

Journal of the Senate

TUESDAY, MAY 3, 2011

The Senate was called to order by the President.

Devotional Exercises

A moment of silence was observed in lieu of devotions.

Recess

On motion of Senator Mazza the Senate recessed until one o'clock and thirty minutes in the afternoon.

Message from the House No. 65

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

Mr. President:

I am directed to inform the Senate that:

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

S. 37. An act relating to expungement of a nonviolent misdemeanor criminal history record.

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

Rep. Koch of Barre Town
Rep. Wizowaty of Burlington
Rep. French of Shrewsbury.

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

S. 94. An act relating to miscellaneous amendments to the motor vehicle laws.

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

Rep. Lanpher of Vergennes
Rep. Bissonnette of Winooski
Rep. Burke of Brattleboro.

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

S. 100. An act relating to making miscellaneous amendments to education laws.

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

Rep. Crawford of Burke
Rep. Donovan of Burlington
Rep. Gilbert of Fairfax.

Called to Order

The Senate was called to order by the President.

Bill Referred

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

H. 53.

An act relating to the Interstate Wildlife Violator Compact.

To the Committee on Rules.

**Proposal of Amendment Amended; Bill Passed in Concurrence with
Proposal of Amendment**

H. 11.

House bill entitled:

An act relating to the discharge of pharmaceutical waste to state waters.

Was taken up.

Thereupon, pending third reading of the bill, Senator Campbell moved that the Senate propose to the House to amend the Senate proposal of amendment by adding a new section to be numbered Sec. 4 to read as follows:

Sec. 4. 18 V.S.A. § 4284 is amended to read:

§ 4284. PROTECTION AND DISCLOSURE OF INFORMATION

* * *

(b) The department shall be authorized to provide data to only the following persons:

* * *

(6) The commissioner of public safety, personally, if the commissioner of health personally makes the disclosure, has consulted with at least one of the patient's health care providers, and believes that the disclosure is necessary to avert a serious and imminent threat to a person or the public.

(7) A trained law enforcement officer employed by the department of public safety who is requesting data relating to a patient for the purpose of a bona fide investigation of that patient.

(8) Personnel or contractors, as necessary for establishing and maintaining the VPMS.

* * *

Thereupon, pending the question, Shall the Senate propose to the House to amend the bill as moved by Senator Campbell? Senator Sears raised a *point of order* under Sec. 402 of Mason's Manual of Legislative Procedure on the grounds that the proposal of amendment offered by Senator Campbell was *not germane* to the bill and therefore could not be considered by the Senate.

Thereupon, the President *sustained* the point of order and ruled that the proposal of amendment recommended by Senator Campbell was *not germane* to the bill as it did not satisfy the criteria of Mason's Rule 402 regarding germaneness in that it was not naturally related to and did not follow in a logical sequence the subject matter of the original proposal.

The President thereupon declared that the proposal of amendment offered by Senator Campbell could *not* be considered by the Senate and the proposal of amendment was ordered stricken.

Thereupon, the bill was read the third time and passed in concurrence with proposal of amendment.

**Proposal of Amendment Amended; Bill Passed in Concurrence with
Proposal of Amendment**

H. 201.

House bill entitled:

An act relating to hospice and palliative care.

Was taken up.

Thereupon, pending third reading of the bill, Senator Miller moved that the Senate propose to the House to amend the *Eighth* Senate proposal of amendment in Sec. 11(c) by inserting a new subdivision to be subdivision (4) to read as follows:

(4) an examination of the relationship between the wishes expressed in an advance directive and the DNR/COLST order.

And by making the subsection grammatically correct.

Which was agreed to.

Thereupon, the bill was read the third time and passed in concurrence with proposal of amendment.

Rules Suspended; Committee Relieved of Further Consideration; Bills Committed

H. 451.

On motion of Senator Campbell, the rules were suspended, and H. 451 was taken up for immediate consideration, for the purpose of relieving the Committee on Rules from further consideration of the bill. Thereupon, on motion of Senator Campbell, the Committee on Rules was relieved of House bill entitled:

An act relating to amending the charter of the town of Shelburne,
and the bill was committed to the Committee on Government Operations.

H. 455.

On motion of Senator Campbell, the rules were suspended, and H. 455 was taken up for immediate consideration, for the purpose of relieving the Committee on Rules from further consideration of the bill. Thereupon, on motion of Senator Campbell, the Committee on Rules was relieved of House bill entitled:

An act relating to the enhanced 911 emergency response system,
and the bill was committed to the Committee on Government Operations.

Bill Amended; Third Reading Ordered

S. 95.

Senator McCormack, for the Committee on Finance, to which was referred Senate bill entitled:

An act relating to exemptions for newspaper deliverers from the unemployment statutes; relieving an employer's experience rating record of charges; studying the receipt of unemployment compensation between academic terms; allowing school employees to be paid wages over the course of a year; and requiring employers to furnish required work apparel.

Reported recommending that the bill be amended as follows:

First: By striking out Sec. 2 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 2 to read as follows:

Sec. 2. STUDY

(a) The commissioner of labor in consultation with the Vermont school boards association and any other interested parties shall study the issue of allowing the receipt of unemployment benefits between academic terms for noninstructional employees. The study shall consider the costs of allowing receipt of such benefits, the employees who would be eligible for benefits, and any other relevant issues. In addition, the study shall consider the potential benefit to those employees of school-district-coordinated job placement services for the months between academic terms.

(b) The commissioner shall also study the issue of whether wages paid by an elderly individual for in-home assistance should be subject to the unemployment insurance statutes.

(c) The commissioner shall report his or her findings and any recommendations to the senate committee on economic development, housing and general affairs and the house committee on commerce and economic development by January 15, 2012.

Second: By striking out Sec. 3 in its entirety and inserting in lieu thereof a new section to be numbered Sec. 3 to read as follows:

Sec. 3. 21 V.S.A. § 1301 is amended to read:

§ 1301. DEFINITIONS

The following words and phrases, as used in this chapter, shall have the following meanings unless the context clearly requires otherwise:

* * *

(6)(A)(i) “Employment,” subject to the other provisions of this subdivision (6), means service within the jurisdiction of this state, performed prior to January 1, 1978, which was employment as defined in this subdivision prior to such date and, subject to the other provisions of this subdivision, service performed after December 31, 1977, by an employee, as defined in subsections 3306(i) and (o) of the Federal Unemployment Tax Act, including service in interstate commerce, performed for wages or under any contract of hire, written or oral, expressed or implied. Services partly within and partly without this state may by election as hereinbefore provided be treated as if wholly within the jurisdiction of this state. And whenever an employing unit shall have elected to come under the provisions of a similar act of a state where a part of the services of an employee are performed, the commissioner, upon his or her approval of said election as to any such employee, may treat the

services covered by said approved election as having been performed wholly without the jurisdiction of this state.

* * *

(C) The term “employment” shall not include:

* * *

(xxi) Service performed by a direct seller if the individual is in compliance with all the following:

(I) The individual is engaged in:

(aa) the trade or business of selling or soliciting the sale of consumer products, including services or other intangibles, in the home or a location other than in a permanent retail establishment, including whether the sale or solicitation of a sale is to any buyer on a buy-sell basis, a deposit-commission basis, or any similar basis for resale by the buyer or any other person.

(bb) the trade or business of the delivery or distribution of weekly or monthly newspapers, including any services directly related to such trade or business.

(II) Substantially all the remuneration, whether or not received in cash, for the performance of the services described in subdivision (I) of this subdivision (C)(xxi) is directly related to sales or other output, including the performance of services, rather than to the number of hours worked.

(III) The services performed by the individual are performed pursuant to a written contract between the individual and the person for whom the services are performed, and the contract provides that the individual will not be treated as an employee for federal and state tax purposes.

* * *

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. 21 V.S.A. § 385a is added to read:

§ 385a. REQUIRED APPAREL

An employer that requires its employees to wear apparel which displays the employer's trademark, logo, or other identifying characteristic, or that requires its employees to wear apparel sold or produced by the employer shall furnish and replace as necessary at least one week's worth of apparel free of charge to the employees. An employee shall be responsible for maintaining the apparel in good condition.

Fourth: By adding a new section to be numbered Sec. 8 to read as follows:

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.

And that when so amended the bill ought to pass.

Thereupon, pending the question, Shall the bill be amended as recommended by the Committee on Finance?, on motion of Senator Galbraith the question was divided and that the *third* proposal of amendment be considered separately.

Thereupon, the question, Shall the bill be amended as recommended by the Committee on Finance in the *first*, *second* and *fourth* proposals of amendment?, were decided in the affirmative.

Thereupon, the question, Shall the bill be amended as recommended by the Committee on Finance in the *third* proposal of amendment?, was decided in the affirmative.

Thereupon, the bill was read the second time by title only pursuant to Rule 43.

Thereupon, pending the question, Shall the bill be read a third time?, Senator Sears moved that the bill be amended by striking out Sec. 6 in its entirety.

Which was disagreed to on a roll call, Yeas 7, Nays 23.

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

Roll Call

Those Senators who voted in the affirmative were: Brock, Carris, Flory, Hartwell, Mazza, Mullin, Sears.

Those Senators who voted in the negative were: Ashe, Ayer, Baruth, Benning, Campbell, Cummings, Doyle, Fox, Galbraith, Giard, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, McCormack, Miller, Nitka, Pollina, Snelling, Starr, Westman, White.

Thereupon, the question, Shall the bill be read a third time?, was agreed to on a roll call, Yeas 29, Nays 1.

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

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Baruth, Benning, Brock, Campbell, Carris, Cummings, Doyle, Fox, Galbraith, Giard, Hartwell, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, Mazza, McCormack, Miller, Mullin, Nitka, Pollina, Sears, Snelling, Starr, Westman, White.

The Senator who voted in the negative was: Flory.

Third Reading Ordered

H. 428.

Senator Kittell, for the Committee on Education, to which was referred House bill entitled:

An act relating to requiring supervisory unions to perform common duties.

Reported that the bill ought to pass in concurrence.

Thereupon, the bill was read the second time by title only pursuant to Rule 43.

Thereupon, pending the question, Shall the bill be read a third time?, Senator Illuzzi moved that the Senate propose to the House to amend the bill by striking out Sec. 3 in its entirety and inserting in lieu thereof two new sections to be numbered Sec. 3 and Sec. 4 to read as follows:

Sec. 3. SUPERINTENDENT VACANCY; STRUCTURAL CHANGES

(a) The state board of education shall require that any supervisory union, including a supervisory district, that wishes to hire a superintendent shall:

(1) operate without a superintendent or hire a superintendent for a period that does not extend beyond the last day of the next fiscal year; and

(2) explore structural changes that will result in real dollar efficiencies, operational efficiencies, expanded student learning opportunities, and improved student outcomes. The supervisory union shall report the results of its exploration to the state board within 24 months after the meeting at which the board instructs the supervisory union to begin the exploration.

Sec. 4. EFFECTIVE DATES

Sec. 1 and Sec. 2 shall take effect on passage. Sec. 3 shall take effect on passage and shall apply to all supervisory unions that are not employing a permanent superintendent on that date.

Which was disagreed to.

Thereupon, pending the question, Shall the bill be read third time?, Senator Sears moved to amend bill in Sec. 2, 16 V.S.A. § 1431, by striking out subsection (d) in its entirety and inserting in lieu thereof a new subsection (d) to read as follows:

(d) Participation in athletic activity. A coach shall not permit a youth athlete to train or compete with a school athletic team if the athlete has been removed, prohibited, or otherwise discontinued from participating in any training session or competition associated with a school athletic team due to symptoms of a concussion or other head injury, until the athlete has been examined by and received written permission to participate in athletic activities from a licensed health care provider trained in the evaluation and management of concussions and other head injuries.

Thereupon, pending the question, Shall the Senate propose to the House to amend the bill as proposed by Senator Sears?, Senator Sears requested and was granted leave to with the proposal of amendment.

Thereupon, third reading of the bill was ordered.

Rules Suspended; Bills on Notice Calendar for Immediate Consideration

On motion of Senator Campbell, the rules were suspended, and the following bills and Joint resolution, appearing on the Calendar for notice, were ordered to be brought up for immediate consideration:

S. 108, H. 26, H. 202, H. 443, J.R.H. 19.

**Report of Committee of Conference Accepted and Adopted on the Part of
the Senate; Rules Suspended; Bill Messaged**

H. 202.

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

To the Senate and House of Representatives:

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

An act relating to 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 out 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 care 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

Thereupon, the question, Shall the Senate accept and adopt the report of the Committee of Conference?, was decided in the affirmative on a roll call, Yeas 21, Nays 9.

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

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Baruth, Campbell, Carris, Cummings, Fox, *Galbraith, Giard, Hartwell, Kitchel, Kittell, Lyons, MacDonald, McCormack, Miller, Mullin, Nitka, Pollina, Sears, White.

Those Senators who voted in the negative were: Benning, Brock, Doyle, Flory, Illuzzi, Mazza, Snelling, Starr, Westman.

*Senator Galbraith explained his vote as follows:

“Mr. President:

“I voted yes because I believe strongly in the goal of H. 202 to establish a publicly-financed, government-run health care program so that all Vermonters have quality health care by right. Were I designing a health care system from scratch, I would have gone beyond H. 202 to make hospitals public institutions and Doctors and other medical personnel public employees.

“But, we are not creating a health care system from scratch. We have to work with the patchwork system of health care that already exists in this country. We must be pragmatic. I am concerned that so much in this bill is

not pragmatic. The bill avoids the difficult issue of financing. The Conference Committee decided that Green Mountain care must cover Vermonters serving in the military even though they already have publicly-funded, government-provided health care and even though Green Mountain Care cannot possibly serve their needs. The bill also forces federal employees and retirees who have health care as a retirement benefit into the system even when it would save the state money not to include them

“Vermont has a history of enacting comprehensive health care plans that never materialize. Unless we are pragmatic, the promise in the bill will never become a reality.”

Thereupon, on motion of Senator Campbell, the rules were suspended, and the bill was ordered messaged to the House forthwith.

**Proposal of Amendment Amended; Bill Passed in Concurrence with
Proposal of Amendment**

H. 264.

House bill entitled:

An act relating to driving while intoxicated and to forfeiture and registration of motor vehicles .

Was taken up.

Thereupon, pending third reading of the bill, Senator Illuzzi moved that the Senate propose to the House to as follows:

First: In Sec. 2, 23 V.S.A. § 1130(c)(1), after the words “No person who owns or is” by striking out the word “under” and inserting in lieu thereof the word in

Second: In Sec. 4, 23 V.S.A. § 1210(f), by striking out subdivision (3) in its entirety and inserting in lieu thereof a new subdivision (3) to read as follows:

(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.

Third: In Sec. 4, 23 V.S.A. § 1210(g), by striking out subdivision (3) in its entirety and inserting in lieu thereof a new subdivision (3) to read:

(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.

Fourth: In Sec. 18, by striking subsections (a), (b) and (c) in their entirety and inserting in lieu thereof new subsections (a), (b), (c) and (d) to read as follows:

(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.

Which was agreed.

Thereupon, pending the question, Shall the bill be read third time?, Senators Flory and Illuzzi moved to amend the Senate proposal of amendment in Sec. 2, 23 V.S.A. § 1130, by striking out subsection (c) in its entirety and inserting in lieu thereof a new subsection (c) to read as follows:

(c)(1) No person who owns or is under control of a vehicle shall knowingly 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.

(2) As used in this section, “enable another person to operate the motor vehicle” means to 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.

(e) In a prosecution under this section, the defendant may raise as an affirmative defense to be proven by a preponderance of the evidence that the unlicensed person obtained permission from the defendant to operate the motor vehicle by placing the defendant under duress or subjecting the defendant to coercion.

Thereupon, pending the question, Shall the Senate proposal of amendment be amended as recommended by Senators Illuzzi and Flory?, Senator Flory requested and was granted leave to withdraw the proposal of amendment.

Thereupon, the bill was read the third time and passed in concurrence with proposal of amendment, on a roll call, Yeas 29, Nays 0.

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

Roll Call

Those Senators who voted in the affirmative were: Ashe, Ayer, Baruth, Benning, Brock, Campbell, Carris, Doyle, Flory, Fox, Galbraith, Giard, Hartwell, Illuzzi, Kitchel, Kittell, Lyons, MacDonald, Mazza, McCormack, Miller, Mullin, Nitka, Pollina, Sears, Snelling, Starr, Westman, White.

Those Senators who voted in the negative were: None.

The Senator absent and not voting was: Cummings.

Proposal of Amendment; Third Reading Ordered

H. 198.

Senator Flory, for the Committee on Transportation, to which was referred House bill entitled:

An act relating to a transportation policy to accommodate all users.

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

Sec. 1. 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.

~~(e)~~(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.

And that the bill ought to pass in concurrence with such proposal of amendment.

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

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

H. 26.

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

To the Senate and House of Representatives:

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

An act relating to limiting the application of fertilizer containing phosphorus or nitrogen 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
ROBERT LEWIS*

Committee on the part of the House

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

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

H. 443.

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

To the Senate and House of Representatives:

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

An act relating to the state's transportation program.

Respectfully reports that it has met and considered the same and recommends 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:

<u>FY12</u>	<u>As Proposed</u>	<u>As Amended</u>	<u>Change</u>
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:

<u>FY12</u>	<u>As Proposed</u>	<u>As Amended</u>	<u>Change</u>
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:

<u>FY12</u>	<u>As Proposed</u>	<u>As Amended</u>	<u>Change</u>
Construction	250,000	300,000	50,000
Total	250,000	300,000	50,000
<u>Sources of funds</u>			
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.

<u>FY12</u>	<u>As Proposed</u>	<u>As Amended</u>	<u>Change</u>
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
<u>Sources of funds</u>			
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:

<u>FY12</u>	<u>As Proposed</u>	<u>As Amended</u>	<u>Change</u>
Grants	375,000	390,000	15,000
Total	375,000	390,000	15,000
<u>Sources of funds</u>			
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 to 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. 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.

~~(e)~~(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
M. JANE KITCHEL
RICHARD A. WESTMAN*

Committee on the part of the Senate

*PATRICK M. BRENNAN
DAVID E. POTTER
TIMOTHY R. CORCORAN*

Committee on the part of the House

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

Rules Suspended; Bill Passed

S. 95.

Pending entry on the Calendar for action tomorrow, on motion of Senator Campbell, the rules were suspended and Senate bill entitled:

An act relating to exemptions for newspaper deliverers from the unemployment statutes; relieving an employer's experience rating record of charges; studying the receipt of unemployment compensation between academic terms; allowing school employees to be paid wages over the course of a year; and requiring employers to furnish required work apparel.

Was placed on all remaining stages of its passage forthwith.

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

Rules Suspended; Bill Passed in Concurrence with Proposals of Amendment; Bill Messaged

H. 198.

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

An act relating to a transportation policy to accommodate all users.

Was placed on all remaining stages of its passage in concurrence with proposal of amendment forthwith.

Thereupon, the bill was read the third time and passed in concurrence with proposals of amendment.

Thereupon, on motion of Senator Campbell, the rules were suspended and the bill was ordered messaged to the House forthwith.

Rules Suspended; Bills Messaged

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

H. 11, H. 26, H. 201, H. 264, H. 443.

Recess

On motion of Senator Campbell the Senate recessed until the fall of the gavel.

Called to Order

The Senate was called to order by the President.

Message from the House No. 66

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

Mr. President:

I am directed to inform the Senate that:

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

H. 237. An act relating to the use value program.

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

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

S. 77. An act relating to water testing of private wells.

S. 92. An act relating to the protection of students' health by requiring the use of safe cleaning products in schools.

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

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

H. 153. An act relating to human trafficking.

H. 438. An act relating to the department of banking, insurance, securities, and health care administration.

H. 448. An act relating to contributions to the state and municipal employees' retirement systems.

And has severally concurred therein.

The House has considered the report of the Committee of Conference upon the disagreeing votes of the two Houses on Senate bill of the following title:

S. 94. An act relating to miscellaneous amendments to the motor vehicle laws.

And has adopted the same on its part.

House Proposal of Amendment Concurred In with Amendment; Rules Suspended; Bill Messaged

S. 108.

House proposal of amendment to Senate bill entitled:

An act relating to effective strategies to reduce criminal recidivism.

Was taken up.

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

Sec. 1. FINDINGS

The general assembly finds:

(1) From 1996 to 2006, Vermont's prison population doubled. To accommodate this increase, spending on corrections increased 129 percent from \$48 million in fiscal year 1996 to \$130 million in fiscal year 2008. Yet during this time, Vermont's crime rate remained stable and the state has one of the lowest crime rates in the country.

(2) In 2008, the Pew Center on the States estimated that if trends continued, the state prison population would increase 23 percent by 2018, resulting in additional costs of \$82 to \$206 million. In an effort to stem the growth of the prison population, reduce spending on corrections, and increase public safety, the legislature passed justice reinvestment legislation in 2008. Since that time, Vermont's prison population growth has slowed, and in the last year has declined.

(3) A key component to justice reinvestment is using evidence-based practices to reduce recidivism. The Council of State Government's Justice

Center, a leader in providing nonpartisan advice to states on justice reinvestment issues, has identified four key areas to form the basis of criminal justice policy decisions aimed at reducing recidivism.

(A) Focus on the offenders most likely to commit crimes. Studies show that intensive supervision and incarceration can actually increase recidivism rates for low-risk offenders; thus, identifying exactly who should be the focus of the state's efforts is critical.

(B) Invest in programs that work and ensure that they are working well. Drug treatment both in prison and the community, cognitive-behavioral treatment programs, and intensive community supervision combined with treatment oriented programs have shown to reduce recidivism.

(C) Strengthen supervision and deploy swift and certain sanctions. Policymakers should ensure that the offenders most likely to reoffend receive the most intensive supervision, and balance monitoring compliance with participation in programs that can reduce risk to public safety, and respond with immediate, certain, and proportional sanctions.

(D) Use strategies that reduce recidivism in communities where there are a high number of persons under the supervision of the department of corrections.

(4) No national standard exists for defining recidivism. Measures of recidivism used by various correctional agencies include arrest, convictions and return to incarceration. Standard follow-up periods are also essential in comparing recidivism rates. Vermont's primary method of measuring recidivism is the percent of offenders reconvicted for a new offense within three years, which currently stands at 52 percent. However, most states and the Bureau of Justice Statistics use the percent of offenders returned to prison for a new sentence of one year or more or for a revocation of supervision to measure recidivism. Thus, Vermont includes some offenders in recidivist populations who are not counted in other jurisdictions.

* * * Indeterminate Sentences * * *

Sec. 2. 13 V.S.A. § 7031 is amended to read:

§ 7031. FORM OF SENTENCES; MAXIMUM AND MINIMUM TERMS

(a) When a respondent is sentenced to any term of imprisonment, other than for life, the court imposing the sentence shall not fix the term of imprisonment, unless such term is definitely fixed by statute, but shall establish a maximum and may establish a minimum term for which such respondent may be held in imprisonment. The maximum term shall not be more than the longest term fixed by law for the offense of which the respondent is convicted and the minimum term shall be not less than the shortest term fixed by law for such offense. If the court suspends a portion of said sentence, the unsuspended portion of such sentence shall be the minimum term of sentence solely for the purpose of any reductions. A sentence shall not be considered fixed as long as the maximum and minimum terms are not identical.

* * *

* * * Nonviolent Misdemeanors * * *

Sec. 3. 28 V.S.A. § 808 is amended to read:

§ 808. FURLOUGHS GRANTED TO ~~INMATES~~ OFFENDERS

(a) The department may extend the limits of the place of confinement of an ~~inmate~~ offender at any correctional facility if the ~~inmate~~ offender agrees to comply with such conditions of supervision the department, in its sole discretion, deems appropriate for that ~~inmate's~~ offender's furlough. The department may authorize furlough for any of the following reasons:

- (1) To visit a critically ill relative.
- (2) To attend a the funeral of a relative.
- (3) To obtain medical services.
- (4) To contact prospective employers.
- (5) To secure a suitable residence for use upon discharge.

(6) To continue the process of reintegration initiated in a correctional facility. The ~~inmate~~ offender may be placed in a program of conditional reentry status by the department upon the ~~inmate's~~ offender's completion of the minimum term of sentence. While on conditional reentry status, the ~~inmate~~ offender shall be required to participate in programs and activities that hold the ~~inmate~~ offender accountable to victims and the community pursuant to section 2a of this title.

~~(7) When recommended by the department and ordered by a court.~~

~~(A) Treatment furlough. The inmate may be sentenced to serve a term of imprisonment but placed by a court on furlough to participate in such programs administered by the department in the community that reduce the offender's risk to reoffend or that provide reparation to the community in the form of supervised work activities.~~

~~(B)(i) Home confinement furlough. The inmate may be sentenced to serve a term of imprisonment but placed by a court on home confinement furlough that restricts the defendant to a preapproved place of residence continuously, except for authorized absences, enforced by appropriate means of supervision, including electronic monitoring and other conditions such as limitations on alcohol, visitors, and access to firearms imposed by the court, the department, or both. A sentence to home confinement furlough shall not exceed a total of 180 days and shall require the defendant:~~

~~(I) to remain at a preapproved residence at all times except for scheduled and preapproved absences for work, school, treatment, attorney appointments, court appearances, and other obligations as the court may order; or~~

~~(II) to remain at a preapproved residence 24 hours a day on lock-down status except for medical appointments and court appearances.~~

~~(ii) In determining whether a home confinement furlough sentence is appropriate and whether a place of residence is suitable for such a sentence, the court shall consider:~~

~~(I) the nature of the offense with which the defendant was charged and the nature of the offense with which the defendant was convicted;~~

~~(II) the defendant's criminal history record, history of violence, medical and mental health needs, history of supervision, and risk of flight; and~~

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

~~(8) To prepare for reentry into the community.~~

~~(A) Any offender sentenced to incarceration may be furloughed to the community up to 180 days prior to completion of the minimum sentence, at the commissioner's discretion and in accordance with rules adopted pursuant to subdivision (C) of this subdivision (8), provided that an offender sentenced to a minimum term of fewer than 365 days shall not be eligible for furlough under this subdivision until the offender has served at least one half of his or her minimum term of incarceration.~~

~~(B) Except as provided in subdivision (D) of this subdivision (8), any offender sentenced to incarceration is eligible to earn five days toward reintegration furlough, to be applied prior to the expiration of the offender's minimum term, for each month served in the correctional facility during which the inmate has complied with the case plan prepared pursuant to subsection 1(b) of this title and has obeyed all rules and regulations of the facility. Days shall be awarded only if the commissioner determines, in his or her sole discretion, that they have been earned in accordance with rules adopted by the department pursuant to subdivision (C) of this subdivision (8) and shall in no event be awarded automatically. The commissioner's determination shall be final. Days earned under this subdivision may be awarded in addition to the reintegration furlough authorized in subdivision (A) of this subdivision (8). The commissioner shall have the discretion to determine the frequency with which calculations under this subdivision shall be made provided they are made at least as frequently as every six months.~~

~~(C) The commissioner may authorize reintegration furlough under subdivisions (A) and (B) of this subdivision (8) only if the days are awarded in accordance with rules adopted pursuant to chapter 25 of Title 3 designed to:~~

~~(i) Evaluate factors such as risk of reoffense, history of violent behavior, history of compliance with community supervision, compliance with the case plan, progress in treatment programs designed to reduce criminal risk, and obedience to rules and regulations of the facility.~~

~~(ii) Ensure adequate departmental supervision of the offender when furloughed into the community.~~

~~(D) The commissioner may not award days toward reintegration furlough under subdivision (B) of this subdivision (8) if the offender is sentenced to a minimum term of incarceration in excess of five years or is incarcerated for a conviction of one or more of the following crimes:~~

~~(i) Arson causing death as defined in 13 V.S.A. § 501;~~

~~(ii) Assault and robbery with a dangerous weapon as defined in subsection 608(b) of Title 13;~~

~~(iii) Assault and robbery causing bodily injury as defined in subsection 608(c) of Title 13;~~

~~(iv) Aggravated assault as defined in 13 V.S.A. § 1024;~~

~~(v) Murder as defined in 13 V.S.A. § 2301;~~

~~(vi) Manslaughter as defined in 13 V.S.A. § 2304;~~

~~(vii) Kidnapping as defined in 13 V.S.A. § 2405;~~

- ~~(viii) Unlawful restraint as defined in 13 V.S.A. §§ 2406 and 2407;~~
~~(ix) Maiming as defined in 13 V.S.A. § 2701;~~
~~(x) Sexual assault as defined in 13 V.S.A. § 3252(a)(1) or (2);~~
~~(xi) Aggravated sexual assault as defined in 13 V.S.A. § 3253;~~
~~(xii) Burglary into an occupied dwelling as defined in 13 V.S.A. § 1201(e); or~~
~~(xiii) Lewd or lascivious conduct with a child as defined in 13 V.S.A. § 2602.~~

~~(E) An offender incarcerated for driving while under the influence of alcohol under subsection 1210(d) or (e) may be furloughed to the community up to 180 days prior to completion of the minimum sentence at the commissioner's discretion and in accordance with rules adopted pursuant to subdivision (C) of this subdivision (8), provided that an offender sentenced to a minimum term of fewer than 270 days shall not be eligible for furlough under this subdivision until the offender has served at least 90 days of his or her minimum term of incarceration and provided that the commissioner uses electronic equipment to continually monitor the offender's location and blood alcohol level, or other equipment such as an alcohol ignition interlock system, or both.~~

~~(F) Prior to release under this subdivision (8), the department shall screen and, if appropriate, assess each felony drug and property offender for substance abuse treatment needs using an assessment tool designed to assess the suitability of a broad range of treatment services, and it shall use the results of this assessment in preparing a reentry plan. The department shall attempt to identify all necessary services in the reentry plan and work with the offender to make connections to necessary services prior to release so that the offender can begin receiving services immediately upon release.~~

(b) An ~~inmate~~ offender granted a furlough pursuant to this section may be accompanied by an employee of the department, in the discretion of the commissioner, during the period of the ~~inmate's~~ offender's furlough. The department may use electronic monitoring equipment such as global position monitoring, automated voice recognition telephone equipment, and transdermal alcohol monitoring equipment to enable more effective or efficient supervision of individuals placed on furlough.

(c) The extension of the limits of the place of confinement authorized by this section shall in no way be interpreted as a probation or parole of the ~~inmate~~ offender, but shall constitute solely a permitted extension of the limits

of the place of confinement for ~~inmates~~ offenders committed to the custody of the commissioner.

(d) When any enforcement officer, as defined in 23 V.S.A. § 4, employee of the department, or correctional officer responsible for supervising an offender believes the offender is in violation of any verbal or written condition of the furlough, the officer or employee may immediately lodge the offender at a correctional facility or orally or in writing deputize any law enforcement officer or agency to arrest and lodge the offender at such a facility. The officer or employee shall subsequently document the reason for taking such action.

(e) ~~{Deleted.}~~

~~(f) Medical furlough.~~ The commissioner may place on medical furlough any ~~inmate~~ offender who is serving a sentence, including an ~~inmate~~ offender who has not yet served the minimum term of the sentence, who is diagnosed as suffering from a terminal or debilitating condition so as to render the ~~inmate~~ offender unlikely to be physically capable of presenting a danger to society. The commissioner shall develop a policy regarding the application for, standards for eligibility of and supervision of persons on medical furlough. The ~~inmate~~ offender may be released to a hospital, hospice, other licensed inpatient facility or other housing accommodation deemed suitable by the commissioner.

~~(g) Treatment furlough.~~ ~~The department may place on furlough an inmate who has not yet served the minimum term of the sentence, provided the approval of the sentencing judge is first obtained, who, in the department's determination, needs residential treatment services not available in a correctional facility. The services may include treatment for substance abuse or personal violence or any other condition that the department has determined should be addressed in order to reduce the inmate's risk to reoffend or cause harm to himself or herself or to others in the facility. The inmate shall be released only to a hospital or residential treatment facility that provides services to the general population. The state's share of the cost of placement in such a facility, net of any private or federal participation, shall be paid pursuant to memoranda of agreement between and within state agencies reflective of their shared responsibilities to maximize the efficient and effective use of state resources. In the event that a memorandum of agreement cannot be reached, the secretary of administration shall make a final determination as to the manner in which costs will be allocated.~~

~~(h)~~(f) While appropriate community housing is an important consideration in release of ~~inmates~~ offenders, the department of corrections shall not use lack of housing as the sole factor in denying furlough to ~~inmates~~ offenders who have served at least their minimum sentence for a nonviolent misdemeanor or

nonviolent felony provided that public safety and the best interests of the inmate offender will be served by reentering the community on furlough.

(g) Subsections (b)–(f) of this section shall also apply to sections 808a and 808c of this title.

Sec. 3a. 28 V.S.A. §§ 808a–808d are added to read:

§ 808a. TREATMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on treatment furlough to participate in such programs administered by the department in the community that reduce the offender's risk to reoffend or that provide reparation to the community in the form of supervised work activities.

(b) Provided the approval of the sentencing judge is first obtained, the department may place on treatment furlough an offender who has not yet served the minimum term of the sentence, who, in the department's determination, needs residential treatment services not available in a correctional facility. The services may include treatment for substance abuse or personal violence or any other condition that the department has determined should be addressed in order to reduce the offender's risk to reoffend or cause harm to himself or herself or to others in the facility. The offender shall be released only to a hospital or residential treatment facility that provides services to the general population. The state's share of the cost of placement in such a facility, net of any private or federal participation, shall be paid pursuant to memoranda of agreement between and within state agencies reflective of their shared responsibilities to maximize the efficient and effective use of state resources. In the event that a memorandum of agreement cannot be reached, the secretary of administration shall make a final determination as to the manner in which costs will be allocated.

(c)(1) Except as provided in subdivision (2) of this subsection, the department, in its own discretion, may place on treatment furlough an offender who has not yet served the minimum term of his or her sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism. An offender shall not be eligible for treatment furlough under this subdivision, if, at the time of sentencing, the court makes written findings that treatment furlough is not likely to ensure public safety or victim safety, or is not likely to reduce the risk of recidivism for the offender.

(2) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(c) and boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323 shall be considered eligible misdemeanors for the sole purpose of subdivision (1) of this subsection.

§ 808b. HOME CONFINEMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on home confinement furlough that restricts the defendant to a preapproved place of residence continuously, except for authorized absences. Home confinement furlough shall be enforced by appropriate means of supervision, including electronic monitoring and other conditions such as limitations on alcohol, visitors, and access to firearms imposed by the court, the department, or both.

(b) The department, in its own discretion, may place on home confinement furlough an offender who has not yet served the minimum term of the sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism. An offender shall not be eligible for home confinement furlough under this subsection, if, at the time of sentencing, the court makes written findings that home confinement furlough is not likely to ensure public safety or victim safety, or is not likely to reduce the risk of recidivism for the offender, or the criteria for a home confinement furlough set forth in this section have not been met. Such a finding shall be set forth as a condition on the mittimus.

(c) A home confinement furlough shall not exceed a total of 180 days and shall require the defendant:

(1) to remain at a preapproved residence at all times except for scheduled and preapproved absences for work, school, treatment, attorney appointments, court appearances, and other obligations as the court may order; or

(2) to remain at a preapproved residence 24 hours a day on lock-down status except for medical appointments and court appearances.

(d) In determining whether a home confinement furlough sentence is appropriate and whether a place of residence is suitable for such a sentence, all of the following shall be considered:

(1) The nature of the offense with which the defendant was charged and the nature of the offense of which the defendant was convicted.

(2) The defendant's criminal history record, history of violence, medical and mental health needs, history of supervision, and risk of flight.

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

(e) At the request of the department, the court may vacate a condition of a mittimus prohibiting home confinement issued under subsection (b) of this section, based upon a showing of changed circumstances by the department.

§ 808c. REINTEGRATION FURLOUGH

(a)(1) To prepare for reentry into the community, an offender sentenced to incarceration may be furloughed to the community up to 180 days prior to completion of the minimum sentence, at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (c) of this section. Except as provided in subdivision (2) of this subsection, an offender sentenced to a minimum term of fewer than 365 days shall not be eligible for furlough under this subdivision until the offender has served at least one-half of his or her minimum term of incarceration.

(2) An offender sentenced to a minimum term of fewer than 365 days for an eligible misdemeanor as defined in section 808d of this title shall be eligible for furlough under this subdivision, provided the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism. An offender shall not be eligible for a reintegration furlough under this subdivision if, at the time of sentencing, the court makes written findings that it is not likely to ensure public safety or victim safety, or is not likely to reduce the risk of recidivism for the offender.

(b) Except as provided in subsection (d) of this section, an offender sentenced to incarceration is eligible to earn five days toward reintegration furlough, to be applied prior to the expiration of the offender's minimum term, for each month served in the correctional facility during which the offender has complied with the case plan prepared pursuant to subsection 1(b) of this title and has obeyed all rules and regulations of the facility. Days shall be awarded only if the commissioner determines, in his or her sole discretion, that they have been earned in accordance with rules adopted by the department pursuant to subsection (c) of this section and shall in no event be awarded automatically. The commissioner's determination shall be final. Days earned under this subsection may be awarded in addition to the reintegration furlough authorized in subsection (a) of this section. The commissioner shall have the discretion to

determine the frequency with which calculations under this subsection shall be made provided they are made at least as frequently as every six months.

(c) The commissioner may authorize reintegration furlough under subsections (a) and (b) of this section only if the days are awarded in accordance with rules adopted pursuant to chapter 25 of Title 3 designed to do the following:

(1) Evaluate factors such as risk of reoffense, history of violent behavior, history of compliance with community supervision, compliance with the case plan, progress in treatment programs designed to reduce criminal risk, and obedience to rules and regulations of the facility.

(2) Ensure adequate departmental supervision of the offender when furloughed into the community.

(d) The commissioner may not award days toward reintegration furlough under subsection (b) of this section if the offender is sentenced to a minimum term of incarceration in excess of five years or is incarcerated for a conviction of one or more of the following crimes:

(1) Arson causing death as defined in 13 V.S.A. § 501;

(2) Assault and robbery with a dangerous weapon as defined in 13 V.S.A. § 608(b);

(3) Assault and robbery causing bodily injury as defined in 13 V.S.A. § 608(c);

(4) Aggravated assault as defined in 13 V.S.A. § 1024;

(5) Murder as defined in 13 V.S.A. § 2301;

(6) Manslaughter as defined in 13 V.S.A. § 2304;

(7) Kidnapping as defined in 13 V.S.A. § 2405;

(8) Unlawful restraint as defined in 13 V.S.A. §§ 2406 and 2407;

(9) Maiming as defined in 13 V.S.A. § 2701;

(10) Sexual assault as defined in 13 V.S.A. § 3252(a)(1) or (2);

(11) Aggravated sexual assault as defined in 13 V.S.A. § 3253;

(12) Burglary into an occupied dwelling as defined in 13 V.S.A. § 1201(c); or

(13) Lewd or lascivious conduct with a child as defined in 13 V.S.A. § 2602.

(e) An offender incarcerated for driving while under the influence of alcohol under 23 V.S.A. § 1210(d) or (e) may be furloughed to the community up to 180 days prior to completion of the minimum sentence at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (d) of this section, provided that an offender sentenced to a minimum term of fewer than 270 days shall not be eligible for furlough under this subsection until the offender has served at least 90 days of his or her minimum term of incarceration and provided that the commissioner uses electronic equipment to monitor the offender's location and blood alcohol level continually, or other equipment such as an alcohol ignition interlock system, or both.

(f) Prior to release under this section, the department shall screen and, if appropriate, assess each felony drug and property offender for substance abuse treatment needs using an assessment tool designed to assess the suitability of a broad range of treatment services, and it shall use the results of this assessment in preparing a reentry plan. The department shall attempt to identify all necessary services in the reentry plan and work with the offender to make connections to necessary services prior to release so that the offender can begin receiving services immediately upon release.

§ 808d. DEFINITION; ELIGIBLE MISDEMEANOR; FURLOUGH AT THE DISCRETION OF THE DEPARTMENT

For purposes of sections 808a–808c of this title, “eligible misdemeanor” means a misdemeanor crime that is not one of the following crimes:

(1) Cruelty to animals involving death or torture as defined in 13 V.S.A. § 352(1) and (2).

(2) Simple assault as defined in 13 V.S.A. § 1023(a)(1).

(3) Simple assault with a deadly weapon as defined in 13 V.S.A. § 1023(a)(2).

(4) Simple assault of a law enforcement officer, firefighter, emergency medical personnel member, or health care worker while he or she is performing a lawful duty as defined in 13 V.S.A. § 1023(a)(1).

(5) Reckless endangerment as defined in 13 V.S.A. § 1025.

(6) Simple assault of a correctional officer as defined in 13 V.S.A. § 1028a(a)(1).

(7) Simple assault of a correctional officer as defined in 13 V.S.A. § 1028a(b).

(8) Violation of an abuse prevention order, first offense, as defined in 13 V.S.A. § 1030.

(9) Stalking as defined in 13 V.S.A. § 1062.

(10) Domestic assault as defined in 13 V.S.A. § 1042.

(11) Cruelty to children over 10 years of age by one over 16 years of age as defined in 13 V.S.A. § 1304.

(12) Cruelty by a person having custody of another as defined in 13 V.S.A. § 1305.

(13) Abuse, neglect, or exploitation of a vulnerable adult as provided in 13 V.S.A. §§ 1376-1381.

(14) Hate-motivated crime as defined in 13 V.S.A. § 1455 or burning of a cross or other religious symbol as defined in 13 V.S.A. § 1456.

(15) Voyeurism as defined in 13 V.S.A. § 2605.

(16) Prohibited acts as defined in 13 V.S.A. § 2632.

(17) Obscenity as defined in chapter 63 of Title 13.

(18) Possession of child pornography as defined in 13 V.S.A. § 2827.

(19) Possession of a dangerous or deadly weapon in a school bus or school building as defined in 13 V.S.A. § 4004(a).

(20) Possession of a dangerous or deadly weapon on school property with intent to injure as defined in 13 V.S.A. § 4004(b).

(21) Possession of a firearm in court as defined in 13 V.S.A. § 4016(b)(1).

(22) Possession of a dangerous or deadly weapon in court as defined in 13 V.S.A. § 4016(b)(2).

(23) Failure to comply with the sex offender registry as defined in 13 V.S.A. § 5409.

(24) Careless or negligent operation of a motor vehicle resulting in serious bodily injury or death as defined in 23 V.S.A. § 1091(b).

(25) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(c).

(26) Boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323.

Sec. 3b. EMERGENCY RULES

The department of corrections may adopt emergency rules in accordance with 3 V.S.A. § 844 for the purpose of compliance with 28 V.S.A. § 808c(c) as it relates to 28 V.S.A. § 808c(a)(2).

Sec. 4. NONVIOLENT MISDEMEANOR SENTENCE REVIEW COMMITTEE

(a) Creation of committee. There is created a nonviolent misdemeanor sentence review committee to propose alternatives to incarceration for nonviolent, low-risk misdemeanor offenses.

(b) Membership. The committee shall be composed of the following members:

(1) the chair of the senate committee on judiciary;

(2) the chair of the house committee on judiciary;

(3) a member of the senate appointed by the senate committee on committees;

(4) a member of the house appointed by the speaker of the house;

(5) the governor's special assistant on corrections; and

(6) the administrative judge.

(c) Powers and duties.

(1) The committee shall:

(A) Review the statutory sentences for all nonviolent misdemeanor offenses as defined in 28 V.S.A. § 301.

(B) Consider whether incarceration for such misdemeanors may be counterproductive because it disrupts stabilizing factors such as housing, employment, and treatment.

(C) Examine the policy of housing low-risk misdemeanants with the general prison population and whether alternatives should be employed.

(D) Consider restorative justice principles in its deliberations.

(2) The committee shall consult stakeholders while engaging in its mission.

(3) For purposes of its study of these issues, the committee shall have the legal and administrative assistance of the office of legislative council and the department of corrections.

(d) Report. By December 1, 2011, the committee shall report to the general assembly on its findings and any recommendations for legislative action.

(e) Number of meetings; term of committee; reimbursement. The committee may meet no more than five times and shall cease to exist on January 1, 2012.

(f) Reimbursement. For attendance at meetings during adjournment of the general assembly, legislative members of the committee shall be entitled to compensation and reimbursement for expenses as provided in 2 V.S.A. § 406; and other members of the committee who are not employees of the state of Vermont shall be reimbursed at the per diem rate set in 32 V.S.A. § 1010.

* * * Measuring Recidivism * * *

Sec. 5. STANDARD MEASURE OF RECIDIVISM

(a) Currently, no national standard exists for defining recidivism. Measures of recidivism used by correctional agencies include arrest, convictions, and return to incarceration. Standard follow-up periods are also necessary when comparing recidivism rates. In general, offenders tracked for three years will have higher recidivism rates than offenders only tracked for one year due to a longer period at risk.

(b)(1) In order to target sentences and services effectively to reduce recidivism, the department of corrections shall calculate the rate of recidivism based upon offenders who are sentenced to more than one year of incarceration, who, after release from incarceration, return to prison within three years for a conviction for a new offense or a violation of supervision resulting, and the new incarceration sentence is at least 90 days.

(2) The department shall report on this measure to the general assembly in the department's annual report.

(c) It is the intent of the general assembly that the department of corrections shall generate data based on the measurement described in subsection (b) of this section, including recidivism rates and costs for furlough and intermediate sanctions, and present the data to the joint committee on corrections oversight no later than September 30, 2011.

(d) Upon receipt of the data referred to in subsection (c) of this section and no later than December 15, 2011, the joint committee on corrections oversight, in consultation with the department of corrections, shall establish a goal for reducing the number of recidivists over a one- to two-year period.

Sec. 5a. Sec. D9 of No. 146 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. D9. BUDGETARY SAVINGS; ALLOCATIONS IN FISCAL YEAR 2011

(a) In FY 2011, a total of \$6,350,500.00 in investments in communities and services are included in the department of corrections budget. In Sec. B.338 of H.789 of 2010 (Appropriations Act), a total of \$3,186,000.00 is allocated for investments, and a total of \$3,164,500.00 is allocated in subsection (c) of this section. These investments are intended to result in reduced overall costs in the corrections budget by reducing the levels of incarceration and recidivism. ~~A specific goal of these investments is to reduce the three year recidivism rate from the current level of 53 percent to a level of 40 percent by fiscal year 2014.~~ For each of these investments, the department shall develop benchmarks which can describe how well it is meeting the outcomes in No. 68 of the Acts of the 2009 Adj. Sess. (2010). Where appropriate, the department shall develop these benchmarks in consultation with the organizations with whom it enters into performance-based contracts to carry out these programs and services. The department shall present the benchmarks, and current baselines for each benchmark based on data currently collected to the corrections oversight committee at its meeting in October 2010.

* * *

* * * Strategies * * *

Sec. 6. STRATEGIES TO REDUCE RECIDIVISM

Corrections and law enforcement officials are increasingly interested in sharing information that can lead to more effective resource allocation and coordination to reduce recidivism in communities with a high number of persons under the supervision of the department of corrections. Therefore, the department of corrections shall work with the Vermont League of Cities and Towns, the department of state's attorneys and sheriffs' association, and the association of the chiefs of police to develop strategies that coordinate services provided by state, local, and nonprofit entities to persons in the custody of the commissioner of corrections and that enhance public safety. The department shall keep the joint committee on corrections oversight, the senate and house committees on judiciary, and the house committee on corrections and institutions informed of the groups' efforts on this matter.

* * * Early Screening * * *

Sec. 7. SCREENING CRIMINAL DEFENDANTS AND ALTERNATIVESTO VIDEO ARRAIGNMENT

(a) Screening defendants in the criminal justice system as early as possible to assess risk and needs is essential to reducing recidivism. The court administrator, the commissioner of the department of corrections, the executive

director of the department of state's attorneys and sheriffs, and the defender general shall work cooperatively to develop a statewide plan for screening all persons who are charged with a violent misdemeanor or any felony as early as possible and shall report their efforts to the general assembly no later than October 15, 2011.

(b) The group shall also study and propose alternatives to video arraignments, including the use of conference calls and the existing telephone system used by attorneys to reach their clients in correctional facilities. The group shall report to the house and senate committees on judiciary by October 15, 2011 on the results of the study and status of implementing any alternatives.

* * * Increasing the Use of Home Confinement
as a Sentencing Option * * *

Sec. 8. USE OF HOME CONFINEMENT AS AN ALTERNATIVE TO INCARCERATION IN A CORRECTIONAL FACILITY

(a) In Sec. 7 of No. 157 of the Acts of the 2009 Adj. Sess. (2010), the general assembly created home confinement furlough whereby the court could sentence a person to serve a term of imprisonment but place the person to serve that term continuously at a preapproved residence under numerous restrictions. Between the date of enactment of the new law—July 1, 2010—and February 28, 2011, home confinement was ordered only 25 times. The general assembly finds that the law is not being utilized with the frequency that the general assembly intended.

(b) The administrative judge, the commissioner of the department of corrections, the executive director of the department of state's attorneys and sheriffs, and the defender general shall work individually and cooperatively to increase awareness among attorneys, judges, and probation officers of the option of home confinement as provided in 28 V.S.A. § 808(b).

(c) The entities identified in subsection (b) of this section shall keep the joint committee on corrections oversight, the senate and house committees on judiciary, and the house committee on corrections and institutions informed of their efforts on this matter.

* * * Video Arraignments * * *

Sec. 9. SUSPENSION OF VIDEO ARRAIGNMENTS; REGIONAL ARRANGEMENTS

The general assembly finds that the use of video conferencing for arraignments has resulted in cost-shifting, higher costs, and logistical problems. Therefore, unless it is necessary for the interests of justice, the use

of video conferencing for arraignments shall be suspended until the general assembly determines that there is evidence to support that it can be done in a manner that is cost-effective and efficient and ensures defendants' due process rights.

Sec. 9a. FEASIBILITY STUDY

(a) The general assembly recognizes that the corrections population is part of the greater community and, therefore, any proposed study for the purpose of reforming offender health care should be conducted within the context and framework of the state's ongoing health care reform efforts for the entire state. The general assembly further recognizes that creating barriers to health care based on one's status as an offender is not in the state's best interests because it contradicts Vermont's efforts to create systems of care that work for all Vermonters.

(b) The agency of administration in conjunction with the joint fiscal office shall conduct a study which draws on resources across states agencies on how the state can best provide quality health care services to people incarcerated in Vermont at a cost savings to the state.

(c) The agency of administration will report its progress to the house committee on corrections and institutions and the house and senate committees on judiciary or before January 15, 2012.

* * * Recidivism Reduction Study * * *

Sec. 10. RECIDIVISM REDUCTION STUDY, EVALUATION OF WORK CAMPS; VERMONT CENTER FOR JUSTICE RESEARCH

(a) Research suggests that short, swift and certain sanctions may be effective at reducing recidivism among certain groups of offenders. Programs that employ strategies have shown reduced rates of recidivism, drug use, missed appointments with probation officers, and probation revocations for program participants versus rates for control group participants. The general assembly and representatives of all statewide criminal justice agencies have been working to develop an innovative pilot project to reduce recidivism based on such a model, but more information is needed to ascertain how these principles can be applied in Vermont to achieve clearly stated goals set forth by the joint committee on corrections oversight with respect to reductions in recidivism.

(b) The Vermont center for justice research specializes in collecting and analyzing criminal and juvenile justice information and providing technical assistance to state and local criminal justice agencies. The center shall evaluate innovative programs and initiatives, including local programs and prison-based initiatives, best practices, and contemporary research regarding

assessments of programmatic alternatives and pilot projects relating to reducing recidivism in the criminal justice system. The center's research shall focus on evidence-based initiatives related to swift and sure delivery of sanctions and effective interventions for offenders. The center shall make its recommendations to the senate and house committees on judiciary and the joint committee on corrections oversight by December 1, 2011.

(c) In addition to the requirements of subsection (b) of this section, the center shall conduct an outcome assessment of Vermont's two work camps. The evaluation shall focus on:

(1) The percentage of defendants who recidivate after release from the work camp;

(2) When defendants recidivate after release from the work camp;

(3) The nature of crimes committed by defendants who recidivate; and

(4) In which jurisdictions crimes are committed by recidivists.

(d) The center shall issue a final report of its findings to the senate and house committees on judiciary and the joint committee on corrections oversight by January 15, 2012.

* * * Improving Community Supervision
Through a Reduction of Administrative Burden * * *

Sec. 11. DEPARTMENT OF CORRECTIONS; REDUCTION IN ADMINISTRATIVE REQUIREMENTS FOR PROBATION AND PAROLE OFFICERS

To improve community supervision, the department of corrections shall undertake a review of the administrative requirements placed on field officers and shall reduce paperwork handled by these officers. In its efforts, the department shall strongly consider the use of technology to assist field officers and the efficiency of providing portable devices so that officers would not need to leave the field to file reports. The department shall keep the joint committee on corrections oversight, the senate and house committees on judiciary, and the house committee on corrections and institutions informed of their efforts on this matter.

Sec. 12. APPROPRIATION

(a) There is appropriated in fiscal year 2012 the sum of \$4,800.00 from the general fund to the department of corrections for a grant to the Vermont center for justice research to evaluate innovative programs and initiatives, including local programs and prison-based initiatives, best practices, and contemporary

research regarding assessments of programmatic alternatives and pilot projects relating to reducing recidivism in the criminal justice system.

(b) There is appropriated in fiscal year 2012 the sum of \$5,600.00 from the general fund to the Vermont center for justice research for the purpose of conducting an outcome assessment of Vermont's two work camps.

(c) There is appropriated in fiscal year 2012 the sum of \$4,000.00 from the general fund to the Vermont criminal information center for the purpose of upgrading the Vermont criminal history information program to accept bulk criminal history requests by the name and date of birth of the research subject.

Sec. 13. EFFECTIVE DATES

Sec. 2 of this act shall take effect on passage, and the remainder of the act shall take effect on July 1, 2011.

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

The Senate concurs in the House proposal of amendment with the following proposal of amendment thereto:

First: By adding a new section to be numbered Sec. 1 to read as follows:

Sec. 1. SHORT TITLE

This act may be referred to and cited as "The War on Recidivism Act."

And be renumbering the existing Sec. 1 to be Sec. 1a.

Second: In Sec. 3a, in 28 V.S.A. § 808a(c)(1), by striking out the last sentence, and in 28 V.S.A. § 808b, by striking the last two sentences in subsection (b) and by striking subsection (e) in its entirety, and in 28 V.S.A. § 808c(a)(2), by striking the last sentence.

Third: By adding a new section to be numbered Sec. 3c to read as follows:

Sec. 3c. 28 V.S.A. §§ 808a–808d are amended to read:

§ 808a. TREATMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on treatment furlough to participate in such programs administered by the department in the community that reduce the offender's risk to reoffend or that provide reparation to the community in the form of supervised work activities.

(b) Provided the approval of the sentencing judge is first obtained, the department may place on treatment furlough an offender who has not yet

served the minimum term of the sentence, who, in the department's determination, needs residential treatment services not available in a correctional facility. The services may include treatment for substance abuse or personal violence or any other condition that the department has determined should be addressed in order to reduce the offender's risk to reoffend or cause harm to himself or herself or to others in the facility. The offender shall be released only to a hospital or residential treatment facility that provides services to the general population. The state's share of the cost of placement in such a facility, net of any private or federal participation, shall be paid pursuant to memoranda of agreement between and within state agencies reflective of their shared responsibilities to maximize the efficient and effective use of state resources. In the event that a memorandum of agreement cannot be reached, the secretary of administration shall make a final determination as to the manner in which costs will be allocated.

~~(c)(1) Except as provided in subdivision (2) of this subsection, the department, in its own discretion, may place on treatment furlough an offender who has not yet served the minimum term of his or her sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism.~~

~~(2) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(e) and boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323 shall be considered eligible misdemeanors for the sole purpose of subdivision (1) of this subsection.~~

§ 808b. HOME CONFINEMENT FURLOUGH

(a) An offender may be sentenced to serve a term of imprisonment, but placed by a court on home confinement furlough that restricts the defendant to a preapproved place of residence continuously, except for authorized absences. Home confinement furlough shall be enforced by appropriate means of supervision, including electronic monitoring and other conditions such as limitations on alcohol, visitors, and access to firearms imposed by the court, the department, or both.

~~(b) The department, in its own discretion, may place on home confinement furlough an offender who has not yet served the minimum term of the sentence for an eligible misdemeanor as defined in section 808d of this title if the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism.~~

(c) A home confinement furlough shall not exceed a total of 180 days and shall require the defendant:

(1) to remain at a preapproved residence at all times except for scheduled and preapproved absences for work, school, treatment, attorney appointments, court appearances, and other obligations as the court may order; or

(2) to remain at a preapproved residence 24 hours a day on lock-down status except for medical appointments and court appearances.

(d) In determining whether a home confinement furlough sentence is appropriate and whether a place of residence is suitable for such a sentence, all of the following shall be considered:

(1) The nature of the offense with which the defendant was charged and the nature of the offense of which the defendant was convicted.

(2) The defendant's criminal history record, history of violence, medical and mental health needs, history of supervision, and risk of flight.

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

§ 808c. REINTEGRATION FURLOUGH

(a)(4) To prepare for reentry into the community, an offender sentenced to incarceration may be furloughed to the community up to 180 days prior to completion of the minimum sentence, at the commissioner's discretion and in

accordance with rules adopted pursuant to subsection (c) of this section. ~~Except as provided in subdivision (2) of this subsection, an~~ An offender sentenced to a minimum term of fewer than 365 days shall not be eligible for furlough under this subdivision until the offender has served at least one-half of his or her minimum term of incarceration.

~~(2) An offender sentenced to a minimum term of fewer than 365 days for an eligible misdemeanor as defined in section 808d of this title shall be eligible for furlough under this subdivision, provided the department has made a determination based upon a risk assessment that the offender poses a low risk to public safety or victim safety and that employing an alternative to incarceration to hold the offender accountable is likely to reduce the risk of recidivism.~~

(b) Except as provided in subsection (d) of this section, an offender sentenced to incarceration is eligible to earn five days toward reintegration furlough, to be applied prior to the expiration of the offender's minimum term, for each month served in the correctional facility during which the offender has complied with the case plan prepared pursuant to subsection 1(b) of this title and has obeyed all rules and regulations of the facility. Days shall be awarded only if the commissioner determines, in his or her sole discretion, that they have been earned in accordance with rules adopted by the department pursuant to subsection (c) of this section and shall in no event be awarded automatically. The commissioner's determination shall be final. Days earned under this subsection may be awarded in addition to the reintegration furlough authorized in subsection (a) of this section. The commissioner shall have the discretion to determine the frequency with which calculations under this subsection shall be made provided they are made at least as frequently as every six months.

(c) The commissioner may authorize reintegration furlough under subsections (a) and (b) of this section only if the days are awarded in accordance with rules adopted pursuant to chapter 25 of Title 3 designed to do the following:

(1) Evaluate factors such as risk of reoffense, history of violent behavior, history of compliance with community supervision, compliance with the case plan, progress in treatment programs designed to reduce criminal risk, and obedience to rules and regulations of the facility.

(2) Ensure adequate departmental supervision of the offender when furloughed into the community.

(d) The commissioner may not award days toward reintegration furlough under subsection (b) of this section if the offender is sentenced to a minimum term of incarceration in excess of five years or is incarcerated for a conviction of one or more of the following crimes:

-
- (1) Arson causing death as defined in 13 V.S.A. § 501;
 - (2) Assault and robbery with a dangerous weapon as defined in 13 V.S.A. § 608(b);
 - (3) Assault and robbery causing bodily injury as defined in 13 V.S.A. § 608(c);
 - (4) Aggravated assault as defined in 13 V.S.A. § 1024;
 - (5) Murder as defined in 13 V.S.A. § 2301;
 - (6) Manslaughter as defined in 13 V.S.A. § 2304;
 - (7) Kidnapping as defined in 13 V.S.A. § 2405;
 - (8) Unlawful restraint as defined in 13 V.S.A. §§ 2406 and 2407;
 - (9) Maiming as defined in 13 V.S.A. § 2701;
 - (10) Sexual assault as defined in 13 V.S.A. § 3252(a)(1) or (2);
 - (11) Aggravated sexual assault as defined in 13 V.S.A. § 3253;
 - (12) Burglary into an occupied dwelling as defined in 13 V.S.A. § 1201(c); or
 - (13) Lewd or lascivious conduct with a child as defined in 13 V.S.A. § 2602.

(e) An offender incarcerated for driving while under the influence of alcohol under 23 V.S.A. § 1210(d) or (e) may be furloughed to the community up to 180 days prior to completion of the minimum sentence at the commissioner's discretion and in accordance with rules adopted pursuant to subsection (d) of this section, provided that an offender sentenced to a minimum term of fewer than 270 days shall not be eligible for furlough under this subsection until the offender has served at least 90 days of his or her minimum term of incarceration and provided that the commissioner uses electronic equipment to monitor the offender's location and blood alcohol level continually, or other equipment such as an alcohol ignition interlock system, or both.

(f) Prior to release under this section, the department shall screen and, if appropriate, assess each felony drug and property offender for substance abuse treatment needs using an assessment tool designed to assess the suitability of a broad range of treatment services, and it shall use the results of this assessment in preparing a reentry plan. The department shall attempt to identify all necessary services in the reentry plan and work with the offender to make connections to necessary services prior to release so that the offender can begin receiving services immediately upon release.

~~§ 808d. DEFINITION; ELIGIBLE MISDEMEANOR; FURLOUGH AT THE DISCRETION OF THE DEPARTMENT~~

~~For purposes of sections 808a-808c of this title, “eligible misdemeanor” means a misdemeanor crime that is not one of the following crimes:~~

~~(1) Cruelty to animals involving death or torture as defined in 13 V.S.A. § 352(1) and (2).~~

~~(2) Simple assault as defined in 13 V.S.A. § 1023(a)(1).~~

~~(3) Simple assault with a deadly weapon as defined in 13 V.S.A. § 1023(a)(2).~~

~~(4) Simple assault of a law enforcement officer, firefighter, emergency medical personnel member, or health care worker while he or she is performing a lawful duty as defined in 13 V.S.A. § 1023(a)(1).~~

~~(5) Reckless endangerment as defined in 13 V.S.A. § 1025.~~

~~(6) Simple assault of a correctional officer as defined in 13 V.S.A. § 1028a(a)(1).~~

~~(7) Simple assault of a correctional officer as defined in 13 V.S.A. § 1028a(b).~~

~~(8) Violation of an abuse prevention order, first offense, as defined in 13 V.S.A. § 1030.~~

~~(9) Stalking as defined in 13 V.S.A. § 1062.~~

~~(10) Domestic assault as defined in 13 V.S.A. § 1042.~~

~~(11) Cruelty to children over 10 years of age by one over 16 years of age as defined in 13 V.S.A. § 1304.~~

~~(12) Cruelty by a person having custody of another as defined in 13 V.S.A. § 1305.~~

~~(13) Abuse, neglect, or exploitation of a vulnerable adult as provided in 13 V.S.A. §§ 1376-1381.~~

~~(14) Hate motivated crime as defined in 13 V.S.A. § 1455 or burning of a cross or other religious symbol as defined in 13 V.S.A. § 1456.~~

~~(15) Voyeurism as defined in 13 V.S.A. § 2605.~~

~~(16) Prohibited acts as defined in 13 V.S.A. § 2632.~~

~~(17) Obscenity as defined in chapter 63 of Title 13.~~

~~(18) Possession of child pornography as defined in 13 V.S.A. § 2827.~~

~~(19) Possession of a dangerous or deadly weapon in a school bus or school building as defined in 13 V.S.A. § 4004(a).~~

~~(20) Possession of a dangerous or deadly weapon on school property with intent to injure as defined in 13 V.S.A. § 4004(b).~~

~~(21) Possession of a firearm in court as defined in 13 V.S.A. § 4016(b)(1).~~

~~(22) Possession of a dangerous or deadly weapon in court as defined in 13 V.S.A. § 4016(b)(2).~~

~~(23) Failure to comply with the sex offender registry as defined in 13 V.S.A. § 5409.~~

~~(24) Careless or negligent operation of a motor vehicle resulting in serious bodily injury or death as defined in 23 V.S.A. § 1091(b).~~

~~(25) Driving under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. §§ 1201 and 1210(e).~~

~~(26) Boating under the influence of alcohol or drugs, second offense, as defined in 23 V.S.A. § 3323.~~

Fourth: In Sec. 4, by adding a new subdivision (b)(1) to read as follows:

(1) a former member of either the house committee on judiciary or the senate committee on judiciary appointed jointly by the speaker of the house and the senate committee on committees;

and be renumbering the existing subdivisions to be numerically correct

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

Sec. 6. PLACE-BASED STRATEGIES TO REDUCE RECIDIVISM

Some Vermont communities have a disproportionate number of residents who have been through the correctional system. Corrections and law enforcement officials are increasingly interested in sharing information that can lead to more effective resource allocation and coordination to reduce recidivism in communities with a high number of persons under the supervision of the department of corrections. Therefore, the department of corrections shall work with the Vermont League of Cities and Towns, the association of the chiefs of police, and other local law enforcement agencies to develop strategies that coordinate services provided by state, local, and nonprofit entities to persons in the custody of the commissioner of corrections and that enhance public safety. The department shall keep the joint committee on corrections oversight, the senate and house committees on judiciary, and the

house committee on corrections and institutions informed of the groups' efforts on this matter.

Sixth: By striking out Sec. 10 in its entirety and inserting in lieu thereof a new Sec. 10 to read as follows:

Sec. 10. RECIDIVISM REDUCTION STUDY, EVALUATION OF WORK CAMPS; VERMONT CENTER FOR JUSTICE RESEARCH

(a) Research suggests that short, swift and certain sanctions may be effective at reducing recidivism among certain groups of offenders. Programs that employ strategies such as those of Georgia's Probation Options Management (POM) and Hawaii's Opportunity Probation with Enforcement (HOPE) have shown reduced rates of recidivism, drug use, missed appointments with probation officers, and probation revocations for program participants versus rates for control group participants. The general assembly and representatives of all statewide criminal justice agencies have been working to develop an innovative pilot project to reduce recidivism based on such a model, but more information is needed to ascertain how these principles can be applied in Vermont to achieve clearly stated goals set forth by the joint committee on corrections oversight with respect to reductions in recidivism.

(b) The Vermont center for justice research has been engaged in discussions with stakeholders regarding the employment of strategies used in POM and HOPE and specializes in collecting and analyzing criminal and juvenile justice information and providing technical assistance to state and local criminal justice agencies.

(c) The center shall evaluate innovative programs and initiatives, including local programs and prison-based initiatives, best practices, and contemporary research regarding assessments of programmatic alternatives and pilot projects relating to reducing recidivism in the criminal justice system. The center's research shall focus on evidence-based initiatives related to swift and sure delivery of sanctions and effective interventions for offenders. The center shall make its recommendations to the senate and house committees on judiciary and the joint committee on corrections oversight by December 1, 2011.

Seventh: By striking out Sec. 11 in its entirety and inserting in lieu thereof a new Sec. 11 to read as follows:

Sec. 11. DEPARTMENT OF CORRECTIONS; REDUCTION IN ADMINISTRATIVE BURDEN ON PROBATION AND PAROLE OFFICERS

(a) The general assembly finds that the current burden of administrative paperwork on probation and parole officers impedes their ability to supervise

offenders in the community. Additionally, some paperwork, such as the offender responsibility plan, has diverged from its laudable original purpose and become unnecessarily time-consuming for staff and of little value to offenders. Rather than spending time in the field, visiting offenders at home, and checking on employment and housing, officers are forced to spend an inordinate amount of time at their desks filling out paperwork.

(b) To improve community supervision by getting more probation and parole officers out on the streets, the department of corrections shall undertake a review of the administrative burden placed on field officers and shall reduce paperwork handled by these officers by 50 percent as of July 1, 2012. In its efforts, the department shall strongly consider the use of technology to assist field officers and the efficiency of providing portable devices so that officers would not need to leave the field to file reports. The department shall keep the joint committee on corrections oversight, the senate and house committees on judiciary, and the house committee on corrections and institutions informed of their efforts on this matter.

Eighth: By adding a new section to be numbered Sec. 11a to read as follows:

Sec. 11a. 28 V.S.A. § 122 is added to read:

§ 122. CONTRACTING FOR PROGRAMMING AND SERVICES

For the purpose of securing programming and services for offenders, the department of corrections shall publicly advertise or invite three or more bids. The contract for any such programming and services shall be awarded to one of the three lowest responsible bidders, conforming to specification, with consideration being given to the time required for provision of services, purpose for which required, competency and responsibility of bidder, and his or her ability to render satisfactory services, but the commissioner with the approval of the secretary of human services shall have the right to reject any and all bids and to invite other bids.

Ninth: By adding a new section to be numbered Sec. 11b to read as follows:

Sec. 11b. 13 V.S.A. § 5241 is added to read:

§ 5241. MALPRACTICE CLAIM AGAINST DEFENDER GENERAL; SUCCESSFUL INEFFECTIVE ASSISTANCE CLAIM REQUIRED

No action shall be brought for professional negligence against a criminal defense attorney under contract with or providing ad hoc legal services for the office of the defender general unless the plaintiff has first successfully prevailed in a claim for post-conviction relief based upon ineffective assistance

of counsel against that criminal defense attorney in the same or a substantially related matter. Failure to prevail in a claim for post-conviction relief based upon ineffective assistance of counsel against a criminal defense attorney under contract with or providing ad hoc legal services for the office of the defender general shall bar any claim against the attorney based upon the attorney's representation in the same or a substantially related matter.

Tenth: By striking out Sec. 13 in its entirety and inserting in lieu thereof a new Sec. 13 to read as follows:

Sec. 13. EFFECTIVE DATES

- (a) Sec. 2 of this act shall take effect on passage.
- (b) Sec. 3c shall take effect April 1, 2013.
- (c) The remainder of the act shall take effect on July 1, 2011.

Which was agreed to.

Thereupon, on motion of Senator Carris, the rules were suspended, and the bill was ordered messaged to the House forthwith.

Adjournment

On motion of Senator Carris, the Senate adjourned until ten o'clock in the morning.