5) §§ 2854(5) and 2856(b) shall take effect 60 days after the adoption of the rule referenced in 26 V.S.A. § 2854(5).

(For text see House Journal 4/19 - 4/20/11)

H. 420

An act relating to the office of professional regulation

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

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

Sec. 5. 26 V.S.A. chapter 28 is amended to read:

CHAPTER 28. NURSING

Subchapter 1. Registered and Licensed Practical Nursing

* * *

§ 1572. DEFINITIONS

As used in this chapter:

* * *

(4) "Advanced practice registered nurse" or "APRN" means a licensed registered nurse authorized to practice in this state who, because of specialized education and experience, is endorsed to perform acts of medical diagnosis and to prescribe medical, therapeutic, or corrective measures under administrative rules adopted by the board.

(5) "License" means a current authorization permitting the practice of nursing as a registered nurse, licensed practical nurse, or advanced practice registered nurse.

§ 1573. VERMONT STATE BOARD OF NURSING

(a) There is hereby created a Vermont state board of nursing consisting of ~~five~~ six registered nurses, including at least ~~one endorsed~~ two licensed as ~~an~~ advanced practice registered ~~nurse~~ nurses, two practical nurses, one nursing assistant, and two public members. Board members shall be appointed by the governor pursuant to 3 V.S.A. §§ 129b and 2004.

* * *

§ 1573a. APRN SUBCOMMITTEE

The board shall appoint a subcommittee to study and report to the board on matters relating to advanced practice registered nurse practice. The subcommittee shall be composed of at least five members. The majority shall be advanced practice registered nurses who are licensed and in good standing in this state. At least one member shall be a member of the public, and at least

one member shall be a physician designated by the board of medical practice. Members of the subcommittee shall be entitled to compensation at the rate provided in 32 V.S.A. § 1010.

* * *

§ 1582. REGULATORY AUTHORITY; UNPROFESSIONAL CONDUCT

(a) The board may deny an application for registration, licensure, or relicensure; revoke or suspend any license to practice nursing issued by it; or discipline or in other ways condition the practice of a registrant or licensee upon due notice and opportunity for hearing in compliance with the provisions of ~~chapter 25 of Title 3,~~ 3 V.S.A. chapter 25 if the person engages in the following conduct or the conduct set forth in ~~section 129a of Title~~ 3 V.S.A. § 129a:

(1) Has made or caused to be made a false, fraudulent, or forged statement or representation in procuring or attempting to procure registration or renew a license to practice nursing;

* * *

(6) Has a mental, emotional, or physical disability, the nature of which interferes with ability to practice nursing competently; ~~or~~

(7) Engages in conduct of a character likely to deceive, defraud, or harm the public;

(8) Has willfully omitted to file or record or has willfully impeded or obstructed a filing or recording or has induced another person to omit to file or record medical reports required by law;

(9) Has knowingly aided or abetted a health care provider who is not legally practicing within the state in the provision of health care services;

(10) Has permitted his or her name or license to be used by a person, group, or corporation when not actually in charge of or responsible for the treatment given;

(11) Has failed to comply with the patient bill of rights provisions of 18 V.S.A. § 1852; or

(12) Has committed any sexual misconduct that exploits the provider–patient relationship, including sexual contact with a patient, surrogates, or key third parties.

(b) Procedure. The board shall establish a discipline process based on this chapter and the Administrative Procedure Act.

(c) Appeals. ~~(1)~~ Any person or institution aggrieved by any action of the

board under this section or section 1581 of this title may appeal as provided in ~~section 130a of Title~~ 3 V.S.A. § 130a.

(d) A person shall not be liable in a civil action for damages resulting from the good faith reporting of information to the board about incompetent, unprofessional, or unlawful conduct of a nurse.

* * *

§ 1584. PROHIBITIONS; OFFENSES

(a) It shall be a violation of this chapter for any person, including any corporation, association, or individual, to:

* * *

(7) Employ unlicensed persons to practice registered ~~or~~ nursing, practical nursing, or as a nursing assistant.

* * *

Subchapter 3. Advanced Practice Registered Nurses

§ 1611. ADVANCED PRACTICE REGISTERED NURSE LICENSURE

To be eligible for an APRN license, an applicant shall:

(1) have a degree or certificate from a Vermont graduate nursing program approved by the board or a graduate program approved by a state or a national accrediting agency that includes a curriculum substantially equivalent to programs approved by the board. The educational program shall meet the educational standards set by the national accrediting board and the national certifying board. Programs shall include a supervised clinical component in the role and population focus of the applicant's certification. The program shall prepare nurses to practice advanced nursing in a role as a nurse practitioner, certified nurse midwife, certified nurse anesthetist, or clinical nurse specialist in psychiatric or mental health nursing and shall include, at a minimum, graduate level courses in:

(A) advanced pharmacotherapeutics;

(B) advanced patient assessment; and

(C) advanced pathophysiology;

(2) hold a degree or certificate from an accredited graduate-level educational program preparing the applicant for one of the four recognized APRN roles described in subdivision (1) of this section and have educational preparation consistent with the applicant's certification, role, population focus, and specialty practice; and

(3) hold current advanced nursing certification in a role and population focus granted by a national certifying organization recognized by the board.

§ 1612. PRACTICE GUIDELINES

(a) APRN licensees shall submit for review individual practice guidelines and receive board approval of the practice guidelines. Practice guidelines shall reflect current standards of advanced nursing practice specific to the APRN's role, population focus, and specialty.

(b) Licensees shall submit for review individual practice guidelines and receive board approval of the practice guidelines:

(1) prior to initial employment;

(2) upon application for renewal of an APRN's registered nurse license; and

(3) prior to a change in the APRN's employment or clinical role, population focus, or specialty.

§ 1613. TRANSITION TO PRACTICE

(a) Graduates with fewer than 24 months and 2,400 hours of licensed active advanced nursing practice in an initial role and population focus or fewer than 12 months and 1,600 hours for any additional role and population focus shall have a formal agreement with a collaborating provider as required by board rule. APRNs shall have and maintain signed and dated copies of all required collaborative provider agreements as part of the practice guidelines. An APRN required to practice with a collaborative provider agreement may not engage in solo practice, except with regard to a role and population focus in which the APRN has met the requirements of this subsection.

(b) An APRN who satisfies the requirements to engage in solo practice pursuant to subsection (a) of this section shall notify the board that these requirements have been met.

§ 1614. APRN RENEWAL

An APRN license renewal application shall include:

(1) documentation of completion of the APRN practice requirement;

(2) a current certification by a national APRN specialty certifying organization;

(3) current practice guidelines; and

(4) a current collaborative provider agreement if required for transition to practice.

§ 1615. REGULATORY AUTHORITY; UNPROFESSIONAL CONDUCT

(a) The board may deny an application for licensure or renewal or may revoke, suspend, or otherwise discipline an advanced practice registered nurse upon due notice and opportunity for hearing in compliance with the provisions of 3 V.S.A. chapter 25 if the person engages in the conduct set forth in 3 V.S.A. § 129a or section 1582 of this title or any of the following:

(1) abandonment of a patient in violation of the duty to maintain a provider–patient relationship within the reasonable expectations of continuing care or referral.

(2) solicitation of professional patronage by agents or persons or profiting from the acts of those representing themselves to be agents of the licensed APRN.

(3) division of fees or agreeing to split or divide the fees received for professional services for any person for bringing or referring a patient.

(4) practice beyond those acts and situations that are within the practice guidelines approved by the board for an APRN and within the limits of the knowledge and experience of the APRN, and, for an APRN who is practicing under a collaborative agreement, practice beyond those acts and situations that are within both the usual scope of the collaborating provider's practice and the terms of the collaborative agreement.

(5) for an APRN who acts as the collaborating provider for an APRN who is practicing under a collaboration agreement, allowing the mentored APRN to perform a medical act which is outside the usual scope of the mentor's own practice or which the mentored APRN is not qualified to perform by training or experience or which is not consistent with the requirements of this chapter and the rules of the board.

(6) providing, prescribing, dispensing, or furnishing medical services or prescription medication or prescription-only devices to a person in response to any communication transmitted or received by computer or other electronic means when the licensee fails to take the following actions to establish and maintain a proper provider–patient relationship:

(A) a reasonable effort to verify that the person requesting medication is in fact the patient and is in fact who the person claims to be;

(B) establishment of documented diagnosis through the use of accepted medical practices; and

(C) maintenance of a current medical record.

(7) prescribing, selling, administering, distributing, ordering, or

dispensing any drug legally classified as a controlled substance for his or her own use or for an immediate family member.

(8) signing a blank or undated prescription form.

(b)(1) For the purposes of subdivision (a)(6) of this section, an electronic, online, or telephonic evaluation by questionnaire is inadequate for the initial evaluation of the patient.

(2) The following would not be in violation of subdivision (a)(6) of this section:

(A) initial admission orders for newly hospitalized patients;

(B) prescribing for a patient of another provider for whom the prescriber has taken call;

(C) prescribing for a patient examined by a licensed APRN, physician assistant, or other practitioner authorized by law and supported by the APRN;

(D) continuing medication on a short-term basis for a new patient prior to the patient's first appointment; or

(E) emergency situations where the life or health of the patient is in imminent danger.

Second: By striking out Sec. 6 in its entirety

Third: In Sec. 12, in 26 V.S.A. § 3322, by striking out subsection (b) in its entirety and inserting in lieu thereof a new subsection (b) to read:

(b) The licensed appraiser shall include within the body of the appraisal report the amount of the appraiser's fee for appraisal services.

Fourth: By striking out Sec. 15 in its entirety and inserting in lieu thereof a new Sec. 15 to read:

Sec. 15. STAKEHOLDER WORKGROUP

Not later than July 1, 2011, the Vermont board of nursing shall convene a workgroup consisting of representatives from nursing homes, hospice agencies, the agency of human services, and nursing assistant educators to make recommendations to the board on the standards for administration of medication by medication nursing assistants as well as standards for education and competency of medication nursing assistants. The board shall submit a report to the general assembly on the status of efforts to establish these standards not later than January 15, 2012.

Fifth: By striking out Sec. 16 (effective date) and inserting in lieu thereof

the following:

Sec. 16. 17 V.S.A. § 2121 is amended to read:

§ 2121. ELIGIBILITY OF VOTERS

(a) Any person may register to vote in the town of his or her residence in any election held in a political subdivision of this state in which he or she resides who, on election day:

(1) is a citizen of the United States;

(2) is a resident of the state of Vermont;

(3) has taken the voter's oath; and

(4) is 18 years of age or more

~~may register to vote in the town of his residence in any election held in a political subdivision of this state in which he resides~~.

(b) Any person meeting the requirements of subdivisions (a)(1)–(3) of this section who will be 18 years of age on or before the date of a general election may register and vote in the primary election immediately preceding that general election.

Sec. 17. 17 V.S.A. § 2702 is amended to read:

§ 2702. NOMINATING PETITION

The name of any person shall be printed upon the primary ballot as a candidate for nomination by any major political party if petitions signed by at least one thousand voters in accordance with sections 2353, 2354, and 2358 of this title are filed with the secretary of state, together with the written consent of the person to the printing of the person's name on the ballot. Petitions shall be filed not later than 5:00 p.m. on the ~~third~~ first Monday after the first Tuesday of January preceding the primary election. The petition shall be in a form prescribed by the secretary of state. A person's name shall not be listed as a candidate on the primary ballot of more than one party in the same election. Each petition shall be accompanied by a filing fee of $2,000.00 to be paid to the secretary of state and deposited by the secretary of state into the general fund. However, if the petition of a candidate is accompanied by the affidavit of the candidate, which shall be available for public inspection, that the candidate and the candidate's campaign committee are without sufficient funds to pay the filing fee, the secretary of state shall waive all but $300.00 of the payment of the filing fee by that candidate.

Sec. 18. EFFECTIVE DATE

This act shall take effect on passage.

and by renumbering the sections to be numerically correct

(For text see House Journal 4/1 - 4/5/11)

NOTICE CALENDAR

Favorable with Amendment

S. 74

An act relating to the transferring of the animal spaying and neutering program to the department of health

Rep. Evans of Essex, for the Committee on Government Operations**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 20 V.S.A § 3815 is amended to read:

§ 3815. DOG, CAT, AND WOLF-HYBRID SPAYING AND NEUTERING PROGRAM

(a) The ~~agency of agriculture, food and markets shall establish by rule a process by which a qualified organization~~ agency of human services shall administer a dog, cat, and wolf-hybrid spaying and neutering program providing reduced-cost spaying and neutering services and presurgical immunization for dogs, cats, and wolf-hybrids owned or cared for by low income individuals. The agency shall implement the program through an agreement with a qualified organization consistent with the applicable administrative rules.

(b) The program shall reimburse veterinarians who voluntarily consent to spay or neuter dogs, cats, and wolf-hybrids under the auspices of the program. The reimbursement shall be less any co-payment by the owner of a dog, cat, or wolf-hybrid for the cost of each spaying or neutering procedure.

(c) ~~The agency of agriculture, food and markets is authorized to promulgate an emergency administrative rule by August 1, 2009, the purpose of which shall be that only a dog, cat, or wolf-hybrid acquired for no compensation shall be eligible for funding from the animal spaying and neutering program established under this section. The rule shall provide consideration for the financial ability of the funding applicant to pay for the requested service. For the purposes of this subsection, a nominal fee or donation required for adoption of a dog, cat, or wolf-hybrid shall not constitute compensation paid for the animal~~ The secretary of human services may adopt and amend rules pursuant to chapter 25 of Title 3 to enable the agency to carry out the purposes of this act.

Sec. 2. 20 V.S.A. § 3816 is amended to read:

§ 3816. ANIMAL SPAYING AND NEUTERING FUND; CREATION

(a) There is created, pursuant to subchapter 5 of chapter 7 of Title 32, in the ~~agency of agriculture, food and markets~~ agency of human services the dog, cat, and wolf-hybrid spaying and neutering special fund to finance the costs of the dog, cat, and wolf-hybrid spaying and neutering program established in section 3815 of this title.

(b) Revenue for the fund shall be derived from:

(1) The ~~$2.00~~ surcharge payment paid to a municipality pursuant to subdivision 3581(c)(1) of this title.

(2) Gifts from private donors.

(3) Any appropriation which the general assembly makes to the fund.

(c) Interest earned on the fund shall be retained in the fund.

(d) The ~~agency may offset the cost of administering the dog, cat, and wolf-hybrid spaying and neutering program from the fund created in subsection (a) of this section in accordance with the provisions of section 10 of Title 6~~ agency of human services shall use the revenue in the fund created in subsection (a) of this section for administering the dog, cat, and wolf-hybrid spaying and neutering program.

Sec. 3. ADMINISTRATIVE RULE APPLICABILITY

The agency of human services shall administer the dog, cat, and wolf-hybrid spaying and neutering program established in 20 V.S.A. § 3815 pursuant to the applicable administrative rule which became effective on July 1, 2010 until the rule is amended to reflect the transfer of the jurisdiction of the program to the agency of human services.

Sec. 4. EFFECTIVE DATE

This act shall take effect on July 1, 2011.

and that after passage the title of the bill be amended to read: "An act relating to the transferring of the animal spaying and neutering program to the agency of human services"

(Committee vote: 9-0-2)

(For text see Senate Journal 4/19 - 4/20/11)

S. 96

An act relating to technical corrections to the workers' compensation statutes

Rep. Botzow of Pownal, for the Committee on Commerce and Economic Development**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds that it is important to ensure that an injured worker's medical records and personal information are kept secure and that health care providers, workers' compensation insurers, and the department of labor adopt practices that are consistent with relevant state and federal statutes regarding medical and personal privacy.

Sec. 2. 21 V.S.A. § 641 is amended to read:

§ 641. VOCATIONAL REHABILITATION

* * *

(c) Any vocational rehabilitation plan for a claimant presented to the employer shall be deemed valid if the employer was provided an opportunity to participate in the development of the plan and has made no objections or changes within 21 days after submission. A vocational rehabilitation counselor shall provide the employer with a written invitation to participate in plan development, including the date, time, and place to provide an opportunity to participate in the development of the plan, with a copy to the department. The participation in the development of the plan may be conducted by telephone. The written notice shall be evidence of the opportunity to participate in plan development and shall be appended to the proposed plan.

* * *

Sec. 3. 21 V.S.A. § 640b is added to read:

§ 640b. REQUEST FOR PREAUTHORIZATION TO DETERMINE IF PROPOSED TREATMENT IS NECESSARY

(a) Within 14 days of receiving a request for preauthorization for a proposed medical treatment and medical evidence supporting the requested treatment, a workers' compensation insurer shall:

(1) authorize the treatment and notify the health care provider, the injured worker, and the department; or

(2)(A) deny the treatment because the entire claim is disputed and the

commissioner has not issued an interim order to pay benefits; or

(B) deny the treatment if, based on a preponderance of credible medical evidence specifically addressing the proposed treatment, it is unreasonable or unnecessary. The insurer shall notify the health care provider, the injured worker, and the department of the decision to deny treatment; or

(3) notify the health care provider, the injured worker, and the department that the insurer has scheduled an examination of the employee or ordered a medical record review pursuant to section 655 of this title. Based on the examination or review, the insurer shall authorize or deny the treatment and notify the department and the injured worker of the decision within 45 days of a request for preauthorization. The commissioner may in his or her sole discretion grant a 10-day extension to the insurer to authorize or deny treatment, and such an extension shall not be subject to appeal.

(b) If the insurer fails to authorize or deny the treatment pursuant to subsection (a) of this section within 14 days of receiving a request, the claimant or health care provider may request that the department issue an order authorizing treatment. After receipt of the request, the department shall issue an interim order within five days after notice to the insurer, and five days in which to respond, absent evidence that the entire claim is disputed. Upon request of a party, the commissioner shall notify the parties that the treatment has been authorized by operation of law.

(c) If the insurer denies the preauthorization of the treatment pursuant to subdivision (a)(2) or (3) of this section, the commissioner may on his or her own initiative or upon a request by the claimant issue an order authorizing the treatment if he or she finds that the evidence shows that the treatment is reasonable, necessary, and related to the work injury.

Sec. 4. 21 V.S.A. § 655a is added to read:

§ 655a. RELEASE OF RELEVANT MEDICAL RECORDS BY HEALTH CARE PROVIDERS; DEPARTMENT TO OVERSEE RELEASE AND USE OF RELEVANT MEDICAL INFORMATION

(a) Health care providers examining or attending the examination of an injured worker pursuant to this chapter shall provide relevant medical records and reports as requested by the injured worker, the employer, or the department regarding the diagnosis, condition, or treatment of the worker, permanent impairment, or any restrictions or limitations on the worker's ability to work upon receiving a written medical release authorization from the injured worker. The authorization shall be on a form approved by the department. If the relevance of any medical information is disputed, the department shall determine whether the requested medical information is relevant.

(b) Medical information relevant to the specific claim includes a past history of complaints or treatment of a condition similar to that presented in the claim or other conditions related to the same body part. Information that may be requested includes:

(1) Minimum data to justify services and payment, including that on the standard paper 1500 form or electronic 837 form.

(2) Office notes of the examination relating to the injury diagnosis or treatment.

(3) Any other relevant provider records contained in the file.

(c) An injured worker shall only be obligated to sign a medical record release authorization approved by the department.

(d) Any medical information received by the employer or the insurance carrier that is found not to be relevant to the claim may not be used to deny or limit a claim. The commissioner may order that specific disclosure requests be denied or rescinded and may make such other interim orders as are appropriate.

(e) Any medical information received in conjunction with a claim shall be used only for the purpose of advancing or defending a claim relating to the injury or of investigating a claim of false representation or of ensuring compliance with the workers' compensation statutes and rules.

Sec. 5. 21 V.S.A. § 692 is amended to read:

§ 692. PENALTIES; FAILURE TO INSURE; STOP WORK ORDERS

(a) Failure to insure. If after a hearing under section 688 of this title, the commissioner determines that an employer has failed to comply with the provisions of section 687 of this title, the employer shall be assessed an administrative penalty of not more than $100.00 for every day for the first seven days the employer neglected to secure liability and not more than $150.00 for every day thereafter.

* * *

Sec. 6. Sec. 32 of No. 54 of the Acts of 2009 is amended to read:

Sec. 32. WORKERS' COMPENSATION; STATE CONTRACTS; COMPLIANCE WITH DAVIS-BACON

(a) The agencies of administration and transportation shall establish procedures to assure that state contracting procedures and contracts are designed to minimize the incidents of miscoding of employees in NCCI job codes and misclassification of the status of workers as independent contractors rather than employees by state contractors on projects with a total project cost

of more than $250,000.00 by requiring those contractors to provide, at a minimum, all the following:

* * *

(3) For construction and transportation projects over $250,000.00, a payroll process by which during every pay period the contractor collects from the subcontractors or independent contractors a list of all workers who were on the jobsite during the pay period, the work performed by those workers on the jobsite, and a daily census of the jobsite. This information, including confirmation that contractors, subcontractors, and independent contractors have the appropriate workers' compensation coverage for all workers at the job site, and similar information for the subcontractors regarding their subcontractors shall also be provided to the department of labor and to the department of banking, insurance, securities, and health care administration, upon request, and shall be available to the public.

* * *

(c) The agencies shall assure that any state contract funded in whole or in part with American Recovery and Reinvestment Act of 2009 (ARRA) monies or any project for which the state granted, allocated, or awarded ARRA monies shall comply with the payment of Davis-Bacon wages when required by ARRA. However, in the event the applicable Davis-Bacon wages in any county have not been updated in the previous three years, the minimum state required wage for a state contract subject to Davis-Bacon wages under ARRA shall be that of the Vermont county that has most recently updated its applicable Davis-Bacon wages, provided this provision does not result in the loss of ARRA funds and is not otherwise contrary to federal law. In the event that the most recently updated Davis-Bacon wages cannot be determined due to the simultaneous updating by two or more counties, the agencies may select the minimum state-required wage for a state contract subject to Davis-Bacon wages under ARRA from among those counties.

Sec. 7. 21 V.S.A. § 1314 is amended to read:

§ 1314. REPORTS AND RECORDS; SEPARATION INFORMATION; DETERMINATION OF ELIGIBILITY; FAILURE TO REPORT EMPLOYMENT INFORMATION; DISCLOSURE OF INFORMATION TO OTHER STATE AGENCIES TO INVESTIGATE MISCLASSIFICATION OR MISCODING

* * *

(d)(1) Except as otherwise provided in this chapter, information obtained

from any employing unit or individual in the administration of this chapter, and determinations as to the benefit rights of any individual shall be held confidential and shall not be disclosed or open to public inspection in any manner revealing the individual's or employing unit's identity, nor be admissible in evidence in any action or proceeding other than one arising out of this chapter, or to support or facilitate an investigation by a public agency identified in subdivision (e)(1) of this section.

(2) An individual or his or her duly authorized agent may be supplied with information from those records to the extent necessary for the proper presentation of his or her claims for benefits or to inform him or her of his or her existing or prospective rights to benefits; an employing unit may be furnished with such information as may be deemed proper, within the discretion of the commissioner, to enable it to fully discharge its obligations and safeguard its rights under this chapter.

~~(2)~~(3) Automatic data processing services and systems and programming services within the department of labor shall be the responsibility and under the direct control of the commissioner in the administration of this chapter and chapter 15 of this title.

~~(3)~~(4) Notwithstanding the provisions in subdivision (2) of this section, the department of labor shall, at the request of the agency of administration, perform such services for other departments and agencies of the state as are within the capacity of its data processing equipment and personnel, provided that such services can be accomplished without undue interference with the designated work of the department of labor

(e)(1) Subject to such restrictions as the board may by regulation prescribe, information from unemployment insurance records may be made available to any public officer or public agency of this or any other state or the federal government dealing with the administration or regulation of relief, public assistance, unemployment compensation, a system of public employment offices, wages and hours of employment, workers' compensation, misclassification or miscoding of workers, occupational safety and health, or a public works program for purposes appropriate to the necessary operation of those offices or agencies. The commissioner may also make information available to colleges, universities, and public agencies of the state for use in connection with research projects of a public service nature, and to the Vermont economic progress council with regard to the administration of subchapter 11E of chapter 151 of Title 32; but no person associated with those institutions or agencies may disclose that information in any manner which would reveal the identity of any individual or employing unit from or concerning whom the information was obtained by the commissioner.

* * *

Sec. 8. 21 V.S.A. § 1453 is amended to read:

§ 1453. APPROVAL OR REJECTION; RESUBMISSION

The commissioner shall approve or reject a plan in writing within ~~15~~ 30 days of its receipt, and in the case of rejection shall state the reasons therefor. The reasons for rejection shall be final and nonappealable, but the employer shall be allowed to submit another plan for approval.

Sec. 9. REPORT

The department of labor shall review and assess information relating to workers' compensation medical information and records to determine whether the scope of information contained in the medical records exceeds that relating only to a work-related injury and whether nonrelevant medical information is being sent to the department without redaction. The department shall report its findings and any recommendations to the house committee on commerce and economic development and the senate committee on economic development, housing and general affairs by January 15, 2012.

Sec. 10. EFFECTIVE DATES

This section and Secs. 5, 6, 7, 8, and 9 of this act shall take effect on passage. The remaining sections shall take effect on July 1, 2011.

and that after passage the title of the bill be amended to read: "An act relating to the workers' compensation and unemployment compensation statutes"

(Committee vote: 9-0-2)

(No Senate Amendments)

S. 104

An act relating to modifications to the ban on gifts by manufacturers of prescribed products

Rep. Till of Jericho, for the Committee on Health Care**,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 18 V.S.A. § 4631a is amended to read:

§ 4631a. 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 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 or for health care services on behalf of an employee of the manufacturer.

(H) Other research paid at fair market value, as long as the manufacturer on behalf of which the survey or other research is conducted is unaware of the identity of the health care provider receiving expenditures related to the research.

(I) 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) 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.

(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 (7)(A); or

(iii) an officer, employee, agent, or contractor of a person described in subdivision (i) of this subdivision (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 (7) who is employed solely by a manufacturer.

(8) "Health care provider" means a health care professional, 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.

(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. The term also does not include a manufacturer whose only prescribed products are classified as Class I by the U.S. Food and Drug Administration, are exempt from pre-market notification under Section 510(k) of the federal Food, Drug and Cosmetic Act, and are sold over-the-counter without a prescription.

(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.

(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.

(12) "Prescribed product" means a drug or device as defined in section 201 of the federal Food, Drug and Cosmetic Act, 21 U.S.C. § 321, a compound drug or drugs, or a biological product as defined in section 351 of the Public Health Service Act, 42 U.S.C. § 262, for human use.

(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. The term does not include prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.

(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 education credit, features multiple presenters on scientific research, or is authorized by the 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~~ 120 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.~~ Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded 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. 2. 18 V.S.A. § 4632 is amended to read:

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

(a)(1)(A) Annually on or before ~~October~~ April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the ~~fiscal~~ preceding calendar 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 to health care providers 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 for the use for which the clinical trial is being conducted or ~~two~~

four 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;

(iv) interview or health care 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; and

(vi) loans of medical devices for short-term trial periods pursuant to subdivision 4631a(b)(2)(B) of this title, provided the loan results in the purchase, lease, or other comparable arrangement of the medical device after issuance of a certificate of need pursuant to chapter 221, subchapter 5 of this title.

(B) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year:

(i) if the manufacturer is reporting other allowable expenditures or permitted gifts pursuant to subdivision (a)(1)(A) of this section, the product, dosage, number of units, and recipient information of over-the-counter drugs, nonprescription medical devices, and items of nonprescription durable medical equipment provided to a health care provider for free distribution to patients pursuant to subdivision 4631a(b)(2)(A) of this title; provided that any public reporting of such information shall not include information that allows for the identification of individual recipients of samples or connects individual recipients with the monetary value of the samples provided.

(ii) for each research activity described in subdivision 4631a(a)(1)(H) of this title, the number of health care providers participating in the research, the total amount paid to the entity conducting the research, and, if a product is distributed as part of the research, the product name, dosage, and number of units distributed.

(iii) the product, dosage, and number of units of prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program, reported separately for products distributed to individuals residing in Vermont and for products distributed to health care providers.

(C) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year the value, nature, purpose, and recipient information

of any allowable expenditure or gift 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 for the use for which the clinical trial is being conducted or ~~two~~ four 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.

(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~~ determines 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.

(3) Annually on ~~July~~ January 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.

(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~~ subdivisions (a)(1)(B) and (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 or, in the case of an institution, foundation, or organization, the federal tax identification number or the identification number assigned by the attorney general.

(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~~ October 1. The report shall include:

(A) Information on allowable expenditures and permitted 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. In accordance with subdivisions (1)(B) and (2)(A) of this subsection, information on samples of prescribed products and of over-the-counter drugs, nonprescription medical devices, and items of nonprescription durable medical equipment shall be presented in aggregate form.

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

(6) After issuance of the report required by subdivision (5) of this subsection and except as otherwise provided in ~~subdivision~~ subdivisions

(1)(B)(i) and (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.

(7) The department 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 department may select the data most relevant to its analysis. The department shall report its analysis annually to the general assembly and the governor on or before ~~October 1~~ March 1.

(b)(1) ~~Annually on July 1~~ Beginning January 1, 2013 and annually thereafter, 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 section 4631a of 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.

Sec. 3. REPORTING FEES

(a) Notwithstanding the provisions of 18 V.S.A. § 4632(b)(1), on July 1, 2011, 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 18 V.S.A. § 4632(a) for the fiscal year ending June 30, 2011.

(b) Notwithstanding the provisions of 18 V.S.A. § 4632(b)(1), on January 1, 2012, the office of the attorney general shall collect a $250.00 fee from each manufacturer of prescribed products filing disclosures of expenditures greater than zero described in 18 V.S.A. § 4632(a) for the six-month period from July 1, 2011 through December 31, 2011.

Sec. 4. ELECTRONIC PRIOR AUTHORIZATION

The commissioner of Vermont health access and the Vermont information technology leaders (VITL), in collaboration with health insurers, prescribers, representatives of the independent pharmacy community, and other interested parties, shall evaluate the use of electronic means for requesting and granting prior authorization for prescription drugs. No later than January 15, 2012, the commissioner and VITL shall report their findings to the senate committee on health and welfare and the house committee on health care and make recommendations for processes to develop standards for electronic prior authorizations.

Sec. 5. EFFECTIVE DATES

This act shall take effect on July 1, 2011, except that, in Sec. 2, the amendments to 18 V.S.A. § 4632(a)(1)(B) shall take effect on January 1, 2012.

(Committee vote: 7-3-1)

(For text see Senate Journal 4/20 -4/21/11)

Rep. Clarkson of Woodstock, for the Committee on **Ways and Means,** recommends the bill ought to pass when amended as recommended by the Committee on **Health Care.**

(Committee Vote: 11-0-0)

Senate Proposal of Amendment

H. 198

An act relating to a transportation policy to accommodate all users

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

Sec. 1. PURPOSE

The purpose of this bill is to ensure that the needs of all users of Vermont's transportation system—including motorists, bicyclists, public transportation users, and pedestrians of all ages and abilities—are considered in all state and municipally managed transportation projects and project phases, including planning, development, construction, and maintenance, except in the case of projects or project components involving unpaved highways. These "complete streets" principles shall be integral to the transportation policy of Vermont.

Sec. 2. 19 V.S.A. § 10b is amended to read:

§ 10b. STATEMENT OF POLICY; GENERAL

(a) The agency shall be the responsible agency of the state for the

development of transportation policy. It shall develop a mission statement to reflect:

(1) that state transportation policy ~~encompassing, coordinating, and integrating~~ shall be to encompass, coordinate, and integrate all modes of transportation~~,~~ and to consider "complete streets" principles, which are principles of safety and accommodation of all transportation system users, regardless of age, ability, or modal preference; and

(2) the need for transportation projects that will improve the state's economic infrastructure, as well as the use of resources in efficient, coordinated, integrated, cost-effective, and environmentally sound ways.

(b) The agency shall coordinate planning and education efforts with those of the Vermont climate change oversight committee and those of local and regional planning entities:

(1) to assure that the transportation system as a whole is integrated, that access to the transportation system as a whole is integrated, and that statewide, local, and regional conservation and efficiency opportunities and practices are integrated; and

(2) to support employer or local or regional government-led conservation, efficiency, rideshare, and bicycle programs and other innovative transportation advances, especially employer-based incentives.

~~(b)~~(c) In developing the state's annual transportation program, the agency shall, consistent with the planning goals listed in 24 V.S.A. § 4302 as amended by No. 200 of the Acts of the 1987 Adj. Sess. (1988) and with appropriate consideration to local, regional, and state agency plans:

(1) Develop or incorporate designs that provide integrated, safe, and efficient transportation ~~and promote~~.

(2)(A) Consider the safety and accommodation of all transportation system users—including motorists, bicyclists, public transportation users, and pedestrians of all ages and abilities—in all state and municipally managed transportation projects and project phases, including planning, development, construction, and maintenance, except in the case of projects or project components involving unpaved highways. If, after the consideration required under this subdivision, a state-managed project does not incorporate complete streets principles, the project manager shall make a written determination, supported by documentation and available for public inspection at the agency, that one or more of the following circumstances exist:

(i) Use of the transportation facility by pedestrians, bicyclists, or other users is prohibited by law.

(ii) The cost of incorporating complete streets principles is disproportionate to the need or probable use as determined by factors including land use, current and projected user volumes, population density, crash data, historic and natural resource constraints, and maintenance requirements. The agency shall consult local and regional plans, as appropriate, in assessing these and any other relevant factors.

(iii) Incorporating complete streets principles is outside the scope of a project because of its very nature.

(B) The written determination required under subdivision (A) of this subdivision (2) shall be final and shall not be subject to appeal or further review.

(3) Promote economic opportunities for Vermonters and the best use of the state's environmental and historic resources.

~~(2)~~(4) Manage available funding to:

(A) give priority to preserving the functionality of the existing transportation infrastructure, including bicycle and pedestrian trails regardless of whether they are located along a highway shoulder; and

(B) adhere to credible project delivery schedules.

~~(c)~~(d) The agency of transportation, in developing each of the program prioritization systems schedules for all modes of transportation, shall include the following throughout the process:

(1) The agency shall annually solicit input from each of the regional planning commissions and the Chittenden County metropolitan planning organization on regional priorities within each schedule, and those inputs shall be factored into the prioritizations for each program area and shall afford the opportunity of adding new projects to the schedules.

(2) Each year the agency shall provide in the front of the transportation program book a detailed explanation describing the factors in the prioritization system that creates each project list.

Sec. 3. 19 V.S.A. § 309d is added to read:

§ 309d. POLICY FOR MUNICIPALLY MANAGED TRANSPORTATION PROJECTS

(a) Except in the case of projects or project components involving unpaved highways, for all transportation projects and project phases managed by a municipality, including planning, development, construction, or maintenance, it is the policy of this state for municipalities to consider "complete streets" principles, which are principles of safety and accommodation of all

transportation system users, regardless of age, ability, or modal preference. If, after the consideration required under this section, a project does not incorporate complete streets principles, the municipality managing the project shall make a written determination, supported by documentation and available for public inspection at the office of the municipal clerk and at the agency of transportation, that one or more of the following circumstances exist:

(1) Use of the transportation facility by pedestrians, bicyclists, or other users is prohibited by law.

(2) The cost of incorporating complete streets principles is disproportionate to the need or probable use as determined by factors such as land use, current and projected user volumes, population density, crash data, historic and natural resource constraints, and maintenance requirements. The municipality shall consult local and regional plans, as appropriate, in assessing these and any other relevant factors.

(3) Incorporating complete streets principles is outside the scope of a project because of its very nature.

(b) The written determination required by subsection (a) of this section shall be final and shall not be subject to appeal or further review.

Sec. 4. REPORTING AND TRANSITION RULE

(a) By March 15, 2012, the agency of transportation shall report to the house and senate committees on transportation on its activities to comply with this act.

(b) The agency shall make available to the public upon request and in an easily understandable format a list of all state and municipally managed projects that have incorporated complete streets principles, accompanied by a description of each project and its location.

(c) The agency shall make available to the public upon request and in an easily understandable format a list of all state and municipally managed projects that have not incorporated complete streets principles pursuant to an exemption of Sec. 2, 19 V.S.A. § 10b(c)(2)(A), or Sec. 3, 19 V.S.A. § 309d(a), of this act. This list shall specify which exemption applied.

(d) The agency and municipalities shall be exempt from the requirement to assign exemptions pursuant to Sec. 2, 19 V.S.A. § 10b(c)(2)(A), or Sec. 3, 19 V.S.A. § 309d(a), of this act and from the reporting requirements of this section with respect to any project for which preliminary engineering is complete as of the effective date of this act.

Sec. 5. EFFECTIVE DATE

This act shall take effect on July 1, 2011.

(For text see House Journal 2011)

H. 201

An act relating to hospice and palliative care

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

First: By striking out the Sec. 3 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 3 to read as follows:

Sec. 3. REQUEST FOR A WAIVER

By no later than July 1, 2012, the agency of human services shall include as a part of its application request for a demonstration project from the Centers for Medicare and Medicaid Services to integrate care for dual eligible individuals the additional proposal of allowing the state to provide for an "enhanced hospice access" benefit, whereby the definition of "terminal illness" is expanded from six months' life expectancy to that of 12 months and participants may access hospice without being required to first discontinue curative therapy. Also, by no later than July 1, 2013, the agency of human services shall submit a Global Commitment Medicaid waiver amendment to provide funding for the same enhanced hospice access benefit.

Second: In Sec. 4, subsection (c), by striking out the following: "Assembly of Home Health Agencies, Inc." and inserting in lieu thereof the following: Vermont Assembly of Home Health and Hospice Agencies

Third: By striking out Sec. 7 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 7 to read as follows:

Sec. 7. 26 V.S.A. § 1400 is amended to read:

§ 1400. RENEWAL OF LICENSE; CONTINUING MEDICAL EDUCATION

(a) Every person licensed to practice medicine ~~and surgery~~ by the board shall apply biennially for the renewal of his or her license. ~~One~~ At least one month prior to the date on which renewal is required, the board shall send to each licensee a license renewal application form and notice of the date on which the existing license will expire. On or before the renewal date, the licensee shall file an application for license renewal and pay the required fee. The board shall register the applicant and issue the renewal license. Within one month following the date renewal is required, the board shall pay the license renewal fees into the medical practice board special fund ~~and shall file a list of licensees with the department of health~~.

(b) A licensee applying for renewal of an active license to practice medicine shall have completed continuing medical education which shall meet minimum criteria as established by rule, by the board, by August 31, 2012 and which shall be in effect for the renewal of licenses to practice medicine expiring after August 31, 2014. The board shall require a minimum of ten hours of continuing medical education by rule. The training provided by the continuing medical education shall be designed to ensure that the licensee has updated his or her knowledge and skills in his or her own specialties and also has kept abreast of advances in other fields for which patient referrals may be appropriate. The board shall require evidence of current professional competence in recognizing the need for timely appropriate consultations and referrals to ensure fully informed patient choice of treatment options, including treatments such as those offered by hospice, palliative care, and pain management services.

(c) A licensee applying for renewal of an active license to practice medicine shall have practiced medicine within the last three years as defined in section 1311 of this title or have complied with the requirements for updating knowledge and skills as defined by board rules.

(d) A licensee shall demonstrate that the requirements for licensure are met.

(e) A licensee shall promptly provide the board with new or changed information pertinent to the information in his or her license and license renewal applications at the time he or she becomes aware of the new or changed information.

~~(b)~~(f) A person who practices medicine ~~and surgery~~ and who fails to renew his or her license in accordance with the provisions of this section shall be deemed an illegal practitioner and shall forfeit the right to so practice or to hold himself or herself out as a person licensed to practice medicine ~~and surgery~~ in the state until reinstated by the board, but nevertheless a ~~person who was licensed to practice medicine and surgery at the time of his induction, call on reserve commission or enlistment into the armed forces of the United States, shall be entitled to practice medicine and surgery during the time of his service with the armed forces of the United States and for 60 days after separation from such service~~ physician while on extended active duty in the uniformed services of the United States or as a member of the national guard, state guard, or reserve component who is licensed as a physician at the time of an activation or deployment shall receive an extension of licensure up to 90 days following the physician's return from activation or deployment, provided the physician notifies the board of his or her activation or deployment prior to the expiration of the current license and certifies that the circumstances of the activation or deployment impede good faith efforts to make timely application

for renewal of the license.

~~(c)~~(g) Any person who allows a license to lapse by failing to renew the same in accordance with the provisions of this section may be reinstated by the board by payment of the renewal fee and the late renewal penalty, and if applicable, by completion of the continuing medical education requirement as established in subsection (b) of this section and any other requirements for licensure as required by this section and board rule.

Fourth: In Sec. 8, after the following "set forth in 26 V.S.A." by striking out the following: "§ 1400(b)(1) and (2), in the field of field of palliative care, hospice, end-of-life care, and management of chronic pain" and inserting in lieu thereof the following: § 1400(b)

Fifth: In Sec. 10, 18 V.S.A. § 9708, by striking subsection (f) in its entirety. And by relettering the remaining subsections in Sec. 10 to be alphabetically correct

Sixth: In Sec. 10, 18 V.S.A. § 9708, by striking relettered subsection (g) in its entirety and inserting in lieu thereof a new subsection (g) to read as follows:

~~(b)~~(g) A clinician who issues a DNR order ~~may~~ shall authorize issuance of a DNR identification to the ~~principal~~ patient. Uniform minimum requirements for DNR identification shall be determined by rule by the department of health no later than March 1, 2012.

Seventh: In Sec. 10, 18 V.S.A. § 9708, by inserting a new subsection to be lettered subsection (i) to read as follows:

(i) A DNR/COLST order executed prior to July 1, 2011 shall be a valid order if the document complies with the statutory requirements in effect at the time the document was executed or with the provisions of this chapter.

And by relettering the remaining subsections in Sec. 10 to be alphabetically correct.

Eighth: By inserting a new section to be numbered Sec. 11 to read as follows:

* * * STUDY ON DNR/COLST ORDER INFORMED CONSENT * * *

SEC. 11. STUDY ON DNR/COLST ORDER INFORMED CONSENT

(a) The DNR/COLST order informed consent committee is created and shall be convened by the commissioner of health to study criteria to be used for rules concerning individuals who are giving informed consent for a DNR/COLST order issued pursuant to 18 V.S.A. § 9708(b), but who are not the patient, the patient's agent, or the patient's guardian.

(b) The committee shall consist of the following members or their designees:

(1) The commissioners of health; Vermont health access; and disabilities, aging, and independent living;

(2) one representative each from the Vermont Medical Society, the Vermont Ethics Network, the Vermont Association of Hospitals and Health Systems, Vermont Program for Quality in Health Care, the Hospice and Palliative Care Council of Vermont, the Vermont Center for Independent Living, Vermont Area Agencies on Aging, Vermont Assembly of Home Health and Hospice Agencies, and the Vermont Health Care Association;

(3) the long term care ombudsman; and

(4) the state health care ombudsman.

(c) The committee shall make recommendations on the criteria to be used for rules concerning individuals who are giving informed consent for a DNR/COLST order to be issued pursuant to 18 V.S.A. § 9708(b), but who are not the patient, the patient's agent, or the patient's guardian. The committee's recommendations shall include:

(1) which individual or individuals who are not the patient, the patient's agent, or the patient's guardian, but who shall be a family member of the patient or a person with a known close relationship to the patient, are permitted to give informed consent for a DNR/COLST order;

(2) how decisions regarding who is the appropriate person to be giving informed consent for a DNR/COLST order are to be made, which shall include at a minimum the protection of a patient's own wishes in the same manner as set forth in 18 V.S.A. § 9711,

(3) the use of a hospital's internal ethics protocols when there is a disagreement over who is the appropriate person to give informed consent for a DNR/COLST order; and

(4) an examination of the relationship between the wishes expressed in an advance directive and the DNR/COLST order.

(d) The committee shall report by December 1, 2011 to the Vermont health access oversight committee, the chair of the house committee on human services, and the chair of the senate committee on health and welfare on its findings and recommendations.

And by renumbering all remaining sections to be numerically correct.

Ninth: In renumbered Sec. 12, 18 V.S.A. § 9709, subsection (c), by striking out subdivision (5) in its entirety and inserting in lieu thereof new subdivisions

(5) and (6) to read as follows:

(5) Upon transfer or discharge ~~from the~~ to another facility, a copy of any advance directive, DNR order, ~~and clinician order for life sustaining treatment is~~ or COLST order shall be transmitted with the principal ~~or, if~~ or patient. If the transfer is to a health care facility or residential care facility, ~~is~~ any advance directive, DNR order, or COLST order shall be promptly transmitted to the subsequent facility, unless the sending facility has confirmed that the receiving facility has a copy of ~~any~~ the advance directive, DNR order, or ~~clinician order for life sustaining treatment~~ COLST order.

(6) For a patient for whom DNR/COLST orders are documented in a facility-specific manner, any DNR/COLST orders to be continued upon discharge, during transport, or in another setting shall be documented on the Vermont DNR/COLST form issued pursuant to 18 V.S.A. § 9708(b) or on the form as prescribed by the patient's state of residence.

Tenth: By inserting a new section to be numbered Sec. 13 to read as follows:

Sec. 13. 18 V.S.A. § 9713 is amended to read:

§ 9713. IMMUNITY

(a) No individual acting as an agent or guardian shall be subjected to criminal or civil liability for making a decision in good faith pursuant to the terms of an advance directive, or DNA order, or COLST order and the provisions of this chapter.

(b)(1) No health care provider, health care facility, residential care facility, or any other person acting for or under such person's control shall, if the provider or facility has complied with the provisions of this chapter, be subject to civil or criminal liability for:

(A) providing or withholding ~~health care~~ treatment or services in good faith pursuant to the direction of a principal or patient, the provisions of an advance directive, a DNA order, a COLST order, a DNR identification ~~of the principal~~, the consent of a principal or patient with capacity or of the principal's or patient's agent or guardian, or a decision or objection of a principal or patient; or

(B) relying in good faith on a suspended or revoked advance directive, suspended or revoked DNR order, or suspended or revoked COLST order, unless the provider or facility knew or should have known of the suspension or revocation.

(2) No funeral director, crematory operator, cemetery official, procurement organization, or any other person acting for or under such

person's control, shall, if the director, operator, official, or organization has complied with the provisions of this chapter, be subject to civil or criminal liability for providing or withholding its services in good faith pursuant to the provisions of an advance directive, whether or not the advance directive has been suspended or revoked.

(3) Nothing in this subsection shall be construed to establish immunity for the failure to follow standards of professional conduct and to exercise due care in the provision of services.

(c) No employee shall be subjected to an adverse employment decision or evaluation for:

(1) providing or withholding ~~health care~~ treatment or services in good faith pursuant to the direction of a principal or patient, the provisions of an advance directive, a DNR order, a COLST order, a DNR identification ~~of the principal~~, the consent of the ~~principal's~~ principal or patient with capacity or principals or patient's agent or guardian, a decision or objection of a principal or patient, or the provisions of this chapter. This subdivision shall not be construed to establish a defense for the failure to follow standards of professional conduct and to exercise due care in the provision of services;

(2) relying on an amended, suspended, or revoked advance directive, unless the employee knew or should have known of the amendment, suspension or revocation; or

(3) providing notice to the employer of a moral or other conflict pursuant to subdivision 9707(b)(3) of this title, so long as the employee has provided ongoing health care until a new employee or provider has been found to provide the services.

And by renumbering all remaining sections to be numerically correct.

Eleventh: In renumbered Sec. 15, after the following: "This act shall take effect on passage" by inserting the following: , except for Sec. 7, 26 V.S.A. § 1400(c), which shall take effect 60 days after the adoption of the maintenance of licensure rule for physicians

(For text see House Journal March 18 and 24, 2011)

H. 264

An act relating to driving while intoxicated and to forfeiture and registration of motor vehicles

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

Sec. 1. PURPOSE

This act is intended to help prevent the harm caused to Vermonters and their families and friends by chronic DUI offenders who repeatedly operate motor vehicles while under the influence of alcohol or other drugs.

* * * Permitting Unlicensed or Impaired Person to Operate * * *

Sec. 2. 23 V.S.A. § 1130 is amended to read:

§ 1130. PERMITTING UNLICENSED OR IMPAIRED PERSON TO OPERATE

(a) No person shall knowingly employ~~, as operator of a motor vehicle, a~~ another person as an operator of a motor vehicle knowing that the other person is not licensed as provided in this title.

(b) No person shall ~~knowingly~~ permit a motor vehicle owned by him or her or under his or her control to be operated by ~~a~~ another person ~~who~~ if the person who owns or controls the vehicle knows that the other person has no legal right to ~~do so, or in violation of a provision of this title~~ operate the vehicle.

(c)(1) No person who owns or is in control of a vehicle shall intentionally enable another person to operate the vehicle if the person who owns or controls the vehicle has actual knowledge that the operator is:

(A) under the influence of intoxicating liquor; or

(B) under the influence of any other drug or under the combined influence of alcohol and any other drug to a degree which renders the person incapable of driving safely.

(2) In a prosecution under this section, the state shall have the burden of proving beyond a reasonable doubt that the defendant was not placed under duress or subjected to coercion by the other person at the time the defendant enabled the other person to operate the motor vehicle.

(3) As used in this section, "intentionally enable another person to operate the motor vehicle" means to intentionally create a direct and immediate opportunity for another person to operate the motor vehicle.

(d)(1) A person who violates subsection (c) of this section shall be fined not more than $1,000.00 or imprisoned for not more than six months, or both.

(2) If the death or if serious bodily injury as defined in 13 V.S.A. § 1021(2) results to any person other than the operator from a violation of subsection (c) of this section, the person convicted of the violation shall be fined not more than $5,000.00 or imprisoned not more than two years, or both. The provisions of this subdivision do not limit or restrict prosecutions for manslaughter.

* * * DUI penalties, alternative sanctions, and innovative responses * * *

Sec. 3. 23 V.S.A. § 1201 is amended to read:

§ 1201. OPERATING VEHICLE UNDER THE INFLUENCE OF INTOXICATING LIQUOR OR OTHER SUBSTANCE; CRIMINAL REFUSAL

(a) A person shall not operate, attempt to operate, or be in actual physical control of any vehicle on a highway:

(1) when the person's alcohol concentration is 0.08 or more, or 0.02 or more if the person is operating a school bus as defined in subdivision 4(34) of this title; or

(2) when the person is under the influence of intoxicating liquor; or

(3) when the person is under the influence of any other drug or under the combined influence of alcohol and any other drug to a degree which renders the person incapable of driving safely; or

(4) when the person's alcohol concentration is 0.04 or more if the person is operating a commercial motor vehicle as defined in subdivision 4103(4) of this title; or

(5) when the person's alcohol concentration is 0.02 or more if the person has previously been convicted of a second or subsequent violation of this section within the preceding three years and the person's alcohol concentration for the second or subsequent violation was 0.16 or greater.

* * *

Sec. 4. 23 V.S.A. § 1210 is amended to read:

§ 1210. PENALTIES

* * *

(d) Third ~~or subsequent~~ offense. A person convicted of violating section 1201 of this title who has ~~twice~~ previously been convicted two times of a violation of that section shall be fined not more than $2,500.00 or imprisoned not more than five years, or both. At least ~~400 hours of community service shall be performed, or~~ ~~100~~ 96 consecutive hours of the sentence of imprisonment shall be served and may not be suspended or deferred or served as a supervised sentence, except that credit for a sentence of imprisonment may be received for time served in a residential alcohol facility pursuant to sentence if the program is successfully completed. The court may impose a sentence that does not include a term of imprisonment or that does not require that the 96 hours of imprisonment be served consecutively only if the court makes

written findings on the record that such a sentence will serve the interests of justice and public safety.

(e) Fourth or subsequent offense. A person convicted of violating section 1201 of this title who has previously been convicted three times of a violation of that section shall be fined not more than $5,000.00 or imprisoned not more than ten years, or both. At least 192 consecutive hours of the sentence of imprisonment shall be served and may not be suspended or deferred or served as a supervised sentence, except that credit for a sentence of imprisonment may be received for time served in a residential alcohol facility pursuant to sentence if the program is successfully completed. The court shall not impose a sentence that does not include a term of imprisonment unless the court makes written findings on the record that there are compelling reasons why such a sentence will serve the interests of justice and public safety.

~~(e)(1)~~(f)(1) Death resulting. If the death of any person results from a violation of section 1201 of this title, the person convicted of the violation shall be fined not more than $10,000.00 or imprisoned not less than one year nor more than 15 years, or both. The provisions of this subsection do not limit or restrict prosecutions for manslaughter.

(2) If the death of more than one person results from a violation of section 1201 of this title, the operator may be convicted of a separate violation of this subdivision for each decedent.

(3)(A) Death resulting; third or subsequent offense. If the death of any person results from a violation of section 1201 of this title and the person convicted of the violation previously has been convicted two or more times of a violation of that section, a sentence ordered pursuant to this subsection shall, except as provided in subdivision (B) of this subdivision (3), include at least a five-year term of imprisonment. The five-year minimum term of imprisonment required by this subdivision shall be served and may not be suspended, deferred, or served as a supervised sentence. The defendant shall not be eligible for probation, parole, furlough, or any other type of early release until the expiration of the five-year term of imprisonment.

(B) Notwithstanding subdivision (A) of this subdivision (3), if the death of any person results from a violation of section 1201 of this title and the person convicted of the violation previously has been convicted two or more times of a violation of that section, the court may impose a sentence that does not include a term of imprisonment or which includes a term of imprisonment of less than five years if the court makes written findings on the record that such a sentence will serve the interests of justice and public safety.

~~(f)(1)~~(g)(1) Injury resulting. If serious bodily injury, as defined in

13 V.S.A. § 1021(2), results to any person other than the operator from a violation of section 1201 of this title, the person convicted of the violation shall be fined not more than $5,000.00, or imprisoned not more than 15 years, or both.

(2) If serious bodily injury as defined in 13 V.S.A. § 1021(2) results to more than one person other than the operator from a violation of section 1201 of this title, the operator may be convicted of a separate violation of this subdivision for each person injured.

(3)(A) Injury resulting; third or subsequent offense. If serious bodily injury as defined in 13 V.S.A. § 1021(2) results to any person other than the operator from a violation of section 1201 of this title and the person convicted of the violation previously has been convicted two or more times of a violation of section 1201, a sentence ordered pursuant to this subsection shall, except as provided in subdivision (B) of this subdivision (3), include at least a five-year term of imprisonment. The five-year minimum term of imprisonment required by this subdivision shall be served and may not be suspended, deferred, or served as a supervised sentence. The defendant shall not be eligible for probation, parole, furlough, or any other type of early release until the expiration of the five-year term of imprisonment.

(B) Notwithstanding subdivision (A) of this subdivision (3), if serious bodily injury as defined in 13 V.S.A. § 1021(2) results to any person other than the operator from a violation of section 1201 of this title and the person convicted of the violation previously has been convicted two or more times of a violation of section 1201, the court may impose a sentence that does not include a term of imprisonment or which includes a term of imprisonment of less than five years if the court makes written findings on the record that such a sentence will serve the interests of justice and public safety.

~~(g)~~(h) Determination of fines. In determining appropriate fines under this section the court may take into account the total cost to a defendant of alcohol screening, participation in the alcohol and driving education program and therapy and the income of the defendant.

~~(h)~~(i) A person convicted of violating section 1201 of this title shall be assessed a surcharge of $60.00, which shall be added to any fine imposed by the court. The court shall collect and transfer such surcharge to the department of ~~health~~ public safety for deposit in the health department's laboratory services special fund.

~~(i)~~(j) A person convicted of violating section 1201 of this title shall be assessed a surcharge of $50.00, which shall be added to any fine or surcharge imposed by the court. The court shall collect and transfer the surcharge

assessed under this subsection to the office of defender general for deposit in the public defender special fund specifying the source of the monies being deposited. The collection procedures described in 13 V.S.A. § 5240 shall be utilized in the collection of this surcharge.

~~(j)~~(k) A person convicted of violating section 1201 of this title shall be assessed a surcharge of $50.00, which shall be added to any fine or surcharge imposed by the court. The court shall collect and transfer the surcharge assessed under this subsection to be credited to the DUI enforcement fund. The collection procedures described in 13 V.S.A. § 5240 shall be utilized in the collection of this surcharge.

Sec. 5. REPEAL

23 V.S.A. § 1213(a),(b), and (c) within Sec. 9 of No. 126 of the Acts of 2009 Adj. Sess. (2010) are repealed.

Sec. 6. 23 V.S.A. § 1213(a), (b), and (c) are added to read:

(a) First offense. A person whose license or privilege to operate is suspended for a first offense under this subchapter shall be permitted to operate a motor vehicle, other than a commercial motor vehicle as defined in section 4103 of this title, if issued a valid ignition interlock RDL. The commissioner shall issue an ignition interlock RDL to a person eligible under section 1205(a)(2), 1206(a), or 1216(a)(1) of this title upon receipt of a $125.00 application fee, and upon receipt of satisfactory proof of installation of an approved ignition interlock RDL in any motor vehicle to be operated, financial responsibility as provided in section 801 of this title, and enrollment in an alcohol and driving education program. The RDL shall be valid after expiration of the applicable shortened period specified in section 1205(a)(2), 1206(a), or 1216(a)(1) of this title. An ignition interlock RDL shall expire upon reinstatement of a person's regular license or privilege to operate or shall expire unless renewed yearly. The commissioner shall send by first class mail an application for renewal of the RDL at least 30 days prior to the day renewal is required and shall impose the same conditions for renewal as are required for initial issuance of an ignition interlock RDL. The renewal fee shall be $125.00.

(b) Second offense. A person whose license or privilege to operate is suspended for a second offense under this subchapter shall be permitted to operate a motor vehicle, other than a commercial motor vehicle as defined in section 4103 of this title, if issued a valid ignition interlock RDL. The commissioner shall issue an ignition interlock RDL to a person eligible under section 1205(m), 1208(a), or 1216(a)(2) of this title upon receipt of a $125.00 application fee, and upon receipt of satisfactory proof of installation of an

approved ignition interlock RDL in any motor vehicle to be operated, financial responsibility as provided in section 801 of this title, and enrollment in an alcohol and driving rehabilitation program. The RDL shall be valid after expiration of the applicable shortened period specified in section 1205(m), 1208(a), or 1216(a)(2) of this title. An ignition interlock RDL shall expire upon reinstatement of a person's regular license or privilege to operate or shall expire unless renewed yearly. The commissioner shall send by first class mail an application for renewal of the RDL at least 30 days prior to the day renewal is required and shall impose the same conditions for renewal as are required for initial issuance of an ignition interlock RDL. The renewal fee shall be $125.00.

(c) Third or subsequent offense. A person whose license or privilege to operate is suspended or revoked for a third or subsequent offense under this subchapter shall be permitted to operate a motor vehicle, other than a commercial motor vehicle as defined in section 4103 of this title, if issued a valid ignition interlock RDL. The commissioner shall issue an ignition interlock RDL to a person eligible under section 1205(m), 1208(b), or 1216(a)(2) of this title upon receipt of a $125.00 application fee, and upon receipt of satisfactory proof of installation of an approved ignition interlock RDL in any motor vehicle to be operated, financial responsibility as provided in section 801 of this title, and enrollment in an alcohol and driving rehabilitation program. The RDL shall be valid after expiration of the applicable shortened period specified in section 1205(m), 1208(b), or 1216(a)(2) of this title. An ignition interlock RDL shall expire upon reinstatement of a person's regular license or privilege to operate or shall expire unless renewed yearly. The commissioner shall send by first class mail an application for renewal of the RDL at least 30 days prior to the day renewal is required and shall impose the same conditions for renewal as are required for initial issuance of an ignition interlock RDL. The renewal fee shall be $125.00.

Sec. 7. 23 V.S.A. § 1220a is amended to read:

§ 1220a. DUI ENFORCEMENT SPECIAL FUND

(a) There is created a DUI enforcement special fund which shall be a special fund established and managed pursuant to 32 V.S.A. chapter 7 subchapter 5. The DUI enforcement special fund shall be a continuation of and successor to the DUI enforcement special fund established under subsection 1205(r) of this title.

(b) The DUI enforcement special fund shall consist of:

(1) receipts from the surcharges assessed under section 206 and

subsections 674(i), 1091(d), 1094(f), 1128(d), 1133(d), 1205(r), and 1210(j) of this title;

(2) beginning in fiscal year 2000 and thereafter, the first $150,000.00 of revenues collected from fines imposed under subchapter 13 of chapter 13 of this title pertaining to DUI related offenses;

(3) beginning in fiscal year 2000 and thereafter, two percent of the revenues raised by the motor fuel tax on gasoline imposed by chapter 28 of this title; and

(4) any additional funds transferred or appropriated by the general assembly.

(c) The DUI enforcement special fund shall be used for the implementation and enforcement of this subchapter for purposes specified and in amounts appropriated by the general assembly. At least 40 percent of the money collected by the fund each year shall be awarded as grants to municipalities or law enforcement agencies for innovative programs designed to reduce DUI offenses. Priority shall be given to grants requested jointly by more than one law enforcement agency or municipality.

Sec. 8. DEDICATED BEDS FOR CHRONIC REPEAT DUI OFFENDERS

The department of corrections shall report to the joint committee on corrections oversight on or before November 15, 2011 on the feasibility of dedicating 25 beds at the southeast state correctional facility exclusively for chronic repeat DUI offenders. As used in this section, "chronic repeat DUI offender" means a person convicted three or more times of a violation of 23 V.S.A. § 1201.

Sec. 9. COMPREHENSIVE SYSTEM TO REDUCE REPEAT DUI OFFENSES

On or before January 15, 2012, the director of the governor's highway safety program, in consultation with the defender general and the departments of motor vehicles, of public safety, of health and of corrections shall report to the house and senate committees on judiciary a plan for implementation of a comprehensive system of penalties, alternative sanctions, and treatment to reduce the number of persons with repeat offenses of operating motor vehicles while under the influence of alcohol or other drugs. The system may include, among other measures, the following:

(1) a mandatory sobriety program for repeat DUI offenders similar to South Dakota's "24/7 Sobriety Program";

(2) increased penalties for operating a vehicle with an alcohol concentration substantially greater than the legal limit;

(3) methods of responding to DUI offenders who fail to complete the alcohol and driving education program (CRASH) required by 23 V.S.A. § 1209a(a)(1);

(4) enhanced use of ignition interlock devices, with respect to which the ignition interlock effectiveness study required by Sec. 14 of No. 126 of the Acts of 2009 shall be considered;

(5) mandatory alcohol and drug counseling and treatment for persons convicted of operating a motor vehicle while under the influence of alcohol or other drugs;

(6) establishment of a secure facility for housing and treatment of persons convicted of operating a motor vehicle while under the influence of alcohol or drugs;

(7) the circumstances under which the operator of a motor vehicle may be required to submit to a blood test to determine whether he or she has been operating the vehicle while under the influence of a drug other than alcohol;

(8) revisions that may be appropriate to the DUI statutes when the circumstances involve operating a motor vehicle under the influence of a drug that has been legally prescribed to the operator; and

(9) a proposal to permit conditional operator's licenses, which may be issued to a person who has been convicted of DUI for travel to limited places such as work, drug or alcohol treatment, school, or a doctor's office.

* * * Detention of operator * * *

Sec. 10. 23 V.S.A. § 1212 is amended to read:

§ 1212. CONDITIONS OF RELEASE AND PAROLE; ARREST UPON VIOLATION

* * *

(d) A law enforcement officer who observes a person violating a condition of parole requiring that the person not operate a motor vehicle may promptly arrest the person for violating the condition and may detain the person pursuant to 28 V.S.A. § 551. The officer shall immediately notify the parole board of the suspected violation. If the parole board determines pursuant to 28 V.S.A. § 552 that a parole violation has occurred, the board shall notify the state's attorney in the county where the violation occurred.

* * * Miscellaneous * * *

Sec. 11. REPORTS; STUDIES

(a) The court administrator shall report to the senate and house committees

on judiciary on or before January 15, 2012 on the number of persons convicted of violating 23 V.S.A. § 1130(c) (permitting impaired person to operate motor vehicle) since the passage of this act.

(b) Notwithstanding any other provision of law, the court administrator shall conduct a weighted caseload study and analysis or equivalent study within the probate division of the superior court for use by the senate and house committees on appropriations during development of the fiscal year 2013 budget. The results of the study shall be reported to the senate and house committees on judiciary and on appropriations on or before January 15, 2012. The study may be used to review and consider adjustments to the compensation of probate judges.

(c)(1) A committee is established to study modifying the number of interested parties who must be served with notice when a probate proceeding is commenced involving a decedent's estate and reducing the amount of time notice by publication is required to be published in newspapers. The committee shall consider whether reducing the number of interested parties would reduce costs to the estate without unduly prejudicing the rights of potential beneficiaries, and whether constitutional issues would be raised if such changes were made. The committee shall report its findings, together with any recommendations for legislative action, to the senate and house committees on judiciary no later than December 15, 2011.

(2) The committee established by this subsection shall consist of the following members:

(A) one member appointed by the Vermont Probate Judges Association;

(B) one member with experience in probate practice appointed by the Vermont Bar Association; and

(C) one member appointed by the Committee on Vermont Elders.

(3) Members of the committee who are not employees of the state of Vermont shall be entitled to reimbursement at the per diem rate set in 32 V.S.A. § 1010.

Sec. 12. Sec. 22(a) of No. 157 of the Acts of the 2009 Adj. Sess. (2010), as amended by Sec. 1 of No. 5 of the Acts of 2011, is amended to read:

(a) Sec. 18 of this act shall take effect on ~~July 1, 2011~~ July 1, 2012.

Sec. 13. [DELETED]

Sec. 14. 23 V.S.A. § 1203 is amended to read:

§ 1203. ADMINISTRATION OF TESTS; RETENTION OF TEST AND

* * *

(c) When a breath test which is intended to be introduced in evidence is taken with a crimper device or when blood is withdrawn at an officer's request, a sufficient amount of breath or blood, as the case may be, shall be taken to enable the person to have made an independent analysis of the sample, and shall be held for at least 45 days from the date the sample was taken. At any time during that period the person may direct that the sample be sent to an independent laboratory of the person's choosing for an independent analysis. The department of ~~health~~ public safety shall adopt rules providing for the security of the sample. At no time shall the defendant or any agent of the defendant have access to the sample. A preserved sample of breath shall not be required when an infrared breath-testing instrument is used. A person tested with an infrared breath-testing instrument shall have the option of having a second infrared test administered immediately after receiving the results of the first test.

(d) In the case of a breath test administered using an infrared breath testing instrument, the test shall be analyzed in compliance with rules adopted by the department of ~~health~~ public safety. The analyses shall be retained by the state. A sample is adequate if the infrared breath testing instrument analyzes the sample and does not indicate the sample is deficient. Analysis of the person's breath or blood which is available to that person for independent analysis shall be considered valid when performed according to methods approved by the department of ~~health~~ public safety. The analysis performed by the state shall be considered valid when performed according to a method or methods selected by the department of ~~health~~ public safety. The department of ~~health~~ public safety shall use rule making procedures to select its method or methods. Failure of a person to provide an adequate breath sample constitutes a refusal.

(e) [Repealed.]

(f) When a law enforcement officer has reason to believe that a person may be violating or has violated section 1201 of this title, the officer may request the person to provide a sample of breath for a preliminary screening test using a device approved by the commissioner of ~~health~~ public safety for this purpose. The person shall not have the right to consult an attorney prior to submitting to this preliminary breath alcohol screening test. The results of this preliminary screening test may be used for the purpose of deciding whether an arrest should be made and whether to request an evidentiary test and shall not be used in any court proceeding except on those issues. Following the screening test additional tests may be required of the operator pursuant to the provisions of section 1202 of this title.

* * *

(i) The commissioner of ~~health~~ public safety shall adopt emergency rules relating to the operation, maintenance and use of preliminary alcohol screening devices for use by law enforcement officers in enforcing the provisions of this title. The commissioner shall consider relevant standards of the National Highway Traffic Safety Administration in adopting such rules. Any preliminary alcohol screening device authorized for use under this title shall be on the qualified products list of the National Highway Traffic Safety Administration.

* * *

Sec. 15. 23 V.S.A. § 1203a is amended to read:

§ 1203a. INDEPENDENT CHEMICAL TEST; BLOOD TESTS

* * *

(d) The physician, licensed nurse, medical technician, physician's assistant, medical technologist, or laboratory assistant drawing a sample of blood shall use a sample collection kit provided by the department of ~~health~~ public safety or another type of collection kit. The sample shall be identified as to donor, date, and time, sealed and mailed to the department of ~~health~~ public safety where it shall be held for a period of at least 45 days from the date the sample was taken. At any time during that period the person may direct that the sample be sent to an independent laboratory of the person's choosing for an independent analysis. The department of ~~health~~ public safety may recover its costs of supplies, handling and storage.

* * *

Sec. 16. 23 V.S.A. § 1205(h)(1)(D) is amended to read:

(D) whether the test was taken and the test results indicated that the person's alcohol concentration was 0.08 or more at the time of operating, attempting to operate or being in actual physical control of a vehicle in violation of section 1201 of this title, whether the testing methods used were valid and reliable and whether the test results were accurate and accurately evaluated. Evidence that the test was taken and evaluated in compliance with rules adopted by the department of ~~health~~ public safety shall be prima facie evidence that the testing methods used were valid and reliable and that the test results are accurate and were accurately evaluated;

Sec. 17. 23 V.S.A. § 1216 is amended to read:

§ 1216. PERSONS UNDER 21; ALCOHOL CONCENTRATION OF 0.02 OR MORE

* * *

(d) If a law enforcement officer has reasonable grounds to believe that a person is violating this section, the officer may request the person to submit to a breath test using a preliminary screening device approved by the commissioner of ~~health~~ public safety. A refusal to submit to the breath test shall be considered a violation of this section. Notwithstanding any provisions to the contrary in sections 1202 and 1203 of this title:

* * *

Sec. 18. BLOOD AND BREATH ALCOHOL TESTING AND ALCOHOL SCREENING DEVICES; AUTHORITY OF DEPARTMENT OF PUBLIC SAFETY; RULEMAKING

(a) The department of public safety shall adopt rules, which may include emergency rules, to govern the operation, maintenance, and use of blood and breath alcohol testing and alcohol screening devices, and to describe the methods used to exercise the authority granted by this act. Prior to the effective date of the rules required to be adopted by this subsection, the department of public safety may take such steps as are necessary to prepare to assume authority and supervision over operation, maintenance, and use of blood and breath alcohol testing and alcohol screening devices. The rules of the agency of human services pertaining to the blood and breath alcohol testing and alcohol screening program shall remain in effect and govern the program until revised or repealed by rules adopted by the department of public safety, including emergency rules adopted pursuant to this subsection.

(b) The administration shall, in consultation with the Vermont state employees association, ensure that no reduction in positions occurs as a result of the transfer required by this section. The administration shall transfer positions to the department of public safety so that the department may implement the authority granted to it by this act.

(c) On or before January 15, 2012, and on or before January 15 of each of the following two years, the department of public safety shall report to the senate and house committees on judiciary on progress toward identifying and implementing an accreditation process for the blood alcohol testing and alcohol screening program transferred to the department by this section.

(d) Notwithstanding any other provision of law, on March 1, 2012, or on the effective date of the rules required to be adopted by subsection (a) of this section, whichever is earlier, the department of public safety shall assume the authority transferred to it by this act over the blood and breath alcohol testing and alcohol screening program.

Sec. 19. EFFECTIVE DATES

This act shall take effect on passage, except as follows:

(1) Sec. 5 shall take effect on June 30, 2011.

(2) Sec. 6 shall take effect on July 1, 2011.

(3) Secs. 14, 15, 16, and 17 shall take effect on March 1, 2012.

(For text see House Journal March 17 and 18, 2011)

Committee of Conference Report

H. 26

An act relating to limiting the application of fertilizer containing phosphorus or nitrogen to nonagricultural turf

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:

H.26. An act relating to the application of phosphorus fertilizer to nonagricultural turf.

Respectfully reports that it has met and considered the same and recommends that the House accede to the Senate proposal of amendment, and that the bill be further amended as follows:

First: In Sec. 1, 10 V.S.A. § 1266b, by striking out subsection (a) in its entirety and inserting in lieu thereof the following:

(a) Definitions. As used in this section:

(1) "Compost" means a stable humus-like material produced by the controlled biological decomposition of organic matter through active management, but shall not mean sewage, septage, or materials derived from sewage or septage.

(2) "Fertilizer" shall have the same meaning as in 6 V.S.A. § 363(5).

(3) "Impervious surface" means those manmade surfaces, including paved and unpaved roads, parking areas, roofs, driveways, and walkways, from which precipitation runs off rather than infiltrates.

(4) "Manipulated animal or vegetable manure" means manure that is ground, pelletized, mechanically dried, supplemented with plant nutrients or substances other than phosphorus or phosphate, or otherwise treated to assist with the use of manure as fertilizer.

(5) "Nitrogen fertilizer" means fertilizer labeled for use on turf in which

the nitrogen content consists of less than 15 percent slow-release nitrogen.

(6) "Phosphorus fertilizer" means fertilizer labeled for use on turf in which the available phosphate content is greater than 0.67 percent by weight, except that "phosphorus fertilizer" shall not include compost or manipulated animal or vegetable manure.

(7) "Slow release nitrogen" means nitrogen in a form that is released over time and that is not water-soluble nitrogen.

(8)(A) "Turf" means land planted in closely mowed, managed grasses, including residential and commercial property and publicly owned land, parks, and recreation areas.

(B) "Turf" shall not include:

(i) pasture, cropland, land used to grow sod, or any other land used for agricultural production; or

(ii) private and public golf courses.

(9) "Water" or "water of the state" means all rivers, streams, creeks, brooks, reservoirs, ponds, lakes, springs, and all bodies of surface waters, artificial or natural, which are contained within, flow through, or border upon the state or any portion of it.

(10) "Water-soluble nitrogen" means nitrogen in a water-soluble form that does not have slow release properties.

Second: In Sec. 1, 10 V.S.A. § 1266b, by adding a new subsection (c) to read as follows:

(c) Application of nitrogen fertilizer. No person shall apply nitrogen fertilizer to turf.

and by relettering the subsequent subsections to be alphabetically correct

Third: In Sec. 5, by striking out subsection (b) in its entirety and inserting in lieu thereof the following:

(b) Secs. 1 (application of fertilizer), 2 (golf course management plans) and 3 (judicial bureau offense) of this act shall take effect on January 1, 2012, except that 10 V.S.A. § 1266b(b)(2) (agency of agriculture, food and markets soil test authorization) shall take effect on passage.

VIRGINIA V. LYONS
MARK A. MACDONALD
RANDOLPH D. BROCK
Committee on the part of the Senate

JAMES M. MCCULLOUGH
LUCY R. LERICHE
PATTI J. LEWIS
Committee on the part of the House

H. 202

An act relating to a universal and unified health system

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:

H. 202 An act relating to a universal and unified health system

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

Sec. 1. INTENT

(a) It is the intent of the general assembly to create Green Mountain Care to contain costs and to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage. It is the intent of the general assembly to achieve health care reform through the coordinated efforts of an independent board, state government, and the citizens of Vermont, with input from health care professionals, businesses, and members of the public.

(b) It is also the intent of the general assembly to maximize the receipt of federal funds, including those available pursuant to the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and to create a reasonable plan to implement Green Mountain Care as set forth in this act.

Sec. 1a. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(3) 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 of the health care system.

(4) 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, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

(5) Every Vermonter should be able to choose his or her health care providers.

(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.

(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.

(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.

(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.

(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.

(11) The financing of health care in Vermont must be sufficient, fair,

predictable, transparent, sustainable, and shared equitably.

(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.

(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.

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

Sec 1b. 3 V.S.A. § 2222a is amended to read:

§ 2222a. HEALTH CARE SYSTEM REFORM; IMPROVING QUALITY AND AFFORDABILITY

(a) The ~~secretary~~ director of health care reform in the agency of administration shall be responsible for the coordination of health care system reform ~~initiatives~~ efforts among executive branch agencies, departments, and offices, and for coordinating with the Green Mountain Care board established in 18 V.S.A. chapter 220.

(b) The ~~secretary~~ director shall ensure that those executive branch agencies, departments, and offices responsible for the development, improvement, and implementation of Vermont's health care system reform do so in a manner that is coordinated, timely, equitable, patient-centered, and evidence-based, and that seeks to inform and improve the quality and affordability of patient care and public health, contain costs, and attract and retain well-paying jobs in this state.

(c) Vermont's health care system reform ~~initiatives~~ efforts include:

(1) The state's chronic care infrastructure, disease prevention, and management program contained in the blueprint for health established by ~~chapter 13 of Title~~ 18 V.S.A. chapter 13, the goal of which is to achieve a unified, comprehensive, statewide system of care that improves the lives of all Vermonters with or at risk for a chronic condition or disease.

(2) The Vermont health information technology project pursuant to ~~chapter 219 of Title~~ 18 V.S.A. chapter 219.

(3) The multi-payer data collection project pursuant to 18 V.S.A. § 9410.

(4) The common claims administration project pursuant to 18 V.S.A. § 9408.

(5) The consumer price and quality information system pursuant to 18 V.S.A. § 9410.

(6) ~~Any~~ The information technology work done by the quality assurance system pursuant to 18 V.S.A. § 9416.

(7) The public health promotion programs of the agency of human services, including primary prevention for chronic disease, community assessments, school wellness programs, public health information technology, data and surveillance systems, healthy retailers, healthy community design, and alcohol and substance abuse treatment and prevention programs.

(8) ~~Medicaid, the Vermont health access plan, Dr. Dynasaur, premium assistance programs for employer-sponsored insurance, VPharm, and Vermont Rx, which are established in chapter 19 of Title 33 and provide health care coverage to elderly, disabled, and low to middle income Vermonters.~~ The creation of a universal health care system to provide affordable, high-quality health care coverage to all Vermonters and to include federal funds to the maximum extent allowable under federal law and waivers from federal law.

(9) ~~Catamount Health, established in 8 V.S.A. § 4080f, which provides a comprehensive benefit plan with a sliding scale premium based on income to uninsured Vermonters.~~ A reformation of the payment system for health services to encourage quality and efficiency in the delivery of health care as set forth in 18 V.S.A. chapter 220.

(10) ~~The uniform hospital uncompensated car policies.~~ A strategic approach to workforce needs set forth in 18 V.S.A. chapter 222, including retraining programs for workers displaced through increased efficiency and reduced administration in the health care system and ensuring an adequate health care workforce to provide access to health care for all Vermonters.

(11) A plan for public financing of health care coverage for all Vermonters.

(d) ~~The secretary shall report to the commission on health care reform, the health access oversight committee, the house committee on health care, the senate committee on health and welfare, and the governor on or before December 1, 2006, with a five-year strategic plan for implementing Vermont's health care system reform initiatives, together with any recommendations for administration or legislation. Annually, beginning January 15, 2007, the secretary shall report to the general assembly on the progress of the reform initiatives.~~

~~(e)~~ The ~~secretary of administration~~ director of health care reform or designee shall provide information and testimony on the activities included in

this section to the health access oversight committee~~, the commission on health care reform,~~ and to any legislative committee upon request.

* * * Road Map to a Universal and a Unified Health System * * *

Sec. 2. STRATEGIC PLAN; UNIVERSAL AND UNIFIED HEALTH SYSTEM

(a) Vermont must begin to plan now for health care reform, including simplified administration processes, payment reform, and delivery reform, in order to have a publicly financed program of universal and unified health care operational after the occurrence of specific events, including the receipt of a waiver from the federal Exchange requirement from the U.S. Department of Health and Human Services. A waiver will be available in 2017 under the provisions of existing law in the Patient Protection and Affordable Care Act (Public Law 111-148) ("Affordable Care Act"), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and may be available in 2014 under the provisions of two bills, H.R. 844 and S.248, introduced in the 112th Congress. In order to begin the planning efforts, the director of health care reform in the agency of administration shall establish a strategic plan, which shall include time lines and allocations of the responsibilities associated with health care system reform, to further the containment of health care costs, to further Vermont's existing health care system reform efforts as described in 3 V.S.A. § 2222a and to further the following:

(1) As provided in Sec. 4 of this act, all Vermont residents shall be eligible for Green Mountain Care, a universal health care program that will provide health benefits through a single payment system. To the maximum extent allowable under federal law and waivers from federal law, Green Mountain Care shall include health coverage provided under the health benefit exchange established under 33 V.S.A. chapter 18, subchapter 1; under Medicaid; under Medicare; by employers that choose to participate; and to state employees and municipal employees, including teachers. In the event of a modification to the Affordable Care Act by congressional, judicial, or federal administrative action which prohibits implementation of the health benefit exchange; eliminates federal funds available to individuals, employees, or employers; or eliminates the waiver under Section 1332 of the Affordable Care Act, the director of health care reform shall continue, and adjust as appropriate, the planning and cost-containment activities provided in this act related to Green Mountain Care and to creation of a unified, simplified administration system for health insurers offering health benefit plans, including identifying the financing impacts of such a modification on the state and its effects on the activities proposed in this act.

(2)(A) As provided in Sec. 4 of this act, no later than November 1, 2013, the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling individuals and small employers for coverage beginning January 1, 2014. The intent of the general assembly is to establish the Vermont health benefit exchange in a manner such that it may become the foundation for Green Mountain Care.

(B) No later than February 15, 2012, the director of health care reform or designee shall provide the house committee on health care and the senate committees on finance and on health and welfare the following information related to the Vermont health benefit exchange, to the extent available:

(i) a list of the federal health benefits required under the Affordable Care Act as defined in 33 V.S.A. chapter 18, subchapter 1, including covered services and cost-sharing;

(ii) a comparison of the federal health benefits with the Vermont health insurance benefit requirements provided for in 8 V.S.A. chapter 108;

(iii) information relating to the silver, gold, and platinum benefit levels of qualified health benefit plans that may be available in the Vermont health benefit exchange;

(iv) a draft of qualified health benefit plan choices that may be available in the Vermont health benefit exchange;

(v) in collaboration with the three insurers with the largest number of lives, premium estimates for draft plan choices described in subdivision (iv) of this subdivision (B); and

(vi) the status of related tax credits, including small employer tax credits, and of cost-sharing subsidies.

(C) The director shall deliver to the general assembly by January 15, 2015 a report including:

(i) the qualified health benefit plans available in and outside the exchange, current and projected premiums, and enrollment data;

(ii) recommendations for any statutory changes needed to improve the functioning of the exchange, including those needed to reduce premiums and administrative costs for qualified health benefit plans and others the director determines are necessary to achieve cost-effectiveness; and

(iii) Vermont's efforts to obtain a waiver from the exchange requirement under Section 1332 of the Affordable Care Act.

(3) As provided in Sec. 4 of this act, no later than November 1, 2016,

the Vermont health benefit exchange established in 33 V.S.A. chapter 18, subchapter 1 shall begin enrolling large employers for coverage beginning January 1, 2017.

(4) The director shall supervise and oversee, as appropriate, the planning efforts, reports of which are due on January 15, 2012, as provided in Secs. 8 and 10 through 13 of this act, including integration of multiple payers into the Vermont health benefit exchange; a continuation of the planning necessary to ensure an adequate, well-trained primary care workforce; necessary retraining for any employees dislocated from health care professionals or from health insurers due to the simplification in the administration of health care; and unification of health system planning, regulation, and public health.

(5) The director shall supervise the planning efforts, reports of which are due January 15, 2013, as provided in Sec. 9 of this act, to establish the financing necessary for Green Mountain Care, for recruitment and retention programs for health care professionals, and for covering the uninsured and underinsured through Medicaid and the Vermont health benefit exchange.

(6) The director, in collaboration with the agency of human services, shall obtain waivers, exemptions, agreements, legislation, or a combination thereof to ensure that, to the extent possible under federal law, all federal payments provided within the state for health services are paid directly to Green Mountain Care. Green Mountain Care shall assume responsibility for the benefits and services previously paid for by the federal programs, including Medicaid, Medicare, and, after implementation, the Vermont health benefit exchange. In obtaining the waivers, exemptions, agreements, legislation, or combination thereof, the secretary shall negotiate with the federal government a federal contribution for health care services in Vermont that reflects medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, the number of Medicare-eligible individuals, and other factors that may be advantageous to Vermont and that do not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of Green Mountain Care.

(7) No later than January 15, 2012, the secretary of administration or designee shall submit to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary a proposal for potential improvement or reforms to the medical malpractice system for Vermont. The proposal shall be designed to address any findings of defensive medicine, reduce health care costs and medical errors, and protect patients' rights, and shall include the secretary's or designee's consideration of a no-fault system and of confidential pre-suit mediation. In designing the

proposal, the secretary or designee shall consider the findings and recommendations contained in the majority and minority reports of the medical malpractice study committee established by Sec. 292 of No. 122 of the Acts of the 2003 Adj. Sess. (2004).

(b) The Green Mountain Care board established in 18 V.S.A. chapter 220, in collaboration with the director of health care reform in the agency of administration, shall develop a work plan for the board, which may include any necessary processes for implementation of the board's duties, a time line for implementation of the board's duties, and a plan for ensuring sufficient staff to implement the board's duties. The work plan shall be provided to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.

* * * Cost Containment, Budgeting, and Payment Reform * * *

Sec. 3. 18 V.S.A. chapter 220 is added to read:

CHAPTER 220. GREEN MOUNTAIN CARE BOARD

Subchapter 1. Green Mountain Care Board

§ 9371. PRINCIPLES FOR HEALTH CARE REFORM

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

(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, 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.

(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.

(3) 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 of the health care system.

(4) 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, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals,

must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.

(5) Every Vermonter should be able to choose his or her health care providers.

(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.

(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.

(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.

(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.

(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.

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

(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.

(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.

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

§ 9372. PURPOSE

It is the intent of the general assembly to create an independent board to

promote the general good of the state by:

(1) improving the health of the population;

(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;

(3) enhancing the patient and health care professional experience of care;

(4) recruiting and retaining high-quality health care professionals; and

(5) achieving administrative simplification in health care financing and delivery.

§ 9373. DEFINITIONS

As used in this chapter:

(1) "Board" means the Green Mountain Care board established in this chapter.

(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 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.

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

(4) "Global payment" means a payment from a health insurer, Medicaid, Medicare, or other payer for the health services of a defined population of patients for a defined period of time. Such payments may be adjusted to account for the population's underlying risk factors, including severity of illness and socioeconomic factors that may influence the cost of health care for the population.

(5) "Green Mountain Care" means the public–private universal health care program designed to provide health benefits through a simplified, uniform, single administrative system pursuant to 33 V.S.A. chapter 18,

subchapter 2.

(6) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or otherwise authorized by Vermont law to provide professional health services.

(7) "Health care system" means the local, state, regional, or national system of delivering health services, including administrative costs, capital expenditures, preventive care and wellness services.

(8) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of a health benefit plan offered by a public or a private entity. The term does not include Medicaid, the Vermont health access plan, or any other state health care assistance program financed in whole or in part through a federal program.

(9) "Health service" means any treatment or procedure delivered by a health care professional to maintain an individual's physical or mental health or to diagnose or treat an individual's physical or mental health condition, including services ordered by a health care professional, chronic care management, preventive care, wellness services, and medically necessary services to assist in activities of daily living.

(10) "Integrated delivery system" means a group of health care professionals, associated either through employment by a single entity or through a contractual arrangement, that provides health services for a defined population of patients and is compensated through a global payment.

(11) "Manufacturers of prescribed products" shall have the same meaning as "manufacturers" in section 4631a of this title.

(12) "Payment reform" means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

(13) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically

apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

(14) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

§ 9374. BOARD MEMBERSHIP; AUTHORITY

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair and all of the members shall be state employees and shall be exempt from the state classified system. The chair shall receive compensation equal to that of a superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the chair.

(2) The chair and the members of the board shall be nominated by the Green Mountain Care board nominating committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a superior judge. The governor shall not appoint a nominee who was denied confirmation by the senate within the past six years.

(b)(1) The initial term of the chair shall be seven years, and the term of the chair shall be six years thereafter.

(2) The term of each member other than the chair shall be six years, except that of the members first appointed, one each shall serve a term of three years, four years, five years, and six years.

(3) Subject to the nomination and appointment process, a member may serve more than one term.

(4) Members of the board may be removed only for cause. The board shall adopt rules pursuant to 3 V.S.A. chapter 25 to define the basis and process for removal.

(c)(1) No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.

(2) No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member,

individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.

(3) The prohibitions contained in subdivisions (1) and (2) of this subsection shall not be construed to prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

(A) being an insurance policyholder or from receiving health services on the same terms as are available to the public generally;

(B) owning a stock, bond, or other security in an entity subject to supervision or regulation by the board that is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the board member chooses the stock, bond, or security; or

(C) receiving retirement benefits through a defined benefit plan from an entity subject to supervision or regulation by the board.

(4) No board member shall, during his or her term or terms on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board.

(5) No board member may appear before the board or any other state agency on behalf of a person subject to supervision or regulation by the board for a period of one year following his or her last day as a member of the Green Mountain Care board.

(d) The chair shall have general charge of the offices and employees of the board but may hire a director to oversee the administration and operation.

(e)(1) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. Members of such advisory group who are not state employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

(f) In carrying out its duties pursuant to this chapter, the board shall seek the advice of the state health care ombudsman established in 8 V.S.A. § 4089w. The state health care ombudsman shall advise the board regarding the policies, procedures, and rules established pursuant to this chapter. The ombudsman shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the board in order to protect patients' and consumers' interests.

§ 9375. DUTIES

(a) The board shall execute its duties consistent with the principles expressed in 18 V.S.A. § 9371.

(b) The board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in chapter 13, subchapter 2 of this title are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the board's proposed methodologies to the house committee on health care and the senate committee on health and welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of state government to engage in additional cost-containment activities to the extent permitted by state and federal law.

(2) Review and approve Vermont's statewide health information technology plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the state to achieve the principles expressed in section 9371 of this title.

(3) Review and approve the health care workforce development strategic plan created in chapter 222 of this title.

(4) Review the health resource allocation plan created in chapter 221 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business days of receipt of such recommendations and taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board, on:

(A) any insurance rate increases pursuant to 8 V.S.A. chapter 107, beginning January 1, 2012;

(B) hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012; and

(C) certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning July 1, 2012.

(7) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

(8) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

(C) in consultation with the department of health and the director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(D) for cost-containment and limiting the growth in health care expenditures;

(E) for determining the adequacy of the supply and distribution of health care resources in this state;

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the board.

(c) The board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the agency of human services~~,~~ and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the agency of human services shall present a report on the benefit package proposal to the house committee on health care and the senate committee on health and welfare. The report shall describe the covered services to be included in the Green Mountain Care benefit package and any cost-sharing requirements. If the general assembly is not in session at the time that the agency makes its recommendations, the agency shall send its report electronically or by first class mail to each member of the house committee on health care and the senate committee on health and welfare.

(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

(d) Annually on or before January 15, the board shall submit a report of its activities for the preceding state fiscal year to the house committee on health care and the senate committee on health and welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the

work of the board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the board comports with the principles expressed in section 9371 of this title.

(e) All reports prepared by the board shall be available to the public and shall be posted on the board's website.

§ 9376. PAYMENT AMOUNTS; METHODS

(a) It is the intent of the general assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent basis, effective and efficient health services that are in the public interest. It is also the intent of the general assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

(b)(1) The board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the state, and the need for health care professionals in particular areas of the state, particularly in underserved geographic or practice shortage areas.

(2) Nothing in this subsection shall be construed to limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection from a patient without health insurance or other coverage for the service or services received.

(c) The board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the board determines such payments to be appropriate.

(d) To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.

§ 9377. PAYMENT REFORM; PILOTS

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for payment and delivery system reform, including setting the overall policy goals for the pilot projects established in chapter 13, subchapter 2 of this title.

(2) The director of payment reform in the department of Vermont health access shall develop and implement the payment reform pilot projects in accordance with policies established by the board, and the board shall evaluate the effectiveness of such pilot projects in order to inform the payment and delivery system reform.

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

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

(B) health care 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 and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(C) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient

consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(E) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(4) In addition to the objectives identified in subdivision (a)(3) of this section, the design and implementation of payment reform pilot projects may consider:

(A) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(B) with input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(c) To the extent required to avoid federal antitrust violations, the board 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 board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

(d) The board or designee shall apply for grant funding, if available, for the evaluation of the pilot projects described in this section.

§ 9378. PUBLIC PROCESS

The Green Mountain Care board shall provide a process for soliciting public input. The process may include receiving written comments on proposed new or amended rules or holding public hearings or both.

§ 9379. AGENCY COOPERATION

The secretary of administration shall ensure that, in accordance with state and federal privacy laws, the Green Mountain Care board has access to data and analysis held by any executive branch agency which is necessary to carry out the board's duties as described in this chapter.

§ 9380. RULES

The board may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the provisions of this chapter.

§ 9381. APPEALS

(a) The Green Mountain Care board shall adopt procedures for administrative appeals of its actions, orders, or other determinations. Such procedures shall provide for the issuance of a final order and the creation of a record sufficient to serve as the basis for judicial review pursuant to subsection (b) of this section.

(b) Any person aggrieved by a final action, order, or other determination of the Green Mountain Care board may, upon exhaustion of all administrative appeals available pursuant to subsection (a) of this section, appeal to the supreme court pursuant to the Vermont Rules of Appellate Procedure.

Subchapter 2. Green Mountain Care Board Nominating Committee

§ 9390. GREEN MOUNTAIN CARE BOARD NOMINATING COMMITTEE CREATED; COMPOSITION

(a) A Green Mountain Care board nominating committee is created for the nomination of the chair and members of the Green Mountain Care board.

(b)(1) The committee shall consist of nine members who shall be selected as follows:

(A) Two members appointed by the governor.

(B) Two members of the senate, who shall not be members of the same party, to be appointed by the committee on committees.

(C) Two members of the house of representatives, who shall not be members of the same party, to be appointed by the speaker of the house of representatives.

(D) One member each to be appointed by the governor, the president pro tempore of the senate, and the speaker of the house, with knowledge of or expertise in health care policy, health care delivery, or health care financing, to complement that of the remaining members of the committee.

(2) The members of the committee shall serve for terms of two years and may serve for no more than three consecutive terms. All appointments

shall be made between January 1 and February 1 of each odd-numbered year, except to fill a vacancy. Members shall serve until their successors are appointed.

(3) The members shall elect their own chair who shall serve for a term of two years.

(c) For committee meetings held when the general assembly is not in session, the legislative members of the Green Mountain Care board nominating committee shall be entitled to per diem compensation and reimbursement of expenses in accordance with the provisions of 2 V.S.A. § 406. Committee members who are not legislators shall be entitled to per diem compensation and reimbursement of expenses on the same basis as that applicable to the legislative members, and their compensation and reimbursements shall be paid out of the budget of the Green Mountain Care board.

(d) The Green Mountain Care board nominating committee shall use the qualifications described in section 9392 of this title for the nomination of candidates for the chair and members of the Green Mountain Care board. The nominating committee shall adopt procedures for a nomination process based on the rules adopted by the judicial nominating board, and shall make such procedures available to the public.

(e) A quorum of the committee shall consist of five members.

(f) The board is authorized to use the staff and services of appropriate state agencies and departments as necessary to conduct investigations of applicants.

§ 9391. NOMINATION AND APPOINTMENT PROCESS

(a) Whenever a vacancy occurs on the Green Mountain Care board, or when an incumbent does not declare that he or she will be a candidate to succeed himself or herself, the Green Mountain Care board nominating committee shall select for consideration by the committee, by majority vote, provided that a quorum is present, from the applications for membership on the Green Mountain Care board as many candidates as it deems qualified for the position or positions to be filled. The committee shall base its determinations on the qualifications set forth in section 9392 of this section.

(b) The committee shall submit to the governor the names of the persons it deems qualified to be appointed to fill the position or positions.

(c) The governor shall make an appointment to the Green Mountain Care board from the list of qualified candidates submitted pursuant to subsection (b) of this section. The appointment shall be subject to the consent of the senate.

(d) All proceedings of the committee, including the names of candidates considered by the committee and information about any candidate submitted

by any source, shall be confidential.

§ 9392. QUALIFICATIONS FOR NOMINEES

The Green Mountain Care board nominating committee shall assess candidates using the following criteria:

(1) commitment to the principles expressed in section 9371 of this title.

(2) knowledge of or expertise in health care policy, health care delivery, or health care financing, and openness to alternative approaches to health care.

(3) possession of desirable personal characteristics, including integrity, impartiality, health, empathy, experience, diligence, neutrality, administrative and communication skills, social consciousness, public service, and regard for the public good.

(4) knowledge, expertise, and characteristics that complement those of the remaining members of the board.

(5) impartiality and the ability to remain free from undue influence by a personal, business, or professional relationship with any person subject to supervision or regulation by the board.

Sec. 3a. 8 V.S.A. § 4089w(b) is amended to read:

(b) The health care ombudsman office shall:

* * *

(5) Analyze and monitor the development and implementation of federal, state and local laws, regulations, and policies relating to patients and health insurance consumers, including the activities and policies of the Green Mountain Care board established in 18 V.S.A. chapter 220, and recommend changes it deems necessary.

* * *

Sec. 3b. GREEN MOUNTAIN CARE BOARD AND EXCHANGE POSITIONS

(a) On July 1, 2011, five exempt positions are created on the Green Mountain Care board, including:

(1) one chair, Green Mountain Care board; and

(2) four members, Green Mountain Care board.

(b)(1) On or before January 1, 2012, up to nine positions and appropriate amounts for personal services and operating expenses shall be transferred from the department of banking, insurance, securities, and health care administration

to the Green Mountain Care board.

(2) One exempt attorney position shall be transferred from the administrative division in the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

(c) On July 1, 2011, one classified administrative assistant position is created for the Green Mountain Care board.

(d) On or after November 1, 2011, one exempt deputy commissioner position is created in the department of Vermont health access to support the functions provided for in Sec. 4 of this act establishing 33 V.S.A. chapter 18, subchapter 1. The salary and benefits for this position shall be funded from federal funds provided to establish the Vermont health benefit exchange.

(e) On July 1, 2011, one exempt position, director of health care reform, is created in the agency of administration.

* * *

Sec. 3c. 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 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) "Board" means the Green Mountain Care board established in chapter 220 of this title.

(3) "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)~~(4) "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)~~(5) "Chronic care management" means a system of coordinated health care interventions and communications for individuals with chronic conditions, including significant patient self-care efforts, systemic supports for licensed health care practitioners and their patients, and a plan of care emphasizing prevention of complications utilizing evidence-based practice guidelines, patient empowerment strategies, and evaluation of clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health.

(6) "Global payment" means a payment from a health insurer, Medicaid, Medicare, or other payer for the health services of a defined population of patients for a defined period of time. Such payments may be adjusted to account for the population's underlying risk factors, including severity of illness and socioeconomic factors that may influence the cost of health care for the population.

~~(5)~~(7) "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)~~(8) "Health benefit plan" shall have the same meaning as in 8 V.S.A. § 4088h.

~~(7)~~(9) "Health insurer" shall have the same meaning as in section 9402 of this title.

(10) "Health service" means any treatment or procedure delivered by a health care professional to maintain an individual's physical or mental health or to diagnose or treat an individual's physical or mental health condition, including services ordered by a health care professional, chronic care management, preventive care, wellness services, and medically necessary services to assist in activities of daily living.

~~(8)~~(11) "Hospital" shall have the same meaning as in section 9456 of this title.

(12) "Integrated delivery system" means a group of health care professionals, associated either through employment by a single entity or through a contractual arrangement, that provides health services for a defined population of patients and is compensated through a global payment.

(13) "Payment reform" means modifying the method of payment from a fee for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created

pursuant to section 9409 of this title, integrated delivery systems and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies, for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

(14) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

(15) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

Subchapter 1. Blueprint for Health

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

* * *

Subchapter 2. Payment Reform

§ 721. PURPOSE

It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

§ 722. PILOT PROJECTS

(a) The Green Mountain Care board shall be responsible for payment reform and delivery system reform, including setting the overall policy goals for the pilot projects as provided in this subchapter. The director of payment reform in the department of Vermont health access shall develop and implement the payment reform pilot projects consistent with policies established by the board and the board shall evaluate the effectiveness of the pilot projects in order to inform the payment and delivery system reform. Whenever health insurers are involved, the director and the Green Mountain

Care board shall collaborate with the commissioner of banking, insurance, securities, and health care administration.

(b) The director of payment reform shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments to advise the director in developing and implementing the pilot projects and the Green Mountain Care board in setting overall policy goals.

(c) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:

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

(2) health care 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 and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(3) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(4) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(5) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(d) In addition to the objectives identified in subsection (c) of this section, the design and implementation of payment reform pilot projects may consider:

(1) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(2) with input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(e) The first pilot project shall become operational no later than January 1, 2012, and two or more additional pilot projects shall become operational no later than July 1, 2012.

(f) The Green Mountain Care board shall ensure that payment reform pilot projects are consistent with the board's overall efforts to control the rate of growth in health care costs while maintaining or improving health care quality.

§ 723. HEALTH INSURER PARTICIPATION

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

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of banking, insurance, securities, and health care administration. Health insurers shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(b) 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.

§ 724. ANTITRUST PROTECTION

To the extent required to avoid federal antitrust violations, the director 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 director shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal

antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the director determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

§ 725. ADMINISTRATION; RULES

(a) The director of payment reform shall apply for grant funding, if available, for the design and implementation evaluation of the pilot projects described in this section.

(b) The agency of human services may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the provisions of this chapter.

(c) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.

Sec. 3d. 18 V.S.A. § 4631a is amended to read:

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(5) "Gift" means:

(A) Anything of value provided for free to a health care provider ~~for free~~ or to a member of the Green Mountain Care board established in chapter 220 of this title; or

(B) 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 or to a member of the Green Mountain Care board established in chapter 220 of this title, unless:

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

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

* * *

(b)(1) It is unlawful for any manufacturer of a prescribed product or any wholesale distributor of medical devices, or any agent thereof, to offer or give

any gift to a health care provider or to a member of the Green Mountain Care board established in chapter 220 of this title.

* * *

Sec. 3e. 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 or to a member of the Green Mountain Care board established in chapter 220 of this title, 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;

(iv) 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.

* * *

(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~~ present

information in aggregate form; ~~and~~ by selected types of health care providers or individual health care providers, as prioritized each year by the office; and showing the amounts expended on the Green Mountain Care board established in chapter 220 of this title.

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

(6) After issuance of the report required by subdivision (5) of this 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.

* * *

* * * Public–Private Universal Health Care System * * *

Sec. 4. 33 V.S.A. chapter 18 is added to read

CHAPTER 18. PUBLIC–PRIVATE UNIVERSAL HEALTH CARE SYSTEM

Subchapter 1. Vermont Health Benefit Exchange

§ 1801. PURPOSE

(a) It is the intent of the general assembly to establish a Vermont health benefit exchange which meets the policy established in 18 V.S.A. § 9401 and, to the extent allowable under federal law or a waiver of federal law, becomes the mechanism to create Green Mountain Care.

(b) The purpose of the Vermont health benefit exchange is to facilitate the purchase of affordable, qualified health benefit plans in the individual and group markets in this state in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to contain costs; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

(c) Nothing in this chapter shall be construed to reduce, diminish, or otherwise infringe upon the benefits provided to eligible individuals under Medicare.

§ 1802. DEFINITIONS

For purposes of this subchapter:

(1) "Affordable Care Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health

Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended.

(2) "Commissioner" means the commissioner of the department of Vermont health access.

(3) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health services. This term does not include coverage only for accident or disability income insurance, liability insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, or other similar insurance coverage where benefits for health services are secondary or incidental to other insurance benefits as provided under the Affordable Care Act. The term also does not include stand-alone dental or vision benefits; long-term care insurance; specific disease or other limited benefit coverage, Medicare supplemental health benefits, Medicare Advantage plans, and other similar benefits excluded under the Affordable Care Act.

(4) "Health insurer" shall have the same meaning as in 18 V.S.A. § 9402.

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

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

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

(6) "Qualified entity" means an entity with experience in individual and group health insurance, benefit administration, or other experience relevant to health benefit program eligibility, enrollment, or support.

(7) "Qualified health benefit plan" means a health benefit plan which meets the requirements set forth in section 1806 of this title.

(8) "Qualified individual" means an individual, including a minor, who is a Vermont resident and, at the time of enrollment:

(A) is not incarcerated, or is only incarcerated awaiting disposition of charges; and

(B) is, or is reasonably expected to be during the time of enrollment, a citizen or national of the United States or an immigrant lawfully present in

the United States as defined by federal law.

§ 1803. VERMONT HEALTH BENEFIT EXCHANGE

(a)(1) The department of Vermont health access shall establish the Vermont health benefit exchange, which shall be administered by the department in consultation with the advisory committee established in section 402 of this title.

(2) The Vermont health benefit exchange shall be considered a division within the department of Vermont health access and shall be headed by a deputy commissioner as provided in 3 V.S.A. chapter 53.

(b)(1)(A) The Vermont health benefit exchange shall provide qualified individuals and qualified employers with qualified health benefit plans, including the multistate plans required by the Affordable Care Act, with effective dates beginning on or before January 1, 2014. The Vermont health benefit exchange may contract with qualified entities or enter into intergovernmental agreements to facilitate the functions provided by the Vermont health benefit exchange.

(B) Prior to contracting with any health insurer, the Vermont health benefit exchange shall consider the insurer's historic rate increase information required under section 1806 of this title, along with the information and the recommendations provided to the Vermont health benefit exchange by the commissioner of banking, insurance, securities, and health care administration under Section 2794(b)(1)(B) of the federal Public Health Service Act.

(2) To the extent allowable under federal law, the Vermont health benefit exchange may offer health benefits to populations in addition to those eligible under Subtitle D of Title I of the Affordable Care Act, including:

(A) to individuals and employers who are not qualified individuals or qualified employers as defined by this subchapter and by the Affordable Care Act;

(B) Medicaid benefits to individuals who are eligible, upon approval by the Centers for Medicare and Medicaid Services and provided that including these individuals in the health benefit exchange would not reduce their Medicaid benefits;

(C) Medicare benefits to individuals who are eligible, upon approval by the Centers for Medicare and Medicaid Services and provided that including these individuals in the health benefit exchange would not reduce their Medicare benefits; and

(D) state employees and municipal employees, including teachers.

(3) To the extent allowable under federal law, the Vermont health benefit exchange may offer health benefits to employees for injuries arising out of or in the course of employment in lieu of medical benefits provided pursuant to 21 V.S.A. chapter 9 (workers' compensation).

(c)(1) The Vermont health benefit exchange may determine an appropriate method to provide a unified, simplified administration system for health insurers offering qualified health benefit plans. The exchange may include claims administration, benefit management, billing, or other components in the unified system and may achieve simplification by contracting with a single entity for administration and management of all qualified health benefit plans, by licensing or requiring the use of particular software, by requiring health insurers to conform to a standard set of systems and rules, or by another method determined by the commissioner.

(2) The Vermont health benefit exchange may offer certain services, such as wellness programs and services designed to simplify administrative processes, to health insurers offering plans outside the exchange, to workers' compensation insurers, to employers, and to other entities.

(d) The Vermont health benefit exchange may enter into information-sharing agreements with federal and state agencies and other state exchanges to carry out its responsibilities under this subchapter provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and provided such agreements comply with all applicable state and federal laws and regulations.

§ 1804. QUALIFIED EMPLOYERS

[Reserved.]

§ 1805. DUTIES AND RESPONSIBILITIES

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

(1) Offering coverage for health services through qualified health benefit plans, including by creating a process for:

(A) the certification, decertification, and recertification of qualified health benefit plans as described in section 1806 of this title;

(B) enrolling qualified individuals in qualified health benefit plans, including through open enrollment periods as provided in the Affordable Care Act, and ensuring that individuals may transfer coverage between qualified health benefit plans and other sources of coverage as seamlessly as possible;

(C) collecting premium payments made for qualified health benefit

plans from employers and individuals on a pretax basis, including collecting premium payments from multiple employers of one individual for a single plan covering that individual; and

(D) creating a simplified and uniform system for the administration of health benefits.

(2) Determining eligibility for and enrolling individuals in Medicaid, Dr. Dynasaur, VPharm, and VermontRx pursuant to chapter 19 of this title, as well as any other public health benefit program.

(3) Creating and maintaining consumer assistance tools, including a website through which enrollees and prospective enrollees of qualified health benefit plans may obtain standardized comparative information on such plans, a toll-free telephone hotline to respond to requests for assistance, and interactive online communication tools, in a manner that complies with the Americans with Disabilities Act.

(4) Creating standardized forms and formats for presenting health benefit options in the Vermont health benefit exchange, including the use of the uniform outline of coverage established under Section 2715 of the federal Public Health Services Act.

(5) Assigning a quality and wellness rating to each qualified health benefit plan offered through the Vermont health benefit exchange and determining each qualified health benefit plan's level of coverage in accordance with regulations issued by the U.S. Department of Health and Human Services.

(6) Determining enrollee premiums and subsidies as required by the secretary of the U.S. Treasury or of the U.S. Department of Health and Human Services and informing consumers of eligibility for premiums and subsidies, including by providing an electronic calculator to determine the actual cost of coverage after application of any premium tax credit under Section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under Section 1402 of the Affordable Care Act.

(7) Transferring to the secretary of the U.S. Department of the Treasury the name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under Section 36B of the Internal Revenue Code of 1986 for the following reasons:

(A) The employer did not provide minimum essential coverage; or

(B) The employer provided the minimum essential coverage, but it was determined under Section 36B(c)(2)(C) of the Internal Revenue Code to

be either unaffordable to the employee or not to provide the required minimum actuarial value.

(8) Performing duties required by the secretary of the U.S. Department of Health and Human Services or the secretary of the U.S. Department of the Treasury related to determining eligibility for the individual responsibility requirement exemptions, including:

(A) Granting a certification attesting that an individual is exempt from the individual responsibility requirement or from the penalty for violating that requirement, if there is no affordable qualified health benefit plan available through the Vermont health benefit exchange or the individual's employer for that individual or if the individual meets the requirements for any exemption from the individual responsibility requirement or from the penalty pursuant to Section 5000A of the Internal Revenue Code of 1986; and

(B) transferring to the secretary of the U.S. Department of the Treasury a list of the individuals who are issued a certification under subdivision (8)(A) of this section, including the name and taxpayer identification number of each individual.

(9)(A) Transferring to the secretary of the U.S. Department of the Treasury the name and taxpayer identification number of each individual who notifies the Vermont health benefit exchange that he or she has changed employers and of each individual who ceases coverage under a qualified health benefit plan during a plan year and the effective date of that cessation; and

(B) Communicating to each employer the name of each of its employees and the effective date of the cessation reported to the U.S. Department of the Treasury under this subdivision.

(10) Establishing a navigator program as described in section 1807 of this title.

(11) Reviewing the rate of premium growth within and outside the Vermont health benefit exchange.

(12) Consistent with federal law, crediting the amount of any free choice voucher provided pursuant to Section 10108 of the Affordable Care Act to the monthly premium of the plan in which a qualified employee is enrolled and collecting the amount credited from the offering employer.

(13) Providing consumers and health care professionals with satisfaction surveys and other mechanisms for evaluating the performance of qualified health benefit plans and informing the commissioner of Vermont health access and the commissioner of banking, insurance, securities, and health care administration of such performance.

(14) Ensuring consumers have easy and simple access to the relevant grievance and appeals processes pursuant to 8 V.S.A. chapter 107 and 3 V.S.A. § 3090 (human services board).

(15) Consulting with the advisory committee established in section 402 of this title to obtain information and advice as necessary to fulfill the duties outlined in this subchapter.

(16) Referring consumers to the office of health care ombudsman for assistance with grievances, appeals, and other issues involving the Vermont health benefit exchange.

§ 1806. QUALIFIED HEALTH BENEFIT PLANS

(a) Prior to contracting with a health insurer to offer a qualified health benefit plan, the commissioner shall determine that making the plan available through the Vermont health benefit exchange is in the best interest of individuals and qualified employers in this state. In determining the best interest, the commissioner shall consider affordability; promotion of high-quality care, prevention, and wellness; promotion of access to health care; participation in the state's health care reform efforts; and such other criteria as the commissioner, in his or her discretion, deems appropriate.

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

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

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

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

(3) For qualified health benefit plans offered to employers, a deductible which meets the limitations provided in Section 1302 of the Affordable Care Act and any more restrictive deductible requirements specified by the secretary of human services by rule after consultation with the advisory committee established in section 402 of this title and after approval from the Green Mountain Care board established in 18 V.S.A. chapter 220.

(c) A qualified health benefit plan shall meet the following minimum prevention, quality, and wellness requirements:

(1) standards for marketing practices, network adequacy, essential community providers in underserved areas, appropriate services to enable access for underserved individuals or populations, accreditation, quality improvement, and information on quality measures for health benefit plan performance, as provided in Section 1311 of the Affordable Care Act and any more restrictive requirements provided by 8 V.S.A. chapter 107;

(2) quality and wellness standards, including a requirement for joint quality improvement activities with other plans, as specified in rule by the secretary of human services, after consultation with the commissioners of health and of banking, insurance, securities, and health care administration and with the advisory committee established in section 402 of this title; and

(3) standards for participation in the Blueprint for Health as provided in 18 V.S.A. chapter 13.

(d) A health insurer offering a qualified health benefit plan shall use the uniform enrollment forms and descriptions of coverage provided by the commissioner of Vermont health access and the commissioner of banking, insurance, securities, and health care administration.

(e)(1) A health insurer offering a qualified health benefit plan shall comply with the following insurance and consumer information requirements:

(A)(i) Obtain premium approval through the rate review process provided in 8 V.S.A. chapter 107; and

(ii) Submit to the commissioner of banking, insurance, securities, and health care administration a justification for any premium increase before implementation of that increase and prominently post this information on the health insurer's website.

(B) Offer at least one qualified health benefit plan at the silver level and at least one qualified health benefit plan at the gold level that meet the requirements of Section 1302 of the Affordable Care Act and any additional requirements specified by the secretary of human services by rule. In addition, a health insurer may choose to offer one or more qualified health benefit plans

at the platinum level that meet the requirements of Section 1302 of the Affordable Care Act and any additional requirements specified by the secretary of human services by rule.

(C) Charge the same premium rate for a health benefit plan without regard to whether the plan is offered through the Vermont health benefit exchange and without regard to whether the plan is offered directly from the carrier or through an insurance agent.

(D) Provide accurate and timely disclosure of information to the public and to the Vermont health benefit exchange relating to claims denials, enrollment data, rating practices, out-of-network coverage, enrollee and participant rights provided by Title I of the Affordable Care Act, and other information as required by the commissioner of Vermont health access or by the commissioner of banking, insurance, securities, and health care administration. The commissioner of banking, insurance, securities, and health care administration shall define, by rule, the acceptable time frame for provision of information in accordance with this subdivision.

(E) Provide information in a timely manner to an individual, upon request, regarding the cost-sharing amounts for that individual's health benefit plan.

(2) A health insurer offering a qualified health benefit plan shall comply with all other insurance requirements for health insurers as provided in 8 V.S.A. chapter 107 and as specified by rule by the commissioner of banking, insurance, securities, and health care administration.

(f) Consistent with Section 1311(e)(1)(B) of the Affordable Care Act, the Vermont health benefit exchange shall not exclude a health benefit plan:

(1) on the basis that the plan is a fee-for-service plan;

(2) through the imposition of premium price controls by the Vermont health benefit exchange; or

(3) on the basis that the health benefit plan provides for treatments necessary to prevent patients' deaths in circumstances the Vermont health benefit exchange determines are inappropriate or too costly.

§ 1807. NAVIGATORS

(a)(1) The Vermont health benefit exchange shall establish a navigator program to assist individuals and employers in enrolling in a qualified health benefit plan offered under the Vermont health benefit exchange. The Vermont health benefit exchange shall select individuals and entities qualified to serve as navigators and shall award grants to navigators for the performance of their duties.

(2) The Vermont health benefit exchange shall ensure that navigators are available to provide assistance in person or through interactive technology to individuals in all regions of the state in a manner that complies with the Americans with Disabilities Act.

(3) Consistent with Section 1311(i)(4) of the Affordable Care Act, health insurers shall not serve as navigators, and no navigator shall receive any compensation from a health insurer in connection with enrolling individuals or employees in qualified health benefit plans.

(b) Navigators shall have the following duties:

(1) Conduct public education activities to raise awareness of the availability of qualified health benefit plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health benefit plans and concerning the availability of premium tax credits and cost-sharing reductions;

(3) Facilitate enrollment in qualified health benefit plans, Medicaid, Dr. Dynasaur, VPharm, VermontRx, and other public health benefit programs;

(4) Provide referrals to the office of health care ombudsman and any other appropriate agency for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage;

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Vermont health benefit exchange; and

(6) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, VermontRx, other public health benefit programs, or the Vermont health benefit exchange in order to ensure that all eligible individuals are enrolled.

§ 1808. FINANCIAL INTEGRITY

(a) The Vermont health benefit exchange shall:

(1) Keep an accurate accounting of all activities, receipts, and expenditures and submit this information annually as required by federal law;

(2) Cooperate with the secretary of the U.S. Department of Health and Human Services or the inspector general of the U.S. Department of Health and Human Services in any investigation into the affairs of the Vermont health benefit exchange, any examination of the properties and records of the Vermont health benefit exchange, or any requirement for periodic reports in

relation to the activities undertaken by the Vermont health benefit exchange.

(b) In carrying out its activities under this subchapter, the Vermont health benefit exchange shall not use any funds intended for the administrative and operational expenses of the Vermont health benefit exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory modifications.

§ 1809. PUBLICATION OF COSTS AND SATISFACTION SURVEYS

(a) The Vermont health benefit exchange shall publish the average costs of licensing, regulatory fees, and any other payments required by the exchange, as well as the administrative costs of the exchange on a website intended to educate consumers about such costs. This information shall include information on monies lost to waste, fraud, and abuse.

(b) The Vermont health benefit exchange shall publish the deidentified results of the satisfaction surveys and other evaluation mechanisms required pursuant to subdivision 1805(13) of this title on a website intended to enable consumers to compare the qualified health benefit plans offered through the exchange.

§ 1810. RULES

The secretary of human services may adopt rules pursuant to 3 V.S.A. chapter 25 as needed to carry out the duties and functions established in this subchapter.

Subchapter 2. Green Mountain Care

§ 1821. PURPOSE

The purpose of Green Mountain Care is to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless and equitable manner regardless of income, assets, health status, or availability of other health coverage. Green Mountain Care shall contain costs by:

(1) providing incentives to residents to avoid preventable health conditions, promote health, and avoid unnecessary emergency room visits;

(2) establishing innovative payment mechanisms to health care professionals, such as global payments;

(3) encouraging the management of health services through the Blueprint for Health; and

(4) reducing unnecessary administrative expenditures.

§ 1822. IMPLEMENTATION; WAIVER

(a) Green Mountain Care shall be implemented 90 days following the last to occur of:

(1) Receipt of a waiver under Section 1332 of the Affordable Care Act pursuant to subsection (c) of this section.

(2) Enactment of a law establishing the financing for Green Mountain Care.

(3) Approval by the Green Mountain Care board of the initial Green Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

(4) Enactment of the appropriations for the initial Green Mountain Care benefit package proposed by the Green Mountain Care board pursuant to 18 V.S.A. § 9375.

(5) A determination by the Green Mountain Care Board that each of the following conditions will be met:

(A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.

(C) The financing for Green Mountain Care is sustainable.

(D) Administrative expenses will be reduced.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.

(F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

(b) As soon as allowed under federal law, the secretary of administration shall seek a waiver to allow the state to suspend operation of the Vermont health benefit exchange and to enable Vermont to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing subsidies, and small business tax credits provided in the Affordable Care Act. The secretary may seek a waiver from other provisions of the Affordable Care Act as necessary to ensure the operation of Green Mountain Care.

§ 1823. DEFINITIONS

For purposes of this subchapter:

(1) "Agency" means the agency of human services.

(2) "Board" means the Green Mountain Care board established in

18 V.S.A. chapter 220.

(3) "CHIP funds" means federal funds available under Title XXI of the Social Security Act.

(4) "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, and hyperlipidemia.

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

(6) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or otherwise authorized by Vermont law to provide professional health services.

(7) "Health service" means any treatment or procedure delivered by a health care professional to maintain an individual's physical or mental health or to diagnose or treat an individual's physical or mental health condition, including services ordered by a health care professional, chronic care management, preventive care, wellness services, and medically necessary services to assist in activities of daily living.

(8) "Hospital" shall have the same meaning as in 18 V.S.A. § 1902 and may include hospitals located outside the state.

(9) "Preventive care" means health services provided by health care professionals to identify and treat asymptomatic individuals who have risk factors or preclinical disease, but in whom the disease is not clinically apparent, including immunizations and screening, counseling, treatment, and medication determined by scientific evidence to be effective in preventing or detecting a condition.

(10) "Primary care" means health services provided by health care

professionals specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and shall include family planning, prenatal care, and mental health and substance abuse treatment.

(11) "Secretary" means the secretary of human services.

(12) "Vermont resident" means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent. An individual shall not be considered to be a Vermont resident if he or she is 18 years of age or older and is claimed as a dependent on the tax return of a resident of another state.

(13) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

§ 1824. ELIGIBILITY

(a)(1) Upon implementation, all Vermont residents shall be eligible for Green Mountain Care, regardless of whether an employer offers health insurance for which they are eligible. The agency shall establish standards by rule for proof and verification of residency.

(2)(A) Except as otherwise provided in subdivision (C) of this subdivision (2), if an individual is determined to be eligible for Green Mountain Care based on information later found to be false, the agency shall make reasonable efforts to recover from the individual the amounts expended for his or her care. In addition, if the individual knowingly provided the false information, he or she shall be assessed an administrative penalty of not more than $5,000.00.

(B) The agency shall include information on the Green Mountain Care application to provide notice to applicants of the penalty for knowingly providing false information as established in subdivision (2)(A) of this subsection.

(C) An individual determined to be eligible for Green Mountain Care whose health services are paid in whole or in part by Medicaid funds who commits fraud shall be subject to the provisions of chapter 1, subchapter V of this title in lieu of the administrative penalty described in subdivision (A) of this subdivision (2).

(D) Nothing in this section shall be construed to limit or restrict prosecutions under any applicable provision of law.

(3)(A) Except as otherwise provided in this section, a person who is not a Vermont resident shall not be eligible for Green Mountain Care.

(B) Except as otherwise provided in subdivision (C) of this subdivision (3), an individual covered under Green Mountain Care shall inform the agency within 60 days of becoming a resident of another state. An individual who obtains or attempts to obtain health services through Green Mountain Care more than 60 days after becoming a resident of another state shall reimburse the agency for the amounts expended for his or her care and shall be assessed an administrative penalty of not more than $1,000.00 for a first violation and not more than $2,000.00 for any subsequent violation.

(C) An individual whose health services are paid in whole or in part by Medicaid funds who obtains or attempts to obtain health services through Green Mountain Care more than 60 days after becoming a resident of another state shall be subject to the provisions of chapter 1, subchapter V of this title in lieu of the administrative penalty described in subdivision (B) of this subdivision (3).

(D) Nothing in this section shall be construed to limit or restrict prosecutions under any applicable provision of law.

(b) The agency shall establish a procedure to enroll residents in Green Mountain Care.

(c)(1) The agency shall establish by rule a process to allow health care professionals to presume an individual is eligible based on the information provided on a simplified application.

(2) After submission of the application, the agency shall collect additional information as necessary to determine whether Medicaid, Medicare, CHIP, or other federal funds may be applied toward the cost of the health services provided, but shall provide payment for any health services received by the individual from the time the application is submitted.

(3) If an individual presumed eligible for Green Mountain Care pursuant to subdivision (1) of this subsection is later determined not to be eligible for the program, the agency shall make reasonable efforts to recover from the individual the amounts expended for his or her care.

(d) The agency shall adopt rules pursuant to 3 V.S.A. chapter 25 to ensure that Vermont residents who are temporarily out of the state and who intend to return and reside in Vermont remain eligible for Green Mountain Care while outside Vermont.

(e) A nonresident visiting Vermont, or his or her insurer, shall be billed for all services received. The agency may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors and shall adopt rules pursuant to 3 V.S.A.

chapter 25 to carry out the purposes of this subsection.

§ 1825. HEALTH BENEFITS

(a)(1) Green Mountain Care shall include primary care, preventive care, chronic care, acute episodic care, and hospital services and shall include at least the same covered services as those included in the benefit package in effect for the lowest cost Catamount Health plan offered on January 1, 2011.

(2) It is the intent of the general assembly that Green Mountain Care provide a level of coverage that includes benefits that are actuarially equivalent to at least 87 percent of the full actuarial value of the covered health services.

(3) The Green Mountain Care board shall consider whether to impose cost-sharing requirements; if so, whether to make the cost-sharing requirements income-sensitized; and the impact of any cost-sharing requirements on an individual's ability to access care. The board shall consider waiving any cost-sharing requirement for evidence-based primary and preventive care; for palliative care; and for chronic care for individuals participating in chronic care management and, where circumstances warrant, for individuals with chronic conditions who are not participating in a chronic care management program.

(4)(A) The Green Mountain Care board established in 18 V.S.A. chapter 220 shall consider whether to include dental, vision, and hearing benefits in the Green Mountain Care benefit package.

(B) The Green Mountain Care board shall consider whether to include long-term care benefits in the Green Mountain Care benefit package.

(5) Green Mountain Care shall not limit coverage of preexisting conditions.

(6) The Green Mountain Care board shall approve the benefit package and present it to the general assembly as part of its recommendations for the Green Mountain Care budget.

(b)(1)(A) For individuals eligible for Medicaid or CHIP, the benefit package shall include the benefits required by federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

(B) Upon implementation of Green Mountain Care, the benefit package for individuals eligible for Medicaid or CHIP shall also include any optional Medicaid benefits pursuant to 42 U.S.C. § 1396d or services covered under the state plan for CHIP as provided in 42 U.S.C. § 1397cc for which these individuals are eligible on January 1, 2014. Beginning with the second year of Green Mountain Care and going forward, the Green Mountain

Care board may, consistent with federal law, modify these optional benefits, as long as at all times the benefit package for these individuals contains at least the benefits described in subdivision (A) of this subdivision (b)(1).

(2) For children eligible for benefits paid for with Medicaid funds, the benefit package shall include early and periodic screening, diagnosis, and treatment services as defined under federal law.

(3) For individuals eligible for Medicare, the benefit package shall include the benefits provided to these individuals under federal law, as well as any additional benefits provided as part of the Green Mountain Care benefit package.

§ 1826. BLUEPRINT FOR HEALTH

(a) It is the intent of the general assembly that within five years following the implementation of Green Mountain Care, each individual enrolled in Green Mountain Care will have a primary health care professional who is involved with the Blueprint for Health established in 18 V.S.A. chapter 13.

(b) Consistent with the provisions of 18 V.S.A. chapter 13, if an individual enrolled in Green Mountain Care does not have a medical home through the Blueprint for Health, the individual may choose a primary health care professional who is not participating in the Blueprint to serve as the individual's primary care point of contact.

(c) The agency shall determine a method to approve a specialist as a patient's primary health care professional for the purposes of establishing a medical home or primary care point of contact for the patient. The agency shall approve a specialist as a patient's medical home or primary care point of contact on a case-by-case basis and only for a patient who receives the majority of his or her health care from that specialist.

(d) Green Mountain Care shall be integrated with the Blueprint for Health established in 18 V.S.A. chapter 13.

§ 1827. ADMINISTRATION; ENROLLMENT

(a)(1) The agency shall, under an open bidding process, solicit bids from and award contracts to public or private entities for administration of certain elements of Green Mountain Care, such as claims administration and provider relations.

(2) The agency shall ensure that entities awarded contracts pursuant to this subsection do not have a financial incentive to restrict individuals' access to health services. The agency may establish performance measures that provide incentives for contractors to provide timely, accurate, transparent, and courteous services to individuals enrolled in Green Mountain Care and to

health care professionals.

(3) When considering contract bids pursuant to this subsection, the agency shall consider the interests of the state relating to the economy, the location of the entity, and the need to maintain and create jobs in Vermont. The agency may utilize an econometric model to evaluate the net costs of each contract bid.

(b) Nothing in this subchapter shall require an individual with health coverage other than Green Mountain Care to terminate that coverage.

(c) An individual enrolled in Green Mountain Care may elect to maintain supplemental health insurance if the individual so chooses.

(d) Except for cost-sharing, Vermonters shall not be billed any additional amount for health services covered by Green Mountain Care.

(e) The agency shall seek permission from the Centers for Medicare and Medicaid Services to be the administrator for the Medicare program in Vermont. If the agency is unsuccessful in obtaining such permission, Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XVIII of the Social Security Act (Medicare).

(f) Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by any other health benefit plan, including private health insurance, retiree health benefits, or federal health benefit plans offered by the Veterans' Administration, by the military, or to federal employees.

(g) The agency may seek a waiver under Section 1115 of the Social Security Act to include Medicaid and under Section 2107(e)(2)(A) of the Social Security Act to include SCHIP in Green Mountain Care. If the agency is unsuccessful in obtaining one or both of these waivers, Green Mountain Care shall be the secondary payer with respect to any health service that may be covered in whole or in part by Title XIX of the Social Security Act (Medicaid) or Title XXI of the Social Security Act (CHIP), as applicable.

(h) Any prescription drug coverage offered by Green Mountain Care shall be consistent with the standards and procedures applicable to the pharmacy best practices and cost control program established in sections 1996 and 1998 of this title.

(i) Green Mountain Care shall maintain a robust and adequate network of health care professionals located in Vermont or regularly serving Vermont residents, including mental health and substance abuse professionals. The agency shall contract with outside entities as needed to allow for the

appropriate portability of coverage under Green Mountain Care for Vermont residents who are temporarily out of the state.

(j) The agency shall make available the necessary information, forms, access to eligibility or enrollment systems, and billing procedures to health care professionals to ensure immediate enrollment for individuals in Green Mountain Care at the point of service or treatment.

(k) An individual aggrieved by an adverse decision of the agency or plan administrator may appeal to the human services board as provided in 3 V.S.A. § 3090.

(l) The agency, in collaboration with the department of banking, insurance, securities, and health care administration, shall monitor the extent to which residents of other states move to Vermont for the purpose of receiving health services and the impact, positive or negative, of any such migration on Vermont's health care system and on the state's economy, and make appropriate recommendations to the general assembly based on its findings.

§ 1828. BUDGET PROPOSAL

The Green Mountain Care board, in collaboration with the agencies of administration and of human services, shall be responsible for developing each year a three-year Green Mountain Care budget for proposal to the general assembly and to the governor, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

§ 1829. GREEN MOUNTAIN CARE FUND

(a) The Green Mountain Care fund is established in the state treasury as a special fund to be the single source to finance health care coverage for Green Mountain Care.

(b) Into the fund shall be deposited:

(1) transfers or appropriations from the general fund, authorized by the general assembly;

(2) if authorized by a waiver from federal law, federal funds for Medicaid, Medicare, and the Vermont health benefit exchange established in chapter 18, subchapter 1 of this title; and

(3) the proceeds from grants, donations, contributions, taxes, and any other sources of revenue as may be provided by statute or by rule.

(c) The fund shall be administered pursuant to 32 V.S.A. chapter 7, subchapter 5, except that interest earned on the fund and any remaining

balance shall be retained in the fund. The agency shall maintain records indicating the amount of money in the fund at any time.

(d) All monies received by or generated to the fund shall be used only for:

(1) the administration and delivery of health services covered by Green Mountain Care as provided in this subchapter; and

(2) expenses related to the duties and operation of the Green Mountain Care board pursuant to 18 V.S.A. chapter 220.

§ 1830. COLLECTIVE BARGAINING RIGHTS

Nothing in this subchapter shall be construed to limit the ability of collective bargaining units to negotiate for coverage of health services pursuant to 3 V.S.A. § 904 or any other provision of law.

§ 1831. PUBLIC PROCESS

The agency of human services shall provide a process for soliciting public input on the Green Mountain Care benefit package on an ongoing basis, including a mechanism by which members of the public may request inclusion of particular benefits or services. The process may include receiving written comments on proposed new or amended rules or holding public hearings or both.

§ 1832. RULEMAKING

The secretary of human services may adopt rules pursuant to 3 V.S.A. chapter 25 to carry out the purposes of this subchapter. When establishing rules relating to the Green Mountain Care benefit package, the secretary shall ensure that the rules are consistent with the benefit package defined by the Green Mountain Care board pursuant to section 1825 of this title and to 18 V.S.A. chapter 220.

Sec. 4a. HOUSEHOLD HEALTH INSURANCE SURVEY

The department of banking, insurance, securities, and health care administration shall include questions on its household health insurance survey that enable the department to determine the extent to which residents of other states move to Vermont for the purpose of receiving health services. The department shall provide its findings to the agency of human services to enable the agency to monitor migration into the state as required in 33 V.S.A. § 1827.

Sec. 4b. EXCHANGE IMPLEMENTATION

(a) The commissioner of Vermont health access shall make a reasonable effort to maintain contracts with at least two health insurers to provide qualified health benefit plans, in addition to the multistate plans required by the

Affordable Care Act, in the Vermont health benefit exchange in 2014 if at least two health insurers are interested in participating and meet the requirements of 33 V.S.A. § 1806; provided that the commissioner shall not be required to solicit participation by insurers outside the state in order to contract with two insurers.

(b) Nothing in this section shall be construed to require the commissioner to contract with a health insurer to provide a plan that does not meet the requirements specified in 33 V.S.A. chapter 18, subchapter 1.

Sec. 4c. HEALTH COVERAGE FINDINGS AND STUDY

(a) The general assembly finds that:

(1) Federal law requires certain health care providers to provide emergency treatment to all individuals, regardless of immigration status.

(2) Federal law prohibits coverage of undocumented immigrants through Medicaid and through the Vermont health benefit exchange. Federal funds would not be available to cover undocumented immigrants through Green Mountain Care.

(3) Federal law requires that employers provide health insurance coverage for certain immigrants working seasonally in Vermont. Dairy workers, however, are not included in this category because they are year-round workers.

(4) Some employers of undocumented immigrants pay employment taxes for these workers, and these workers do not derive health care benefits from the government.

(b) No later than January 15, 2013, the Green Mountain Care board shall examine and report to the general assembly on:

(1) The potential costs of services provided to undocumented immigrants by health care professionals if these immigrants are not covered through Green Mountain Care, including any increased costs of care delayed due to the lack of coverage for primary care; and

(2) The potential costs of providing coverage for health services to undocumented immigrants through Green Mountain Care, including any state funds necessary to fund the services.

(c) The secretary of administration or designee shall work with Vermont's congressional delegation to:

(1) provide a mechanism for legal status under federal immigration law for nonseasonal farm workers; and

(2) clarify any impacts of covering or not covering undocumented immigrants through Green Mountain Care on the receipt of a waiver under section 1332 of the Affordable Care Act.

Sec. 5. 33 V.S.A. § 401 is amended to read:

§ 401. COMPOSITION OF DEPARTMENT

The department of Vermont health access, created under 3 V.S.A. § 3088, shall consist of the commissioner of Vermont health access, the medical director, a health care eligibility unit; and all divisions within the department, including the divisions of managed care; health care reform; the Vermont health benefit exchange; and Medicaid policy, fiscal, and support services.

Sec. 6. TRANSFER OF POSITIONS; HEALTH CARE ELIGIBILITY UNIT

After March 15, 2012 but not later than July 1, 2013, the secretary of administration shall transfer to and place under the supervision of the commissioner of Vermont health access all employees, professional and support staff, consultants, positions, and all balances of all appropriation amounts for personal services and operating expenses for the administration of health care eligibility currently contained in the department for children and families. No later than January 15, 2012, the secretary shall provide to the house committees on health care and on human services and the senate committee on health and welfare a plan for transferring the positions and funds.

* * * Consumer and Health Care Professional Advisory Committee * * *

Sec. 7. 33 V.S.A. § 402 is added to read:

§ 402. MEDICAID AND EXCHANGE ADVISORY COMMITTEE

(a) A Medicaid and exchange advisory committee is created for the purpose of advising the commissioner of Vermont health access with respect to policy development and program administration for the Vermont health benefit exchange, Medicaid, and Medicaid-funded programs, consistent with the requirements of federal law.

(b)(1) The commissioner of Vermont health access shall appoint members of the advisory committee established by this section, who shall serve staggered three-year terms. The total membership of the advisory committee shall be 22 members. The commissioner may remove members of the committee who fail to attend three consecutive meetings and may appoint replacements. The commissioner may reappoint members to serve more than one term.

(2)(A) The commissioner of Vermont health access shall appoint one

representative of health insurers licensed to do business in Vermont to serve on the advisory committee. The commissioner of health shall also serve on the advisory committee.

(B) Of the remaining members of the advisory committee, one-quarter of the members shall be from each of the following constituencies:

(i) beneficiaries of Medicaid or Medicaid-funded programs.

(ii) individuals, self-employed individuals, and representatives of small businesses eligible for or enrolled in the Vermont health benefit exchange.

(iii) advocates for consumer organizations.

(iv) health care professionals and representatives from a broad range of health care professionals.

(3) Members whose participation is not supported through their employment or association shall receive per diem compensation pursuant to 32 V.S.A. § 1010 and reimbursement of travel expenses. In addition, members who are eligible for Medicaid or who are enrolled in a qualified health benefit plan in the Vermont health benefit exchange and whose income does not exceed 300 percent of the federal poverty level shall also receive reimbursement of expenses, including costs of child care, personal assistance services, and any other service necessary for participation in the advisory committee and approved by the commissioner.

(c)(1) The advisory committee shall have an opportunity to review and comment on agency policy initiatives pertaining to quality improvement initiatives and to health care benefits and eligibility for individuals receiving services through Medicaid, programs funded with Medicaid funds under a Section 1115 waiver, or the Vermont health benefit exchange. It also shall have the opportunity to comment on proposed rules prior to commencement of the rulemaking process pursuant to 3 V.S.A. chapter 25 and on waiver or waiver amendment applications prior to submission to the Centers for Medicare and Medicaid Services.

(2) Prior to the annual budget development process, the department of Vermont health access shall engage the advisory committee in setting priorities, including consideration of scope of benefits, beneficiary eligibility, health care professional reimbursement rates, funding outlook, financing options, and possible budget recommendations.

(d)(1) The advisory committee shall make policy recommendations on proposals of the department of Vermont health access to the department, the Green Mountain Care board, the health access oversight committee, the senate

committee on health and welfare, and the house committees on health care and on human services. When the general assembly is not in session, the commissioner shall respond in writing to these recommendations, a copy of which shall be provided to the members of each of the legislative committees of jurisdiction and to the Green Mountain Care board.

(2) During the legislative session, the commissioner shall provide the advisory committee at regularly scheduled meetings with updates on the status of policy and budget proposals.

(e) The commissioner shall convene the advisory committee at least 10 times during each calendar year. If at least one-third of the members of the advisory committee so choose, the members may convene up to four additional meetings per calendar year on their own initiative by sending a request to the commissioner. The department shall provide the committee with staffing and independent technical assistance as needed to enable it to make effective recommendations.

(f) A majority of the members of the committee shall constitute a quorum, and all action shall be taken upon a majority vote of the members present and voting.

Sec. 8. INTEGRATION PLAN

(a) No later than January 15, 2012, the secretary of administration or designee shall present a factual report and make recommendations to the house committee on health care and the senate committees on health and welfare and on finance on the following issues:

(1) How to fully integrate or align Medicaid, Medicare, private insurance, associations, state employees, and municipal employees into or with the Vermont health benefit exchange and Green Mountain Care established in 33 V.S.A. chapter 18, including:

(A) Whether it is advisable to establish a basic health program for individuals with incomes above 133 percent of the federal poverty level (FPL) and at or below 200 percent of FPL pursuant to Section 1331 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended ("Affordable Care Act"), to ensure that the health coverage is comprehensive and affordable for this population.

(B)(i) The statutory changes necessary to integrate the private insurance markets with the Vermont health benefit exchange, including whether to impose a moratorium on the issuance of new association policies prior to 2014, as well as whether to continue exemptions for associations

pursuant to 8 V.S.A. § 4080a(h)(3) after implementation of the Vermont health benefit exchange and if so, what criteria to use.

(ii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, and for employees, of defining a small employer for purposes of the Vermont health benefit exchange for the period from January 1, 2014 through December 31, 2015 as an employer with up to 50 employees or as an employer with up to 100 employees, including an analysis of the impacts of the definition on teachers, municipal employees, and associations. For purposes of the analysis pursuant to this subdivision, "employer" means all for-profit entities, nonprofit entities, public entities, and individuals who are self-employed.

(iii) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing qualified health benefit plans to be sold to individuals and small groups both inside and outside the Vermont health benefit exchange.

(iv) The advantages and disadvantages for the state, for the Vermont health benefit exchange, for employers, for employees, and for individuals of allowing nonqualified health benefit plans that comply with the provisions of the Affordable Care Act to be sold to individuals and small groups outside the exchange.

(C) In consultation with the Green Mountain Care board, the design of a common benefit package for the Vermont health benefit exchange. When creating the common benefit package, the secretary shall compare the essential benefits package defined under federal regulations implementing the Affordable Care Act with Vermont's insurance mandates, consider the affordability of cost-sharing both with and without the cost-sharing subsidy provided under federal regulations implementing the Affordable Care Act, and determine the feasibility and appropriate design of cost-sharing amounts for evidence-based health services with proven effectiveness.

(D) The impact of the availability of supplemental insurance plans on offerings in the small and individual group markets.

(E) The potential for purchasing prescription drugs in Green Mountain Care through Medicaid, the 340B drug pricing program, or another bulk purchasing mechanism.

(2) Once Green Mountain Care is implemented, whether to allow employers and individuals to purchase coverage for supplemental health services from Green Mountain Care or to allow private insurers to provide supplemental insurance plans.

(3) How to enable parents to make coverage under Green Mountain Care available to an adult child up to age 26 who would not otherwise be eligible for coverage under the program, including a recommendation on the amount of and mechanism for collecting a financial contribution for such coverage and information on the difference in costs to the system between allowing all adult children up to age 26 to be eligible and limiting eligibility to adult children attending a college or university.

(4) whether it is necessary or advisable to implement a financial reserve requirement or reinsurance mechanism to reduce the state's exposure to financial risk in the operation of Green Mountain Care; if so, how to accomplish such implementation; and the impact, if any, on the state's bond rating.

(5) How to fully align the administration of Medicaid, Medicare, Dr. Dynasaur, the Catamount Health premium assistance program, the Vermont health access program, and other public or private health benefit programs in order to simplify the administrative aspects of health care delivery. In his or her recommendations, the secretary or designee shall estimate the cost-savings associated with such administrative simplification and identify any federal waivers or other agreements needed to accomplish the purposes of this subdivision (5).

(b) The commissioner of labor, in consultation with the commissioner of Vermont health access, the commissioner of banking, insurance, securities, and health care administration, and interested stakeholders, shall evaluate the feasibility of integrating or aligning Vermont's workers' compensation system with Green Mountain Care, including providing any covered services in addition to those in the Green Mountain Care benefit package that may be appropriate for injuries arising out of and in the course of employment. No later than January 15, 2012, the commissioner of labor shall report the results of the evaluation and, if integration or alignment has been found to be feasible, make recommendations on how to achieve it.

(c) The commissioner of Vermont health access, in consultation with the commissioner of banking, insurance, securities, and health care administration; the commissioner of taxes; and the commissioner of motor vehicles shall review the requirements for maintaining minimum essential coverage under Section 1501 of the Affordable Care Act, including the enforcement mechanisms provided in that act. No later than January 15, 2012, the commissioner of Vermont health access shall recommend to the house committee on health care and the senate committees on finance and on health and welfare any additional enforcement mechanisms necessary to ensure that most, if not all, Vermonters will obtain sufficient health benefit coverage.

Sec. 9. FINANCING PLANS

(a) The secretary of administration or designee shall recommend two plans for sustainable financing to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance no later than January 15, 2013.

(1) One plan shall recommend the amounts and necessary mechanisms to finance any initiatives which must be implemented by January 1, 2014 in order to provide coverage to all Vermonters in the absence of a waiver from certain federal health care reform provisions established in Section 1332 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and as further amended ("Affordable Care Act").

(2) The second plan shall recommend the amounts and necessary mechanisms to finance Green Mountain Care and any systems improvements needed to achieve a public-private universal health care system. The secretary shall recommend whether nonresidents employed by Vermont businesses should be eligible for Green Mountain Care and solutions to other cross-border issues.

(b) In developing both financing plans, the secretary shall consider the following:

(1) all financing sources, including adjustments to the income tax, a payroll tax, consumption taxes, provider assessments required under 33 V.S.A. chapter 19, the employer assessment required by 21 V.S.A. chapter 25, other new or existing taxes, and additional options as determined by the secretary;

(2) the impacts of the various financing sources, including levels of deductibility of any tax or assessment system contemplated and consistency with the principles of equity expressed in 18 V.S.A. § 9371;

(3) issues involving federal law and taxation;

(4) impacts of tax system changes:

(A) on individuals, households, businesses, public sector entities, and the nonprofit community, including the circumstances under which a particular tax change may result in the potential for double payments, such as premiums and tax obligations;

(B) over time, on changing revenue needs; and

(C) for a transitional period, while the tax system and health care cost structure are changing;

(5) growth in health care spending relative to needs and capacity to pay;

(6) anticipated federal funds that may be used for health services and how to maximize the amount of federal funding available for this purpose;

(7) the amounts required to maintain existing state insurance benefit requirements and other appropriate considerations in order to determine the state contribution toward federal premium tax credits available in the Vermont health benefit exchange pursuant to the Affordable Care Act;

(8) additional funds needed to support recruitment and retention programs for high-quality health care professionals in order to address the shortage of primary care professionals and other specialty care professionals in this state;

(9) additional funds needed to provide coverage for the uninsured who are eligible for Medicaid, Dr. Dynasaur, and the Vermont health benefit exchange in 2014;

(10) funding mechanisms to ensure that operations of both the Vermont health benefit exchange and Green Mountain Care are self-sustaining;

(11) how to maximize the flow of federal funds to the state for individuals eligible for Medicare, such as enrolling eligible individuals in Medicare and paying or supplementing the cost-sharing requirements on their behalf;

(12) the use of financial or other incentives to encourage healthy lifestyles and patient self-management for individuals enrolled in Green Mountain Care;

(13) preserving retirement health benefits while enabling retirees to participate in Green Mountain Care;

(14) the implications of Green Mountain Care on funds set aside to pay for future retiree health benefits; and

(15) changes in federal health funding through reduced payments to health care professionals or through limitations or restrictions on the availability of grant funding or federal matching funds available to states through the Medicaid program.

(c) In developing the financing plan for Green Mountain Care, the secretary of administration or designee shall consult with interested stakeholders, including health care professionals, employers, and members of the public, to determine the potential impact of various financing sources on Vermont businesses and on the state's economy and economic climate. No later than February 1, 2012, the secretary or designee shall report his or her findings on the impact on businesses and the economy and any related recommendations to the house committees on health care and on commerce and to the senate

committees on health and welfare, on finance and on economic development, housing and general affairs.

(d) In addition to the consultation required by subsection (c) of this section, in developing the financing plan for Green Mountain Care, the secretary of administration or designee shall solicit input from interested stakeholders, including health care professionals, employers, and members of the public and shall provide opportunities for public engagement in the design of the financing plan.

(e) The secretary of administration or designee shall consider strategies to address individuals who receive health coverage through the Veterans Administration, TRICARE, the Federal Employees Health Benefits Program, the government of a foreign nation, or from another federal governmental or foreign source.

Sec. 10. HEALTH INFORMATION TECHNOLOGY PLAN

(a) The secretary of administration or designee, in consultation with the Green Mountain Care board and the commissioner of Vermont health access, shall review the health information technology plan required by 18 V.S.A. § 9351 to ensure that the plan reflects the creation of the Vermont health benefit exchange; the transition to a public-private universal health care system pursuant to 33 V.S.A. chapter 18, subchapter 2; and any necessary development or modifications to public health information technology and data and to public health surveillance systems, to ensure that there is progress toward full implementation.

(b) In conducting this review, the secretary of administration may issue a request for proposals for an independent design and implementation plan which would describe how to integrate existing health information systems to carry out the purposes of this act, detail how to develop the necessary capacity in health information systems, determine the funding needed for such development, and quantify the funding sources available for such development. The health information technology plan or design and implementation plan shall also include a review of the multi-payer database established in 18 V.S.A. § 9410 to determine whether there are systems modifications needed to use the database to reduce fraud, waste, and abuse; and shall include other systems analysis as specified by the secretary.

(c) The secretary shall make recommendations to the house committee on health care and the senate committee on health and welfare based on the design and implementation plan no later than January 15, 2012.

Sec. 11. HEALTH SYSTEM PLANNING, REGULATION, AND PUBLIC HEALTH

(a) No later than January 15, 2012, the secretary of administration or designee shall make recommendations to the house committee on health care and the senate committee on health and welfare on how to unify Vermont's current efforts around health system planning, regulation, and public health, including:

(1) How best to align the agency of human services' public health promotion activities with Medicaid, the Vermont health benefit exchange functions, Green Mountain Care, and activities of the Green Mountain Care board established in 18 V.S.A. chapter 220.

(2) After reviewing current resources, including the community health assessments, how to create an integrated system of community health assessments, health promotion, and planning, including by:

(A) improving the use and usefulness of the health resource allocation plan established in 18 V.S.A. § 9405 in order to ensure that health resource planning is effective and efficient; and

(B) recommending a plan to institute a public health impact assessment process to ensure appropriate consideration of the impacts on public health resulting from major policy or planning decisions made by municipalities, local entities, and state agencies.

(3) In collaboration with the director of the Blueprint for Health established in 18 V.S.A. chapter 13 and health care professionals, how to coordinate quality assurance efforts across state government and private payers; optimize quality assurance programs; and ensure that health care professionals in Vermont utilize, are informed of, and engage in evidence-based practice, using standards and algorithms such as those developed by the National Committee for Quality Assurance.

(4) How to reorganize and consolidate health care-related functions in agencies and departments across state government in order to ensure integrated and efficient administration of all of Vermont's health care programs and initiatives.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall review the hospital budget review process provided in 18 V.S.A. chapter 221, subchapter 7, and the certificate of need process provided in 18 V.S.A. chapter 221, subchapter 5 and recommend to the house committee on health care and the senate committee on health and welfare statutory modifications needed to enable the participation of the Green Mountain Care board as set forth in 18 V.S.A. § 9375.

Sec. 12. PAYMENT REFORM; REGULATORY PROCESSES

No later than March 15, 2012, the Green Mountain Care board established in 18 V.S.A. chapter 220, in consultation with the commissioner of banking, insurance, securities, and health care administration and the commissioner of Vermont health access, shall recommend to the house committee on health care and the senate committee on health and welfare any necessary modifications to the regulatory processes for health care professionals and managed care organizations in order to align these processes with the payment reform strategic plan.

Sec. 12a. 18 V.S.A. chapter 222 is added to read:

CHAPTER 222. ACCESS TO HEALTH CARE PROFESSIONALS

§ 9491. HEALTH CARE WORKFORCE; STRATEGIC PLAN

(a) The director of health care reform in the agency of administration shall oversee the development of a current health care workforce development strategic plan that continues efforts to ensure that Vermont has the health care workforce necessary to provide care to all Vermont residents. The director of health care reform may designate an entity responsible for convening meetings and for preparing the draft strategic plan. The Green Mountain Care board established in chapter 220 of this title shall review the draft strategic plan and shall approve the final plan and any subsequent modifications.

(b) The director or designee shall collaborate with the area health education centers, the workforce development council established in 10 V.S.A. § 541, the prekindergarten-16 council established in 16 V.S.A. § 2905, the department of labor, the department of health, the department of Vermont health access and other interested parties, to develop and maintain the plan. The director of health care reform shall ensure that the strategic plan includes recommendations on how to develop Vermont's health care workforce, including:

(1) the current capacity and capacity issues of the health care workforce and delivery system in Vermont, including the shortages of health care professionals, specialty practice areas that regularly face shortages of qualified health care professionals, issues with geographic access to services, and unmet health care needs of Vermonters.

(2) the resources needed to ensure that the health care workforce and the delivery system are able to provide sufficient access to services given demographic factors in the population and in the workforce as well as other factors, and able to participate fully in health care reform initiatives, including how to ensure that all Vermont residents have a medical home through the

Blueprint for Health pursuant to chapter 13 of this title and how to transition to electronic medical records; and

(3) how state government, universities and colleges, the state's educational system, entities providing education and training programs related to the health care workforce, and others may develop the resources in the health care workforce and delivery system to educate, recruit, and retain health care professionals to achieve Vermont's health care reform principles and purposes.

(4) review data on the extent to which individual health care professionals begin and cease to practice in their applicable fields in Vermont.

(5) identify factors which either hinder or assist in recruitment or retention of health care professionals, including an examination of the processes for prior authorizations, and make recommendations for further improving recruitment and retention efforts.

(6) assess the availability of state and federal funds for health care workforce development.

(c) Beginning January 15, 2013, the director or designee shall provide the strategic plan approved by the Green Mountain Care board to the general assembly and shall provide periodic updates on modifications as necessary.

Sec. 13. WORKFORCE ISSUES

(a)(1) Currently, Vermont has a shortage of primary care professionals, and many practices are closed to new patients. It also experiences periodic and geographic shortages of specialty care professionals necessary to ensure that Vermonters have reasonable access to a broad range of health services within the state. In order to ensure sufficient patient access now and in the future, it is necessary to plan for the implementation of Green Mountain Care and utilize Vermont's health care professionals to the fullest extent of their professional competence.

(2) The board of nursing, the board of medical practice, and the office of professional regulation shall collaborate to determine how to optimize the primary care workforce by reviewing the licensure process, scope of practice requirements, reciprocity of licensure, and efficiency of the licensing process, and by identifying any other barriers to augmenting Vermont's primary care workforce. No later than January 15, 2012, the boards and office shall provide to the house committee on health care and the senate committee on health and welfare joint recommendations for improving the primary care workforce through the boards' and office's rules and procedures, including specific recommendations to modify scopes of practice to enable health care

professionals to perform to the fullest extent of their professional competence.

(b) The director of health care reform or designee, in collaboration with the department of labor, and the agency of human services, the prekindergarten-16 council established in 16 V.S.A. § 2905, the workforce development council, and other interested parties, shall create a plan to address the retraining needs of employees who may become dislocated due to a reduction in health care administrative functions when the Vermont health benefit exchange and Green Mountain Care are implemented. The plan shall include consideration of new training programs and scholarships or other financial assistance necessary to ensure adequate resources for training programs and to ensure that employees have access to these programs. The department and agency shall provide information to employers whose workforce may be reduced in order to ensure that the employees are informed of available training opportunities. The department shall provide the plan to the house committee on health care and the senate committee on health and welfare no later than January 15, 2012.

Sec. 13a. PRIOR AUTHORIZATIONS

The Green Mountain Care board shall consider:

(1) compensating health care providers for the completion of requests for prior authorization; and

(2) exempting from prior authorization requirements for specific services in Green Mountain Care those health care professionals whose prior authorization requests are routinely granted for those services.

* * * Cost Estimates * * *

Sec. 14. COST ESTIMATES; MEETINGS

(a) No later than April 21, 2011, the legislative joint fiscal office and the department of banking, insurance, securities, and health care administration shall provide to the house committee on health care and the senate committee on health and welfare an initial, draft estimate of the costs of Vermont's current health care system compared to the costs of a reformed health care system upon implementation of Green Mountain Care and the additional provisions of this act. To the extent possible, the estimates shall be based on the department of banking, insurance, securities, and health care administration's expenditure report and additional data available in the multi-payer database established in 18 V.S.A. § 9410.

(b) The legislative joint fiscal office and the department of banking, insurance, securities, and health care administration shall report their final estimates of the costs described in subsection (a) of this section to the committees of jurisdiction no later than November 1, 2011.

(c) The house committee on health care and the senate committee on health and welfare may meet while the legislature is not in session to receive updates on reports and work in progress related to the provisions of this act. To the extent practicable, such meetings shall coincide with scheduled meetings of the joint fiscal committee.

* * * Rate Review * * *

Sec. 15. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this state nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until a copy of the form, premium rates, and rules for the classification of risks pertaining thereto have been filed with the commissioner of banking, insurance, securities, and health care administration; nor shall any such form, premium rate, or rule be so used until the expiration of 30 days after having been filed, or in the case of a request for a rate increase, until a decision by the Green Mountain Care board as provided herein, unless the commissioner shall sooner give his or her written approval thereto. Prior to approving a rate increase, the commissioner shall seek approval for such rate increase from the Green Mountain Care board established in 18 V.S.A. chapter 220, which shall approve or disapprove the rate increase within 10 business days. The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board.

(2) The commissioner shall review policies and rates to determine whether a policy or rate is affordable, promotes quality care, promotes access to health care, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this state. The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which ~~is unjust, unfair, inequitable, misleading, or contrary to the law of this state~~ does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer. ~~In all other cases, the commissioner shall give his or her approval.~~

(3) After the expiration of ~~such 30 days from the filing of any such form, premium rate or rule,~~ the review period provided herein or at any time after having given written approval, the commissioner may, after a hearing of which at least 20 ~~days~~ days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. Such disapproval shall be effected by written order of

the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.

(b) In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file a summary applicable to the cumulative rate increase. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human Services (HHS) requires for rate increases over 10 percent, and any other information required by the commissioner. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection (c) of this section. In addition, the insurer shall post the summaries on its website.

(c)(1) The commissioner shall provide information to the public on the department's website about the public availability of the filings and summaries required under this section.

(2) Beginning no later than January 1, 2012, the commissioner shall post the filings pursuant to subsection (a) of this section and summaries pursuant to subsection (b) of this section on the department's website within five days of filing. The department shall provide an electronic mechanism for the public to comment on proposed rate increases over five percent. The public shall have 21 days from the posting of the summaries and filings to provide public comment. The department shall review and consider the public comments prior to the expiration of the review period pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for their consideration in approving any rate increases.

(d)(1) The following provisions of this section shall not apply to policies for specific disease, accident, injury, hospital indemnity, dental care, disability income, or other limited benefit coverage, but shall apply to long-term care policies:

(A) the requirement in subdivision (a)(1) for the Green Mountain Care board's approval for any rate increase;

(B) the review standards in subdivision (a)(2) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and

(C) subsections (b) and (c) of this section.

(2) The exemptions from the provisions described in subdivisions (1)(A) through (C) of this subsection shall also apply to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred.

Sec. 15a. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the commissioner, a hospital service corporation may establish, maintain and operate a medical service plan as defined in section 4583 of this title. The commissioner may refuse approval if the commissioner finds that the rates submitted are excessive, inadequate, or unfairly discriminatory or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 15b. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the commissioner for his or her approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the commissioner of a nonrefundable fee of $50.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15c. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the commissioner of banking, insurance, securities, and health care administration under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by such commissioner. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate

therefor shall be accompanied by payment to the commissioner of a nonrefundable fee of $50.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 15d. 8 V.S.A. § 5104(a) is amended to read:

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The commissioner may request and shall receive any information that is needed to determine whether to approve the policy form or rate. In addition to any other information requested, the commissioner shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including but not limited to Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section 4062 of this title.

(2) The commissioner shall refuse to approve the form of evidence of coverage, filing or rate if it contains any provision which is unjust, unfair, inequitable, misleading or contrary to the law of the state or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

* * * Health Benefit Information * * *

Sec. 16. 21 V.S.A. § 2004 is added to read:

§ 2004. HEALTH BENEFIT COSTS

(a) Employers shall provide their employees with an annual statement indicating:

(1) the total monthly premium cost paid for any employer-sponsored health benefit plan;

(2) the employer's share and the employee's share of the total monthly premium; and

(3) any amount the employer contributes toward the employee's cost-sharing requirement or other out-of-pocket expenses.

(b) Notwithstanding the provisions of subsection (a) of this section, an employer who reports the cost of coverage under an employer-sponsored health benefit plan as required by 26 U.S.C. § 6051(a)(14) shall be deemed to be in full compliance with the requirements of this section.

Sec. 16a. 33 V.S.A. § 1901(g) is added to read:

(g) The department of Vermont health access shall post prominently on its website the total per-member per-month cost for each of its Medicaid and Medicaid waiver programs and the amount of the state's share and the beneficiary's share of such cost.

* * * Consumer Protection * * *

Sec. 17. REVIEW OF BAN ON DISCRETIONARY CLAUSES

(a) It is the intent of the general assembly to determine the advantages and disadvantages of enacting a National Association of Insurance Commissioners (NAIC) model act prohibiting insurers from using discretionary clauses in their health benefit contracts. The purpose of the NAIC model act is to prohibit insurance clauses that purport to reserve discretion to the insurer to interpret the terms of the policy, or to provide standards of interpretation or review that are inconsistent with the laws of this state.

(b) No later than January 15, 2012, the commissioner of banking, insurance, securities, and health care administration shall provide a report to the house committee on health care and the senate committee on health and welfare on the advantages and disadvantages of Vermont adopting the NAIC model act.

* * * Single Formulary * * *

Sec. 18. SINGLE FORMULARY RECOMMENDATIONS

No later than January 15, 2012, the department of Vermont health access, after consultation with health insurers, third-party administrators, and the drug utilization and review board, shall provide recommendations to the house committee on health care and the senate committee on health and welfare regarding:

(1) A single prescription drug formulary to be used by all payers of health services which allows for some variations for Medicaid due to the availability of rebates and discounts and which allows health care professionals prescribing drugs purchased pursuant to Section 340B of the Public Health Service Act to use the 340B formulary. The recommendations shall address the feasibility of requesting a waiver from Medicare Part D in order to ensure Medicare participation in the formulary, as well as the feasibility of enabling all prescription drugs purchased by or on behalf of Vermont residents to be

purchased through the Medicaid program or pursuant to the 340B drug pricing program.

(2) A single mechanism for negotiating rebates and discounts across payers using a single formulary, and the advantages and disadvantages of using a single formulary to achieve uniformity of coverage.

(3) A uniform set of drug management rules aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management. The standards for pharmacy benefit management shall address timely decisions, access to clinical peers, access to evidence-based rationales, exemption processes, and tracking and reporting data on prescriber satisfaction.

* * * Repeal of Public Oversight Commission * * *

Sec. 19. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

(15) ~~"Public oversight commission" means the commission established in section 9407 of this title.~~

~~(16)~~ "Unified health care budget" means the budget established in accordance with section 9406 of this title.

~~(17)~~(16) "State health plan" means the plan developed under section 9405 of this title.

Sec. 20. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION PLAN

* * *

(b) On or before July 1, 2005, the commissioner, in consultation with the secretary of human services, shall submit to the governor a four-year health resource allocation plan. The plan shall identify Vermont needs in health care services, programs, and facilities; the resources available to meet those needs; and the priorities for addressing those needs on a statewide basis.

* * *

(2) In the preparation of the plan, the commissioner shall assemble an advisory committee of no fewer than nine nor more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care

system, including health care professionals, payers, third-party payers, and consumer representatives~~, and up to three members of the public oversight commission~~. The advisory committee shall review drafts and provide recommendations to the commissioner during the development of the plan. Upon adoption of the plan, the advisory committee shall be dissolved.

(3) The commissioner, with the advisory committee, shall conduct at least five public hearings, in different regions of the state, on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the commissioner shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the commissioner shall publish in the manner prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place and period during which to direct written comments to the commissioner. In addition, the commissioner may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(4) The commissioner shall develop a mechanism for receiving ongoing public comment regarding the plan and for revising it every four years or as needed. ~~The public oversight commission shall recommend revisions to the plan at least every four years and at any other time it determines revisions are warranted.~~

* * *

Sec. 21. 18 V.S.A. § 9405a is amended to read:

§ 9405a. PUBLIC PARTICIPATION AND STRATEGIC PLANNING

Each hospital shall have a protocol for meaningful public participation in its strategic planning process for identifying and addressing health care needs that the hospital provides or could provide in its service area. Needs identified through the process shall be integrated with the hospital's long-term planning ~~and shall be described as a component of its four-year capital expenditure projections provided to the public oversight commission under subdivision 9407(b)(2) of this title~~. The process shall be updated as necessary to continue to be consistent with such planning and capital expenditure projections, and identified needs shall be summarized in the hospital's community report.

Sec. 22. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The commissioner, in consultation with representatives from ~~the public oversight commission,~~ hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules

establishing a standard format for community reports, as well as the contents, which shall include:

* * *

(c) The community reports shall be provided to the ~~public oversight commission and the~~ commissioner. The commissioner shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators.

Sec. 23. 18 V.S.A. § 9433(c) is amended to read:

(c) The commissioner shall consult with hospitals, nursing homes and professional associations and societies, ~~the public oversight commission,~~ the secretary of human services, and other interested parties in matters of policy affecting the administration of this subchapter.

Sec. 24. 18 V.S.A. § 9440 is amended to read:

§ 9440. PROCEDURES

* * *

(c) The application process shall be as follows:

* * *

(4) Within 90 days of receipt of an application, the commissioner shall notify the applicant that the application contains all necessary information required and is complete, or that the application review period is complete notwithstanding the absence of necessary information. The commissioner may extend the 90-day application review period for an additional 60 days, or for a period of time in excess of 150 days with the consent of the applicant. The time during which the applicant is responding to the commissioner's notice that additional information is required shall not be included within the maximum review period permitted under this subsection. The ~~public oversight commission may recommend, or the~~ commissioner may determine that the certificate of need application shall be denied if the applicant has failed to provide all necessary information required to review the application.

* * *

(d) The review process shall be as follows:

(1) The ~~public oversight commission~~ commissioner shall review:

(A) The application materials provided by the applicant.

(B) ~~The assessment of the applicant's materials provided by the~~

~~department.~~

~~(C)~~ Any information, evidence, or arguments raised by interested parties or amicus curiae, and any other public input.

(2) The ~~public oversight commission~~ department shall hold a public hearing during the course of a review.

(3) ~~The public oversight commission shall make a written findings and a recommendation to the commissioner in favor of or against each application. A record shall be maintained of all information reviewed in connection with each application.~~

~~(4) A review shall be completed and the~~ The commissioner shall make a final decision within 120 days after the date of notification under subdivision (c)(4) of this section. Whenever it is not practicable to complete a review within 120 days, the commissioner may extend the review period up to an additional 30 days. Any review period may be extended with the written consent of the applicant and all other applicants in the case of a review cycle process.

~~(5)~~(4) After reviewing each application ~~and after considering the recommendations of the public oversight commission~~, the commissioner shall make a decision either to issue or to deny the application for a certificate of need. The decision shall be in the form of an approval in whole or in part, or an approval subject to such conditions as the commissioner may impose in furtherance of the purposes of this subchapter, or a denial. In granting a partial approval or a conditional approval the commissioner shall not mandate a new health care project not proposed by the applicant or mandate the deletion of any existing service. Any partial approval or conditional approval must be directly within the scope of the project proposed by the applicant and the criteria used in reviewing the application.

~~(6)(A)~~(5) If the commissioner proposes to render a final decision denying an application in whole or in part, or approving a contested application, the commissioner shall serve the parties with notice of a proposed decision containing proposed findings of fact and conclusions of law, and shall provide the parties an opportunity to file exceptions and present briefs and oral argument to the commissioner. The commissioner may also permit the parties to present additional evidence.

~~(B) If the commissioner's proposed decision is contrary to the recommendation of the public oversight commission:~~

~~(i) the notice of proposed decision shall contain findings of fact and conclusions of law demonstrating that the commissioner fully considered~~

~~all the findings and conclusions of the public oversight commission and explaining why his or her proposed decision is contrary to the recommendation of the public oversight commission and necessary to further the policies and purposes of this subchapter; and~~

~~(ii) the commissioner shall permit the parties to present additional evidence.~~

~~(7)~~(6) Notice of the final decision shall be sent to the applicant, competing applicants, and interested parties. The final decision shall include written findings and conclusions stating the basis of the decision.

~~(8)~~(7) The commissioner shall establish rules governing the compilation of the record used by ~~the public oversight commission and~~ the commissioner in connection with decisions made on applications filed and certificates issued under this subchapter.

(e) The commissioner shall adopt rules governing procedures for the expeditious processing of applications for replacement, repair, rebuilding, or reequipping of any part of a health care facility or health maintenance organization destroyed or damaged as the result of fire, storm, flood, act of God, or civil disturbance, or any other circumstances beyond the control of the applicant where the commissioner finds that the circumstances require action in less time than normally required for review. If the nature of the emergency requires it, an application under this subsection may be reviewed by the commissioner only, without notice and opportunity for public hearing or intervention by any party.

(f) Any applicant, competing applicant, or interested party aggrieved by a final decision of the commissioner under this section may appeal the decision to the supreme court. ~~If the commissioner's decision is contrary to the recommendation of the public oversight commission, the standard of review on appeal shall require that the commissioner's decision be supported by a preponderance of the evidence in the record.~~

* * *

Sec. 25. 18 V.S.A. § 9440a is amended to read:

§ 9440a. APPLICATIONS, INFORMATION, AND TESTIMONY; OATH REQUIRED

(a) Each application filed under this subchapter, any written information required or permitted to be submitted in connection with an application or with the monitoring of an order, decision, or certificate issued by the commissioner, and any testimony taken before the ~~public oversight commission, the~~ commissioner~~,~~ or a hearing officer appointed by the commissioner shall be

submitted or taken under oath. The form and manner of the submission shall be prescribed by the commissioner. The authority granted to the commissioner under this section is in addition to any other authority granted to the commissioner under law.

(b) Each application shall be filed by the applicant's chief executive officer under oath, as provided by subsection (a) of this section. The commissioner may direct that information submitted with the application be submitted under oath by persons with personal knowledge of such information.

(c) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

Sec. 25a. 18 V.S.A. § 9456(h) is amended to read:

(h)(1) If a hospital violates a provision of this section, the commissioner may maintain an action in the superior court of the county in which the hospital is located to enjoin, restrain or prevent such violation.

* * *

(3)(A) The commissioner shall require the officers and directors of a hospital to file under oath, on a form and in a manner prescribed by the commissioner, any information designated by the commissioner and required pursuant to this subchapter. The authority granted to the commissioner under this subsection is in addition to any other authority granted to the commissioner under law.

(B) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the commissioner ~~or to the public oversight commission~~ or to a hearing officer appointed by the commissioner or who knowingly testifies falsely in any proceeding before the commissioner ~~or the public oversight commission~~ or a hearing officer appointed by the commissioner shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

* * * Conforming Revisions * * *

Sec. 26. 18 V.S.A. § 5 is amended to read:

§ 5. DUTIES OF DEPARTMENT OF HEALTH

The department of health ~~is hereby designated as the sole state agency for~~

~~the purposes of~~ shall:

(1) ~~Conducting~~ Conduct studies, ~~developing~~ develop state plans, and ~~administering~~ administer programs and state plans for hospital survey and construction, hospital operation and maintenance, medical care, and treatment of ~~alcoholics and alcoholic rehabilitation~~ substance abuse.

(2) ~~Providing~~ Provide methods of administration and such other action as may be necessary to comply with the requirements of federal acts and regulations as relate to studies, ~~developing~~ development of plans and ~~administering~~ administration of programs in the fields of health, public health, health education, hospital construction and maintenance, and medical care.

(3) ~~Appointing~~ Appoint advisory councils, with the approval of the governor.

(4) ~~Cooperating~~ Cooperate with necessary federal agencies in securing federal funds ~~now or~~ which ~~may hereafter~~ become available to the state for all prevention, public health, wellness, and medical programs.

(5) Seek accreditation through the Public Health Accreditation Board.

(6) Create a state health improvement plan and facilitate local health improvement plans in order to encourage the design of healthy communities and to promote policy initiatives that contribute to community, school, and workplace wellness, which may include providing assistance to employers for wellness program grants, encouraging employers to promote employee engagement in healthy behaviors, and encouraging the appropriate use of the health care system.

Sec. 27. 18 V.S.A. § 9410(a)(1) is amended to read:

(a)(1) The commissioner shall establish and maintain a unified health care data base to enable the commissioner and the Green Mountain Care board to carry out ~~the~~ their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) Determining the capacity and distribution of existing resources.

(B) Identifying health care needs and informing health care policy.

(C) Evaluating the effectiveness of intervention programs on improving patient outcomes.

(D) Comparing costs between various treatment settings and approaches.

(E) Providing information to consumers and purchasers of health care.

(F) Improving the quality and affordability of patient health care and health care coverage.

Sec. 28. Sec. 10 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

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

(a) From the effective date of this act through July 1, ~~2011~~ 2014, 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~~ 2014, 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.

Sec. 29. Sec. 31(d) of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

(d) Term of committee. The committee shall cease to exist on ~~January 31, 2011~~ June 30, 2011.

Sec. 30. Sec. 14 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 14. PAYMENT REFORM; PILOTS

* * *

(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) 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)~~(B) An ongoing program evaluation and improvement protocol.

~~(iii)~~(C) 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.~~

Sec. 31. GREEN MOUNTAIN CARE BOARD NOMINATIONS; APPOINTMENTS

(a) Notwithstanding the provisions of 18 V.S.A. § 9390(b)(2), no later than June 1, 2011, the governor, the speaker of the house of representatives, and the president pro tempore of the senate shall appoint the members of the Green Mountain Care board nominating committee. The members shall serve until their replacements are appointed pursuant to 18 V.S.A. § 9390 between January 1, 2013 and February 1, 2013.

(b) The governor shall appoint the members of the Green Mountain Care board pursuant to the process set forth in 18 V.S.A. chapter 220, subchapter 2, to begin employment no earlier than October 1, 2011. In making the initial appointments to the board, the governor shall ensure that the skills and qualifications of the board members complement those of the other members of the board.

Sec. 32. REPEAL

(a) 33 V.S.A. § 1901c (Medical care advisory board) is repealed effective July 1, 2012.

(b) 18 V.S.A. § 9407 (public oversight commission) is repealed effective July 1, 2011.

Sec. 33. APPROPRIATIONS

(a) In fiscal year 2012, the sum of $703,693.00 in general funds and $321,231.00 in federal funds is appropriated to the Green Mountain Care board to carry out its functions.

(b) In fiscal year 2012, the sum of $25,000.00 is appropriated from the general fund to the secretary of administration for the medical malpractice proposal pursuant to Sec. 2(e) of this act.

(c) In fiscal year 2012, the sum of $138,000.00 is appropriated from the general fund to the agency of administration for salary and benefits for the director of health care reform.

Sec. 33a. COMPENSATION

For fiscal year 2012, the salary for the chair of the Green Mountain Care

board shall be $116,688.00.

Sec. 34. EFFECTIVE DATES

(a) Secs. 1 (intent), 1a (principles), and 2 (strategic plan); 3 (18 V.S.A. chapter 220, subchapter 2 "Green Mountain Care board nominating committee"); 8 (integration plan), and 9 (financing plans); 10 (HIT); 11 (health planning); 12 (regulatory process); 13 (workforce); 14 (cost estimates); 17 (discretionary clauses); 18 (single formulary); 26 (department of health); 28 (ACA grants); 29 (primary care workforce committee); 30 (approval of pilot projects); and 31 (initial Green Mountain Care board nominating committee appointments) of this act and this section shall take effect on passage.

(b) Sec. 1b (agency of administration), and Secs. 3, 18 V.S.A. chapter 220, subchapter 1 (Green Mountain Care board), 3a (health care ombudsman), 3b (positions), 3c (payment reform), 3d and 3e (manufacturers of prescribed products), 4c (health care coverage study), 5 (DVHA), 6 (Health care eligibility), 12a (health care workforce strategic plan); 13a (prior authorizations), 19–25a and 32 (repeal of public oversight commission), 33 (appropriations), and 33a (compensation) shall take effect on July 1, 2011.

(c)(1) Secs. 4 (Vermont health benefit exchange; Green Mountain Care), 4a (household health insurance survey), and 4b (exchange implementation) shall take effect on July 1, 2011.

(2) The Vermont health benefit exchange shall begin enrolling individuals no later than November 1, 2013 and shall be fully operational no later than January 1, 2014.

(3) Green Mountain Care shall be implemented as set forth in 33 V.S.A. § 1822.

(d) Sec. 7, 3 V.S.A. § 402 (Medicaid and exchange advisory board), shall take effect on July 1, 2012.

(e) Secs. 15-15d (rate review) shall take effect on January 1, 2012 and shall apply to all filings on and after January 1, 2012.

(f) Sec. 27 (VHCURES) shall take effect on October 1, 2011.

(g) Secs. 16 (health benefit information) and 16a (Medicaid program costs) shall take effect on January 1, 2012, and the reporting requirement shall apply to each calendar year, beginning with 2012.

CLAIRE D. AYER
KEVIN J. MULLIN
SALLY G. FOX

Committee on the part of the Senate

MARK LARSON
MICHAEL FISHER
SARAH L. COPELAND-HANZAS
Committee on the part of the House

H. 443

An act relating to the state's transportation program

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:

H. 443 An act relating to the state's transportation program

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. TRANSPORTATION PROGRAM

(a) The state's proposed fiscal year 2012 transportation program appended to the agency of transportation's proposed fiscal year 2012 budget, as amended by this act, is adopted to the extent federal, state, and local funds are available.

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

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

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

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

(4) "TIB debt service fund" refers to the transportation infrastructure bonds debt service fund established in 32 V.S.A. § 951a; and

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

* * * Town Highway Bridge * * *

Sec. 2. TOWN HIGHWAY BRIDGE

The following modifications are made to the town highway bridge program:

(1) Development and engineering funding for the Fairfield BRO 1448(22) project in the amount of $16,000.00 in federal funds, $2,000.00 in transportation funds, and $2,000.00 in local funds is deleted.

(2) A new project is added for the reconstruction or replacement of bridge #48 on TH 30 over Wanzer Brook in the town of Fairfield. Development and evaluation spending in the amount of $16,000.00 in federal funds, $2,000.00 in transportation funds, and $2,000.00 in local funds is authorized for the project.

(3) Authorized spending on the Brattleboro-Hinsdale BRF 2000(19)SC project is amended to read:

FY12	As Proposed	As Amended	Change
PE	100,000	0	-100,000
ROW	75,000	0	-75,000
Construction	0	0	0
Total	175,000	0	-175,000
Sources of funds			
State	0	0	0
TIB fund	35,000	0	-35,000
Federal	140,000	0	-140,000
Local	0	0	0
Total	175,000	0	-175,000

(4) Authorized spending on the Stratton culvert TH3 0103 project is amended to read:

FY12	As Proposed	As Amended	Change
PE	40,000	40,000	0
ROW	0	0	0
Construction	0	0	0
Total	40,000	40,000	0
Sources of funds			
State	36,000	1,000	-35,000

TIB fund	0	35,000	35,000
Federal	0	0	0
Local	4,000	4,000	0
Total	40,000	40,000	0

* * * Park and Ride * * *

Sec. 3. PROGRAM DEVELOPMENT – PARK AND RIDE

Authorized spending on the municipal park and ride program within the program development — park and ride program is amended to read:

FY12	As Proposed	As Amended	Change
Construction	250,000	300,000	50,000
Total	250,000	300,000	50,000
Sources of funds			
State	250,000	300,000	50,000
Total	250,000	300,000	50,000

* * * Rail * * *

Sec. 4. RAIL

The following modifications are made to the rail program:

(1) A new project is added to upgrade the western rail corridor to the standards required to support 286,000 pound freight traffic and inter-city passenger rail service. The western rail corridor includes connections from points in New York to the corridor between Bennington, Rutland, Burlington, Essex Junction, and St. Albans to points in Canada.

(2) Authorized spending on the three-way partnership program is amended to read as follows.

FY12	As Proposed	As Amended	Change
PE	0	0	0
ROW	0	0	0
Construction	0	0	0
Other	600,000	555,000	-45,000
Total	600,000	555,000	-45,000
Sources of funds			

State	200,000	185,000	-15,000
Federal	0	0	0
Local	400,000	370,000	-30,000
Total	600,000	555,000	-45,000

Sec. 5. Sec. 18 of No. 164 of the Acts of 2007 Adj. Sess. (2008) is amended to read:

Sec. 18. RAIL

The following modifications are made to the rail program:

(1) Authorized spending on the three-way partnership program is amended to read as follows. ~~In future budget years, funding for the program shall be limited to the costs of specific projects.~~

* * *

* * * Vermont Local Roads * * *

Sec. 6. TOWN HIGHWAY VERMONT LOCAL ROADS

Authorized spending on the Vermont local roads program is amended to read:

FY12	As Proposed	As Amended	Change
Grants	375,000	390,000	15,000
Total	375,000	390,000	15,000
Sources of funds			
State	235,000	235,000	0
Federal	140,000	155,000	15,000
Total	375,000	390,000	15,000

* * * Bike and Pedestrian Facilities * * *

Sec. 7. PROGRAM DEVELOPMENT – BIKE AND PEDESTRIAN FACILITIES

The following modification is made to the program development – bike and pedestrian facilities program: Notwithstanding the authorized project or activity spending approved for the bike and pedestrian program, the secretary shall transfer $10,000.00 in transportation funds authorized for spending within the program to the Vermont Association of Snow Travelers (VAST) for expenditure on the Lamoille Valley Rail Trail project, STP LVRT(1). VAST may use these funds to satisfy a portion of the local match requirement for the

federal earmark for this project, and shall provide the agency an accounting of its use of the funds by June 30, 2012.

* * * Supplemental Paving Spending * * *

Sec. 7a. TRANSPORTATION – SUPPLEMENTAL PAVING SPENDING

(a) Notwithstanding 32 V.S.A. § 706 and the limits on program, project, or activity spending authority approved in the fiscal year 2011 and fiscal year 2012 transportation programs, the secretary, with the approval of the secretary of administration and subject to the provisions of subsection (b) of this section, may transfer up to $2,000,000.00 in transportation fund appropriations, other than appropriations for the town highway state aid, structures, and class 2 roadway programs, to program development (8100001100) – paving, for the specific purpose of improving the condition of selected state highways that have incurred the worst damage caused by the severe winter weather of 2010–2011.

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

(c) This section shall expire on September 30, 2011.

* * * Central Garage * * *

Sec. 8. TRANSFER TO CENTRAL GARAGE FUND

Notwithstanding 19 V.S.A. § 13(c), in fiscal year 2012, the amount of $1,120,000.00 is transferred from the transportation fund to the central garage fund created in 19 V.S.A. § 13.

* * * Cancellation of Projects * * *

Sec. 9. CANCELLATION OF PROJECTS

Pursuant to 19 V.S.A. § 10g(h) (legislative approval for cancellation of projects), the general assembly approves cancellation of the following projects:

(1) Program development — interstate bridges:

(A) Berlin-Montpelier IM 089-1(17) (rehabilitation of bridges

#36N&S, #37N&S, #38N&S, #39, #40N&S, and #41N&S on I-89);

(B) Bethel-Williamstown IR 089-1(12) (deck replacement and structural improvements to several bridges on I-89);

(C) Middlesex-Waterbury IR 089-2(16) (deck replacement and structural improvements to several bridges on I-89);

(D) Brattleboro IR 091-1(23) (at PE and/or ROW phase) (deck replacement on bridges #9N&S on I-91);

(E) Colchester-Highgate IM IR 089-3(18) (at PE and/or ROW phase) (deck replacement and substructure improvements to several bridges on I-89);

(F) Vernon-Putney IR 091-1(17) (at PE and/or ROW phase) (deck replacement and substructure improvements on several bridges along I-91);

(G) Guilford-Brattleboro IM 091-1(32) (proposed) (rehabilitation of bridges #2N&S, #4N&S, #5N&S, #7, #11N&S, and #12 on I-91);

(H) Hartford-Newbury IM 091-2(68) (proposed) (rehabilitation of bridges #45N&S, #46, #47N&S, #48N&S, #49N&S, and #51N&S on I-91);

(I) Hartford-Sharon-Royalton IR 089-1(10) (proposed) (deck replacement and structural improvements to several interstate bridges);

(J) Milton IM 089-3( ) (proposed) (rehabilitation of bridges #82, #84N&S, #85, #89, #90, #91, #92N&S, and #93 on I-89);

(K) Richmond IM 089-2(27) (proposed) (rehabilitation of bridges #52N&S, #53N&S, #54, #55N&S, #56N&S, and #57N&S on I-89);

(L) Rockingham-Weathersfield IR 091-1(24) (proposed) (replacement and substructure improvements to several bridges on I-91);

(M) Sharon-Royalton IR 089-1(9) (proposed) (deck replacement and substructure improvements to several bridges on I-89); and

(N) Windsor-Hartland IR 091-1(21) (proposed) (deck replacement and substructure improvements to several bridges on I-91).

(2) Program development — state highway bridges:

(A) Middlebury BHF 5900(4) (rehabilitation of bridge #2 on Merchants Row (TH 8) over Vermont Railway);

(B) Middlebury BHF 0161(9) (rehabilitation of bridge #102 on VT 30 over Vermont Railway);

(C) Plymouth BRS 0149(3)S (replacement of bridge #8 on VT 100A over Hollow Brook; at PE and/or ROW phase).

(3) Town highway bridges:

(A) Readsboro BRO 1441(28) (replacement of bridge #21 on TH 4 over the West Branch of the Deerfield River);

(B) Fairfield BRO 1448(22) (replacement of bridge #48 on TH 30 over Wanzer Brook; at PE and/or ROW phase);

(C) Northfield BRO 1446(25) (replacement of bridge #50 on TH 25 over Stoney Brook; at PE and/or ROW phase).

(4) Program development — roadway:

(A) Bennington M 1000(10) (VT 67A) (district has constructed some improvements to intersection);

(B) Bridgewater-Woodstock NH 020-2(33)S (US 4) (project scope defined before adoption of Vermont design standards in 1997);

(C) Cavendish STP 0146(9) SC (VT 131) (Cavendish selectboard supports cancellation of project but would like some signage improvements to enhance safety);

(D) Cavendish-Ludlow NH-F 025-1(30) (VT 103) (FHWA requested VTrans to close this project in 2007);

(E) Concord-Lunenburg STP 0218( ) SC (TH 4) (project set up for scoping in 1997 but no funds were ever programmed);

(F) Dorset-Wallingford NH 019-2(20) SC (US 7) (project set up for scoping only and scoping report was completed in 1997);

(G) Dover STP 013-1(12) SC (VT 100) (project set up for scoping only and scoping report was completed in 1997);

(H) Duxbury STP F 013-4(11)S (VT 100) (project scope defined before adoption of Vermont design standards in 1997);

(I) Hartford-Newbury IM 019-2(70) (I-91 drainage/fence) (high-priority safety projects have been completed along this segment of I-91);

(J) Hinesburg STP 0199( ) SC (TH 4/FAS 0199) (project set up for scoping in 1997 but no funds were ever programmed);

(K) Killington STP 022-1(19) SC (VT 100) (project set up for scoping only and the scoping report was completed in 1997);

(L) Marlboro NH F 010-1(25) (VT 9) (project scope defined before adoption of Vermont design standards in 1997);

(M) Newbury STP 026-2( ) (US 302) (origination of project

unknown; project has not been programmed with any funds);

(N) Pownal-Bennington F 019-1(16)C/1 (US 7) (project scope defined before adoption of Vermont design standards in 1997);

(O) Pownal-Bennington F 019-1(16)C/2 (US 7) (project scope defined before adoption of Vermont design standards in 1997);

(P) Readsboro-Whitingham STP RS 0102(13) (VT 100) (project scope defined before adoption of Vermont design standards in 1997);

(Q) Ryegate-St. Johnsbury IM 091-2(74) (I-91 drainage/fence) (high-priority safety projects have been completed along this segment of I-91);

(R) Ryegate-St. Johnsbury IM 091-2(75) (I-91 guardrail/ledge) (high-priority safety projects have been completed along this segment of I-91);

(S) St. Johnsbury-Lyndon IM 091-3(43) (I-91 drainage/fence) (high-priority safety projects have been completed along this segment of I-91);

(T) St. Johnsbury-Lyndon IM 091-3(44) (I-91 guardrail/ledge) (high-priority safety projects have been completed along this segment of I-91);

(U) Townshend STP 015-1(19)S (VT 30) (project set up in 1999 to modify the glare barrier and landscape in the vicinity of BR 3 on VT 30; no design activity or local interest in project since inception);

(V) Vergennes ST 017-1( )S (VT 22A) (VTrans granted city funds to reconstruct and city contracted the work out);

(W) Waitsfield-Moretown-Duxbury STP F 013-4(12)S (VT 100) (project scope defined before adoption of Vermont design standards in 1997);

(X) Wallingford F 025-1(31) (VT 103) (project scope defined before adoption of Vermont design standards in 1997);

(Y) Waterford IM 093-1(11) (I-93 drainage/fence) (high-priority safety projects completed along this segment of I-93);

(Z) Waterford IM 093-1(12) (I-93 guardrail/ledge) (high-priority safety projects completed along this segment of I-93); and

(AA) Williamstown STP RS 0204(3) (VT 64).

* * * FY 2012 Western Rail Corridor Improvements * * *

Sec. 10. WESTERN RAIL CORRIDOR GRANT APPLICATION; FY 2012 CONTINGENT BONDING AUTHORITY

(a) The general assembly finds that intercity passenger rail along Vermont's western rail corridor is of critical importance to the transportation mobility and economic prosperity of the state. The western rail corridor

includes connections from points in New York to the corridor between Bennington, Rutland, Burlington, Essex Junction, and St. Albans to points in Canada.

(b) The agency is encouraged to apply for a federal grant to cover, in whole or in part, the cost of upgrading the state's western rail corridor for intercity passenger rail service. In the grant application, the agency is authorized to identify the bonds authorized by this section as a source of state match funds. Upon its completion, the agency shall send an electronic copy of the grant application to the joint fiscal office.

(c) In the event the state is awarded a federal grant as referenced in subsection (b) of this section, the treasurer is authorized in fiscal year 2012 to issue transportation infrastructure bonds in an amount up to $15,000,000.00 for the purpose of providing any state matching funds required by the federal grant. The treasurer is authorized to increase the issue of transportation infrastructure bonds in the event the treasurer determines that:

(1) the creation and funding of a permanent debt service reserve is advisable to support the successful issuance of the transportation infrastructure bonds; and

(2) the balance of the TIB fund and the TIB debt service fund as of the end of fiscal year 2011 is insufficient to fund such a permanent debt service reserve.

(d) In the event the state is awarded a federal grant as referenced in subsection (b) of this section:

(1) authority to spend the federal grant funds is added to the fiscal year 2012 transportation program – rail program and the amount of federal funds awarded is appropriated to the fiscal year 2012 transportation – rail program; and

(2) if transportation infrastructure bonds are issued pursuant to subsection (c) of this section to fund the project, authority to spend the bond proceeds on the project in an amount needed to match the federal funds authorized in subdivision (d)(1) of this subsection is added to the 2012 fiscal year transportation program – rail program and that amount is appropriated to the fiscal year 2012 transportation – rail program.

Sec. 11. FISCAL YEAR END 2011 TRANSPORTATION FUND SURPLUS

Subject to the funding of the transportation fund stabilization reserve in accordance with 32 V.S.A. § 308a and notwithstanding 32 V.S.A. § 308c (transportation fund surplus reserve), any surplus in the transportation fund as of the end of fiscal year 2011 up to a maximum amount of $1,000,000.00 may be transferred to the TIB debt service fund by order of the secretary of

transportation, with the approval of the secretary of administration, for the purpose of providing the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds that may be issued pursuant to the authority granted in Sec. 10 of this act, to pay the issuance costs of such bonds, or to pay debt service obligations due on such bonds in fiscal years 2012 and 2013.

Sec. 12. FISCAL YEAR END 2011 TIB FUND SURPLUS

Any surplus in the transportation infrastructure bond fund as of the end of fiscal year 2011 up to a maximum amount of $1,000,000.00 may be transferred to the TIB debt service fund by order of the secretary of transportation, with the approval of the secretary of administration, for the purpose of providing the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds that may be issued pursuant to the authority granted in Sec. 10 of this act, to pay the issuance costs of such bonds, or to pay debt service obligations due on such bonds in fiscal years 2012 and 2013.

Sec. 13. AUTHORITY TO REDUCE FISCAL YEAR 2011 APPROPRIATIONS

(a) Notwithstanding 32 V.S.A. § 706 and the limits on program, project, or activity spending authority in the fiscal year 2011 transportation program, the secretary of transportation, with the approval of the secretary of administration and subject to the provisions of subsection (b) of this section, may reduce fiscal year 2011 transportation fund appropriations, other than appropriations for the town highway state aid, structures, and class 2 roadway programs, or TIB fund appropriations, and transfer in fiscal year 2011 the amount of the reductions to the TIB debt service fund for the purpose of providing the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds that may be issued pursuant to the authority granted in Sec. 10 of this act, to pay the issuance costs of such bonds, or to pay debt service obligations due on such bonds in fiscal years 2012 and 2013.

(b) The secretary's authority under subsection (a) of this section to reduce appropriations is limited to appropriations, the reduction of which, by itself, will not have the effect of significantly delaying the planned fiscal year 2011 work schedule of a project which formed the basis of the project's funding in fiscal year 2011.

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

transportation oversight committee.

Sec. 14. CHANGE TO CONSENSUS REVENUE FORECAST

In the event the July 2011 consensus revenue forecast of fiscal year 2012 transportation fund or TIB fund revenue is increased above the January 2011 forecast, the increase up to $2,000,000.00 may be transferred to the TIB debt service fund, by order of the secretary of transportation with the approval of the secretary of administration, for the purpose of providing the funds the treasurer deems likely to be needed to satisfy any debt service reserve requirement of transportation infrastructure bonds that may be issued pursuant to the authority granted in Sec. 10 of this act, to pay the issuance costs of such bonds, or to pay debt service obligations due on such bonds in fiscal years 2012 and 2013.

Sec. 15. AUTHORITY TO REDUCE FISCAL YEAR 2012 APPROPRIATIONS

(a) Notwithstanding 32 V.S.A. § 706 and the limits on program, project, or activity spending authority in the fiscal year 2012 transportation program, the secretary of transportation, with the approval of the secretary of administration and subject to the provisions of subsection (b) of this section, may reduce fiscal year 2012 transportation fund appropriations, other than appropriations for the town highway state aid, structures, and class 2 roadway programs, or TIB fund appropriations, and transfer in fiscal year 2012 the amount of the reductions to the TIB debt service fund for the purpose of providing the funds the treasurer deems likely to be needed to pay debt service obligations of transportation infrastructure bonds authorized by Sec. 10 of this act in fiscal year 2013.

(b) The secretary's authority under subsection (a) of this section to reduce appropriations is limited to appropriations, the reduction of which, by itself, in the context of any spending authorized for the project in the fiscal year 2012 transportation program will not have the effect of significantly delaying the planned work schedule of the project which formed the basis of the project's funding in fiscal years 2012 and 2013.

(c) The agency shall expedite the procedures required to determine the eligibility and certification of federal toll credits with respect to potentially qualifying capital expenditures made by Vermont entities through the end of fiscal year 2011 which, subject to compliance with federal maintenance of effort requirements, would be available for use by the state in fiscal year 2013. The fiscal year 2013 transportation program shall reserve up to $3,000,000.00 of such potentially available federal toll credits and federal formula funds and authorize the secretary to utilize the federal toll credits and federal formula funds to accomplish the objectives of this section.

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

* * * White River Junction Railroad Station * * *

Sec. 16. ACQUISITION OF WHITE RIVER JUNCTION RAILROAD STATION

(a) The agency is authorized to acquire, and to seek federal funds to assist in acquiring, the White River Junction railroad station from Rio Blanco Corporation or its successors in interest for a purchase price of up to $875,000.00. The subject property is a 6,774-square-foot commercial building sited on approximately 0.73 acres of land, is located at 100–106 Railroad Row in the village of White River Junction within the town of Hartford, and is all the same property conveyed to Rio Blanco Corporation by two deeds: Release Deed from Central Vermont Railway, Inc., dated February 1, 1995, and recorded at Book 219, pages 45–50, and Release Deed from Boston & Maine Corporation dated February 2, 1995, and recorded at Book 219, pages 51–60, both in the land records of the town of Hartford.

(b) A new project is added to the fiscal year 2011 and 2012 transportation program — rail program for purchase of the White River Junction railroad station.

(c) Notwithstanding the authorized project or activity spending within the fiscal year 2011 transportation program — rail program and the fiscal year 2012 transportation program — rail program, the secretary is authorized to use up to a total of $875,000.00 in transportation funds or TIB funds approved within the fiscal year 2011 and 2012 rail programs for purchase of the station.

(d) The agency shall promptly report to the joint transportation oversight committee and to the joint fiscal office any action taken under the authority granted in subsection (a) of this section.

(e) Following conveyance of the White River Junction railroad station to the state of Vermont, the agency shall administer the property in accordance with 5 V.S.A. chapter 56 (intercity rail passenger service).

* * * Aviation Program Plan * * *

Sec. 17. AVIATION PROGRAM PLAN

(a) By January 15, 2012, the secretary of transportation shall develop a business plan to achieve the goal of reducing or eliminating the operating deficits of state-owned airports by June 30, 2015. In developing this plan, the

secretary shall review the aviation programs of other states; study whether aircraft registration fees, hangar fees, landing fees for noncommercial aircraft, and other service fees would produce net revenues for the state; estimate the net revenues that would be generated at various fee levels and for various fee types; and review any other subject matter the secretary deems relevant to reducing or eliminating the operating deficits of state-owned airports.

(b) State airports certified by the Federal Aviation Administration pursuant to Part 139 of Title 14 of the Code of Federal Regulations and state airports that provide daily commercial passenger airline service shall be excluded from the business plan required under subsection (a) of this section.

(c) By January 15, 2012, the secretary shall submit the business plan required under subsection (a) of this section to the house and senate committees on transportation and shall include in the plan any recommendations for proposed legislation needed to implement the plan.

* * * Municipal Airports * * *

Sec. 18. 5 V.S.A. § 695 is amended to read:

§ 695. FEDERAL ASSISTANCE

~~No municipality in this state, whether acting alone or jointly with another municipality or with the state shall submit to the Federal Aviation Administration of the United States any project application under the provisions of any federal statute, unless the project and the project application have been first approved by the secretary which approval shall not be unreasonably withheld. No~~ A municipality ~~shall directly accept, receive, receipt for, or disburse any funds granted by the United States under the Federal Airport Act or amendments to that act, but it shall designate~~ may petition the secretary to serve as its agent ~~and in its behalf~~ to accept, receive, ~~receipt~~ account for, and disburse all funds granted by the United States for an airport project. ~~It~~ If the secretary agrees to serve as agent, the municipality shall enter into an agreement with the secretary prescribing the terms and conditions of the agency relationship in accordance with any applicable federal or state laws~~, rules and~~ or regulations ~~and applicable laws of this state~~.

* * * State Aid for Town Highway Roadways and Structures * * *

Sec. 19. 19 V.S.A. § 306 is amended to read:

§ 306. APPROPRIATION; STATE AID FOR TOWN HIGHWAYS

* * *

(e) State aid for town highway structures. There shall be an annual appropriation for grants to municipalities for maintenance, including actions to

extend life expectancy, and for construction of bridges, culverts, and other structures, including causeways and retaining walls, intended to preserve the integrity of the traveled portion of class 1, 2, and 3 town highways. Each fiscal year, the agency shall approve qualifying projects with a total estimated state share cost of ~~$3,490,000.00~~ $5,833,500.00 at a minimum as new grants. The agency's proposed appropriation for the program shall take into account the estimated amount of qualifying invoices submitted to the agency with respect to project grants approved in prior years but not yet completed as well as with respect to new project grants to be approved in the fiscal year. In a given fiscal year, should expenditures in the town highway structures program exceed the amount appropriated, the agency shall advise the governor of the need to request a supplemental appropriation from the general assembly to fund the additional project cost, provided that the agency has previously committed to completing those projects. Funds received as grants for state aid for town highway structures may be used by a municipality to satisfy a portion of the matching requirements for federal earmarks, subject to subsection 309b(c) of this title.

(f), (g) [Deleted.]

(h) Class 2 town highway roadway program. There shall be an annual appropriation for grants to municipalities for resurfacing, rehabilitation, or reconstruction of paved or unpaved class 2 town highways. Each fiscal year, the agency shall approve qualifying projects with a total estimated state share cost of ~~$4,240,000.00~~ $7,248,750.00 at a minimum as new grants. The agency's proposed appropriation for the program shall take into account the estimated amount of qualifying invoices submitted to the agency with respect to project grants approved in prior years but not yet completed as well as with respect to new project grants to be approved in the fiscal year. In a given fiscal year, should expenditures in the town highway class 2 roadway program exceed the amount appropriated, the agency shall advise the governor of the need to request a supplemental appropriation from the general assembly to fund the additional project cost, provided that the agency has previously committed to completing those projects. Funds received as grants for state aid under the class 2 town highway roadway program may be used by a municipality to satisfy a portion of the matching requirements for federal earmarks, subject to subsection 309b(c) of this title.

* * *

* * * Utility Adjustments * * *

Sec. 20. UTILITY ADJUSTMENTS

Notwithstanding chapter 16 of Title 19, during fiscal years 2011, 2012, and

2013, the agency is authorized to pay from a federal earmark for a highway project the costs of adjustments to municipal utilities located within a state highway right-of-way needed to accommodate the project, provided that the earmark involves no state matching funds and no commitment of state or additional federal funds, and provided that the utility adjustment costs are otherwise eligible for federal participation.

* * * Scenic Byways and Roads * * *

Sec. 21. The title of 10 V.S.A. chapter 19 is amended to read:

CHAPTER 19. SCENERY PRESERVATION ~~COUNCIL~~

Sec. 22. 10 V.S.A. § 425 is amended to read:

§ 425. ~~SCENERY PRESERVATION~~ BYWAYS ADVISORY COUNCIL

(a) The ~~scenery preservation~~ byways advisory council shall:

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

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

(3) encourage and assist in fostering public awareness~~,~~ and understanding of, and public participation in promoting, the ~~objectives and functions of scenery preservation and in stimulating public participation and interest~~ current intrinsic scenic and other qualities within byways and scenic road corridors.

(b) The ~~scenery preservation~~ byways advisory council shall consist of ~~seven~~ eight members: the secretary of natural resources or his or her designee; the secretary of transportation or his or her designee; the commissioner of tourism and marketing or his or her designee; and five members appointed by the governor. The terms of the members appointed by the governor shall be for three years, except that he or she shall appoint the first members so that the terms of the members end in one year, two years, and three years. The governor shall designate an appointed member to serve as ~~chairman~~ chair at the governor's pleasure. Except as provided in this section, no state employee or member of any state commission or any federal employee or member of any federal commission shall be eligible for membership on the ~~scenery preservation~~ byways advisory council. Members of the council who are not full-time state employees shall be entitled to a per diem as provided in 32 V.S.A. § 1010(b) and reimbursement for their actual necessary expenses. The ~~council shall meet no more than two times per year, and meetings may be~~

~~called by the~~ chair of the council or the secretary of transportation or his or her designee may call meetings of the council.

(c) ~~The transportation board shall, in consultation with the scenery preservation council, and considering the criteria recommended in subdivision (b)(5) of this section, prepare, adopt and promulgate standards, and criteria for variances therefrom, pursuant to chapter 25 of Title 19, to carry out the purposes of this chapter. The standards shall include, but shall not be limited to, descriptions of techniques for construction, including roadside grading and planting and preservation of intimate roadside environments as well as scenic outlooks. The standards shall further prescribe minimum width, alignment and surface treatment with particular reference to the legislative findings of this act. The standards shall include methods of traffic control, such as signs, speed limits, signals and warnings, which shall not, within appropriate safety considerations, jeopardize the scenic or historic value of such roads. These standards shall be revised as necessary taking into consideration increased weight, load and size of vehicles making use of scenic roads, such as, but not limited, to forest product vehicles, agribusiness vehicles and school buses. No provision of the scenic road law may deny necessary improvement to or maintenance of scenic roads over which such vehicles must travel~~ Rehabilitation or reconstruction of byways or state scenic roads shall be conducted in accordance with the agency of transportation's Vermont Design Standards, as amended. Signs along byways and scenic roads shall be in accordance with the Federal Highway Administration's Manual on Uniform Traffic Control Devices, as amended.

(d) ~~Provisions of this chapter shall apply only within the highway right of way.~~ [Repealed.]

(e) ~~All actions, including promulgation of rules, regulations or recommendations for designation, shall be made pursuant to the provisions of chapter 25 of Title 3.~~ [Repealed.]

Sec. 23. 19 V.S.A. § 2501 is amended to read:

§ 2501. STATE SCENIC ROADS; DESIGNATION AND DISCONTINUANCE

(a) On the recommendation of the ~~scenery preservation~~ byways advisory council, the transportation board may designate or discontinue any state highway, or portion of a state highway, as a state scenic road. The board shall hold a hearing on the recommendation and shall submit a copy of its decision together with its findings to the ~~scenery preservation~~ byways advisory council within 60 days after receipt of the recommendation. The hearing shall be held in the vicinity of the proposed scenic highway.

(b) Annually, the council shall provide information to the agency of commerce and community development on designated scenic roads for inclusion on state maps.

(c) A state scenic road shall not be reconstructed or improved unless the reconstruction or improvement ~~conforms to the standards established by the agency of transportation pursuant to 10 V.S.A. § 425~~ is conducted in accordance with the agency of transportation's Vermont Design Standards, as amended.

Sec. 24. 19 V.S.A. § 2502 is amended to read:

§ 2502. TOWN SCENIC ROADS; DESIGNATION AND DISCONTINUANCE

(a) On recommendation of the planning commission of a municipality, or on the initiative of the legislative body of a municipality, a legislative body may, after one public hearing warned for the purpose, designate or discontinue any town highway or portion of a town highway as a town scenic highway. Such action by the legislative body may be petitioned by the registered voters of the municipality pursuant to the provisions of 24 V.S.A. § 1973.

(b) A town scenic road may be reconstructed or improved in a manner ~~consistent with the standards established by the transportation board, pursuant to 10 V.S.A. § 425~~ consistent with the agency of transportation's Vermont Design Standards, as amended. A class 1, 2 or 3 scenic highway shall still be eligible to receive aid pursuant to the provisions of this title.

(c) ~~The legislative body of a municipality may appeal for a variance from standards promulgated by the transportation board. In these appeals, the board's decision shall be final.~~ [Repealed.]

Sec. 25. 30 V.S.A. § 218c(d)(2) is amended to read:

(2) Prior to the adoption of any transmission system plan, a utility preparing a plan shall host at least two public meetings at which it shall present a draft of the plan and facilitate a public discussion to identify and evaluate nontransmission alternatives. The meetings shall be at separate locations within the state, in proximity to the transmission facilities involved or as otherwise required by the board, and each shall be noticed by at least two advertisements, each occurring between one and three weeks prior to the meetings, in newspapers having general circulation within the state and within the municipalities in which the meetings are to be held. Copies of the notices shall be provided to the public service board, the department of public service, any entity appointed by the public service board pursuant to subdivision 209(d)(2) of this title, the agency of natural resources, the division for historic

preservation, the department of health, the ~~scenery preservation~~ byways advisory council, the agency of transportation, the attorney general, the chair of each regional planning commission, each retail electricity provider within the state, and any public interest group that requests, or has made a standing request for, a copy of the notice. A verbatim transcript of the meetings shall be prepared by the utility preparing the plan, shall be filed with the public service board and the department of public service, and shall be provided at cost to any person requesting it. The plan shall contain a discussion of the principal contentions made at the meetings by members of the public, by any state agency, and by any utility.

Sec. 26. 30 V.S.A. § 248(a)(4)(C) is amended to read:

(C) At the time of filing its application with the board, copies shall be given by the petitioner to the attorney general and the department of public service, and, with respect to facilities within the state, the department of health, agency of natural resources, historic preservation division, ~~scenery preservation council, state planning office,~~ agency of transportation, the agency of agriculture, food and markets and to the chairperson or director of the municipal and regional planning commissions and the municipal legislative body for each town and city in which the proposed facility will be located. At the time of filing its application with the board, the petitioner shall give the byways advisory council notice of the filing.

* * * Rest Areas and Welcome Centers; Funding * * *

Sec. 27. APPORTIONMENT STUDY

The joint fiscal office, in consultation with the commissioner of buildings and general services or designee and the secretary of transportation or designee, shall study how the cost of constructing, rehabilitating, maintaining, staffing, and operating rest areas, information centers, and welcome centers could be apportioned between the general fund and the transportation fund. The joint fiscal office shall submit a report of its findings to the joint transportation oversight committee by November 1, 2011.

* * * State Highway Condemnation Law Study Committee * * *

Sec. 28. STATE HIGHWAY CONDEMNATION LAW STUDY COMMITTEE

(a) A study committee is established, consisting of a member of the house committee on transportation designated by the speaker, a member of the house committee on judiciary designated by the speaker, a member of the senate committee on transportation designated by the committee on committees, a member of the senate committee on judiciary designated by the committee on

committees, a representative of the Vermont Bar Association designated by the association, a representative of the Vermont League of Cities and Towns designated by the league, a representative of the Vermont Society of Land Surveyors designated by the society, and the secretary of transportation or designee who shall serve as chair.

(b) The chair shall call the first meeting of the committee to be held by September 1, 2011, and the committee is authorized to hold up to five in-person meetings. The agency of transportation shall provide administrative support for the committee, and the office of legislative council shall provide staff service to the committee. The secretary of transportation or designee and staff of the office of legislative council shall prepare the report required under subsection (e) of this section based on the findings of the committee, and the committee shall terminate upon delivery of this report.

(c) The committee shall investigate possible changes in the state's highway condemnation law set forth in chapter 5 of Title 19 to achieve improved integration with the transportation planning process, federal and state environmental reviews, legislative oversight of the transportation program under 19 V.S.A. § 10g, and the requirements of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, as amended, 42 U.S.C. § 4601 et seq. The committee also shall investigate the effect of possible changes to chapter 5 of Title 19 on other provisions of law that reference and rely upon the procedures set forth in that chapter.

(d) For attendance at a meeting when the general assembly is not in session, legislative members of the committee shall be entitled to per diem compensation and expense reimbursement as provided in 2 V.S.A. § 406(a).

(e) The committee shall deliver a report of its findings, including any recommendations for proposed legislation, to the house and senate committees on transportation and on judiciary by January 15, 2012.

* * * Sign and Travel Information Law * * *

Sec. 29. 10 V.S.A. § 494 is amended to read:

§ 494. EXEMPT SIGNS

The following signs are exempt from the requirements of this chapter except as indicated in section 495 of this title:

* * *

(16) ~~[Repealed.]~~ Signs displaying a message of congratulations, condolences, birthday wishes, or displaying a message commemorating a personal milestone or event; provided, however, any such message is maintained for not more than two weeks.

* * *

Sec. 30. TRAVEL INFORMATION COUNCIL – RULEMAKING AND RECOMMENDATIONS

(a) By July 1, 2012, the travel information council shall, pursuant to the rulemaking authority granted in 10 V.S.A. § 484(b), adopt rules as to what constitutes flashing intermittent or moving lights or animated or moving parts within the meaning of 10 V.S.A. § 495(a)(3). In adopting these rules, the travel information council shall consider reliable empirical studies of the effect of changing or flashing signs on traffic safety; the current state of sign technology and expected future developments in sign technology; and the findings set forth in 10 V.S.A. § 482 concerning the value of the scenic resources of the state, the importance of providing information regarding services, accommodations, and points of interest to the traveling public, and the hazard created by the proliferation of outdoor advertising. The agency of transportation shall provide staff and administrative support during the rulemaking process.

(b) The travel information council shall study whether, consistent with the legislative findings set forth in 10 V.S.A. § 482, and based on the council's experience enforcing 10 V.S.A. chapter 21, the list of exempt signs at 10 V.S.A. § 494 should be amended. The council shall report its findings to the house and senate committees on transportation and to the house and senate committees on natural resources and energy by January 15, 2012.

* * * Motor Fuel Transportation Infrastructure Assessment * * *

Sec. 31. 23 V.S.A. § 3106(a) is amended to read:

(a) Except for sales of motor fuels between distributors licensed in this state, which sales shall be exempt from the tax and from the motor fuel transportation infrastructure assessment, in all cases not exempt from the tax under the laws of the United States at the time of filing the report required by section 3108 of this title, each distributor shall pay to the commissioner a tax of $0.19 upon each gallon of motor fuel sold by the distributor, and a motor fuel transportation infrastructure assessment in the amount of two percent of the retail price ~~exclusive of all federal and state taxes~~ upon each gallon of motor fuel sold by the distributor, exclusive of: all federal and state taxes, the petroleum distributor licensing fee established by 10 V.S.A. § 1942, and the motor fuel transportation infrastructure assessment authorized by this section. The retail price shall be based upon the average retail prices for regular gasoline determined and published by the department of public service. The retail price applicable for the January–March quarter shall be the average of the retail prices published by the department of public service the prior

October, November, and December; and the retail price applicable in each succeeding calendar quarter shall be equal to the average of the retail prices published by the department of public service in the preceding quarter. The distributor shall also pay to the commissioner a tax and a motor fuel transportation infrastructure assessment in the same amounts upon each gallon of motor fuel used within the state by him or her.

* * * Public Transit Advisory Council * * *

Sec. 32. 24 V.S.A. § 5084 is amended to read:

§ 5084. PUBLIC TRANSIT ADVISORY COUNCIL

(a) A public transit advisory council shall be created by the secretary of transportation under 19 V.S.A. § 7(f)(5), to consist of the following members:

(1) the secretary of transportation or designee;

(2) ~~the executive director of the Vermont public transportation association;~~

~~(3)~~ three representatives of the Vermont public transportation association;

~~(4)~~(3) a representative of the Chittenden County transportation authority;

~~(5)~~(4) the secretary of human services or designee;

~~(6)~~(5) the commissioner of ~~employment and training~~ labor or designee;

~~(7)~~(6) the secretary of commerce and community development or designee;

~~(8)~~(7) a representative of the Vermont center for independent living;

~~(9)~~(8) a representative of the ~~council~~ community of Vermont elders;

~~(10)~~(9) a representative of private bus operators and taxi services;

~~(11)~~(10) a representative of Vermont intercity bus operators;

~~(12)~~(11) a representative of the Vermont association of planning and development agencies;

~~(13)~~(12) a representative of the Vermont league of cities and towns;

~~(14)~~(13) a citizen appointed by the governor;

~~(15)~~(14) a member of the senate, appointed by the committee on committees; and

~~(16)~~(15) a member of the house of representatives, appointed by the

speaker.

* * *

* * * Public Transportation Planning; Annual Reporting * * *

Sec. 33. 24 V.S.A. § 5089(b) is amended to read:

(b) Recognizing that the growing demand for new regional and commuter services must be considered within the context of the continuing need for local transit services that meet basic mobility needs, the agency of transportation shall consult annually with the regional planning commissions and public transit providers in advance of the award of available planning funds. The agency shall maintain a working list of both short- and long-term planning needs, goals, and objectives that balances the needs for regional service with the need for local service. Available planning funds shall be awarded in accordance with state and federal law and as deemed necessary and appropriate by the agency following consultation with the regional planning commissions and the public transit providers. ~~The agency shall report annually to the general assembly on planning needs, expenditures, and cooperative planning efforts.~~

Sec. 34. 24 V.S.A. § 5092 is amended to read:

§ 5092. REPORTS

The agency of transportation, in cooperation with the public transit advisory council, shall develop an annual report of financial and performance data of all public transit systems that receive operating subsidies in any form from the state or federal government, including but not limited to subsidies related to the elders and persons with disabilities transportation program for service and capital equipment. Financial and performance data on the elders and persons with disabilities transportation program shall be a separate category in the report. The report shall be modeled on the Federal Transit Administration's national transit database program with such modifications as appropriate for the various services~~, including the~~ and guidance found in ~~the most current short-range public transportation plans and~~ the most current state policy plan. The report shall describe any action taken by the agency pursuant to contractual authority to terminate funding for routes or to request service changes for failure to meet performance standards. The report shall be available to the general assembly by January 15 of each year.

* * * Temporary Siting of Meteorological Stations * * *

Sec. 35. 30 V.S.A. § 246 is amended to read:

§ 246. TEMPORARY SITING OF METEOROLOGICAL STATIONS

(a) For purposes of this section, a "meteorological station" consists of one temporary tower, which may include guy wires, and attached instrumentation to collect and record wind speed, wind direction, and atmospheric conditions.

(b) The public service board shall establish by rule or order standards and procedures governing application for, and issuance or revocation of, a certificate of public good for the temporary installation of one or more meteorological stations under the provisions of section 248 of this title. A meteorological station shall be deemed to promote the public good of the state if it is in compliance with the criteria of this section and the board rules or orders. An applicant for a certificate of public good for a meteorological station shall be exempt from the requirements of subsection 202(f) of this title.

(c) In developing rules or orders, the board:

(1) Shall develop a simple application form and shall require that completed applications be filed with the board, the department of public service, the agency of natural resources, the agency of transportation, and the municipality in which the meteorological station is proposed to be located.

* * *

* * * Transportation Program; Project Dates * * *

Sec. 36. 19 V.S.A. § 10g(o) is added to read:

(o) For projects initially approved by the general assembly for inclusion in the state transportation program after January 1, 2006, the agency's proposed transportation program prepared pursuant to subsection (a) of this section and the official transportation program prepared pursuant to subsection (f) of this section shall include the year in which such projects were first approved by the general assembly.

* * * Possession of Valid Operator's License * * *

Sec. 37. 23 V.S.A. § 611 is amended to read:

§ 611. POSSESSION OF LICENSE CERTIFICATE

Every licensee shall have his or her operator's license certificate in his or her immediate possession at all times when operating a motor vehicle. However, no person charged with violating this section or section 610 of this title shall be convicted if he or she produces in court or to the ~~arresting~~ enforcement officer an operator's license certificate theretofore issued to him or her ~~and valid~~ which, at the time of his or her ~~arrest or within 14 days following its expiration~~ citation, was valid or had expired within the prior 14 days.

* * * Inspection Stickers * * *

Sec. 38. 23 V.S.A. § 1222 is amended to read:

§ 1222. INSPECTION OF REGISTERED VEHICLES

(a) Except for school buses which shall be inspected as prescribed in section 1282 of this title and motor buses as defined in subdivision 4(17) of this title which shall be inspected twice during the calendar year at six-month intervals, all motor vehicles registered in this state shall be inspected once each year. Any motor vehicle, trailer or semi-trailer not currently inspected in this state shall be inspected within 15 days from the date of its registration in the state of Vermont.

(b) The inspections shall be made at garages or qualified service stations, designated by the commissioner as inspection stations, for the purpose of determining whether those motor vehicles are properly equipped and maintained in good mechanical condition. The charges for such inspections made by garages or qualified service stations designated to conduct periodic inspections shall be subject to the approval of the commissioner.

~~(b)~~ If a fee is charged for inspection, it shall be based upon the hourly rate charged by each official inspection station or it may be a flat rate fee and, in either instance, the fee shall be prominently posted and displayed beside the official inspection station certificate. In addition, the official inspection station may disclose the state inspection certificate charge on the repair order as a separate item and collect the charge from the consumer.

(c) A person shall not operate a motor vehicle unless it has been inspected as required by this section and has a valid certification of inspection affixed to it. A person shall be subject to a fine of not more than $5.00 if he or she is cited for a violation of this section within 14 days of expiration of the motor vehicle inspection sticker. The month of next inspection for all motor vehicles shall be shown on the current inspection certificate affixed to the vehicle.

~~(c)~~(d) Notwithstanding the provisions of subsection (a) of this section, an exhibition vehicle of model year 1940 or before registered as prescribed in section 373 of this title or a trailer registered as prescribed in subdivision 371(a)(1)(A) of this title shall be exempt from inspection; provided, however, the vehicle must be equipped as originally manufactured, must be in good mechanical condition, and must meet the applicable standards of the inspection manual.

* * * Parking for Blind and Disabled * * *

Sec. 39. 23 V.S.A. § 304a(d) is amended to read:

(d) A person ~~who is blind or~~ who has an ambulatory disability ~~may~~ or an individual transporting a person who is blind shall be permitted to park and to

park without fee for ~~not more than~~ at least 10 continuous days in a parking ~~zone~~ space or area which is restricted as to the length of time parking is permitted or where parking fees are assessed, except that this minimum period shall be 24 continuous hours for parking in a state or municipally operated parking garage. This section shall not apply to ~~zones~~ spaces or areas in which parking, standing, or stopping of all vehicles is prohibited~~,~~ by law or by any parking ban, or which are reserved for special vehicles~~, or where parking is prohibited by any parking ban~~. As a condition to this privilege, the vehicle shall display the special handicapped plate or placard issued by the commissioner or a special registration license plate or placard issued by any other jurisdiction.

Sec. 40. 20 V.S.A. § 2904 is amended to read:

§ 2904. PARKING SPACES

Any parking facility on the premises of a public building shall contain at least the number of parking spaces required by ADAAG standards, and in any event at least one parking space, as ~~free~~ designated parking for individuals with ambulatory disabilities or blind individuals patronizing the building. The space or spaces shall be accessibly and proximately located to the building, and, subject to 23 V.S.A. § 304a(d), shall be provided free of charge. Consideration shall be given to the distribution of spaces in accordance with the frequency and persistence of parking needs. Such spaces shall be designated by a clearly visible sign that cannot be obscured by a vehicle parked in the space, by the international symbol of access and, where appropriate, by the words "van accessible"; shall otherwise conform to ADAAG standards; and shall be in accordance with the standards established under section 2902 of this title.

Sec. 41. EFFECTIVE DATES

(a) This section, Secs. 7a (supplemental paving spending), 10 (western rail corridor grant application), 13 (authority to reduce fiscal year 2011 appropriations), 16 (White River Junction railroad station), 17 (aviation program plan), 20 (utility adjustments), and 29–30 (sign law provisions) shall take effect on passage.

(b) Sec. 36 (transportation program project dates) shall take effect on January 1, 2012.

(c) All other sections of this act shall take effect on July 1, 2011.

RICHARD T. MAZZA
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Committee on the part of the Senate

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