Journal of the Senate

MONDAY, APRIL 23, 2012

The Senate was called to order by the President.

Devotional Exercises

A moment of silence was observed in lieu of devotions.

Pledge of Allegiance

The President then led the members of the Senate in the pledge of allegiance.

Message from the House No. 56

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

Mr. President:

I am directed to inform the Senate that:

The House has considered the report of the 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.

And has adopted the same on its part.

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

H.C.R. 353. House concurrent resolution designating May 6–12, 2012 as National Nurses Week in Vermont.

H.C.R. 354. House concurrent resolution congratulating the Bromley Mountain Ski Resort and the Bromley Outing Club on celebrating their respective 75th and 60th anniversaries.

H.C.R. 355. House concurrent resolution congratulating the Champlain Valley Union High School Redhawks 2012 Division I championship girls' Nordic ski team.

H.C.R. 356. House concurrent resolution commemorating the 25th anniversary of the Rutland Open Door Mission at its Park Street location.

H.C.R. 357. House concurrent resolution in memory of Allyn Seward of East Wallingford.

H.C.R. 358. House concurrent resolution congratulating Circus Smirkus on its 25th anniversary.

H.C.R. 359. House concurrent resolution congratulating Marita Johnson on being named the Springfield Regional Chamber of Commerce's 23rd Annual Citizen of the Year.

H.C.R. 360. House concurrent resolution honoring Brian Lowe for his volunteer ornithological protection activities.

H.C.R. 361. House concurrent resolution congratulating the Woodstock Union High School Wasps on winning their third consecutive Division II boys' Nordic skiing championship.

H.C.R. 362. House concurrent resolution honoring the educational and community leadership of Jerry Sullivan.

H.C.R. 363. House concurrent resolution congratulating Alfred L. Pinsonneault Jr. on 50 exemplary years of service with the Town of Bennington Rescue Squad, Inc..

H.C.R. 364. House concurrent resolution honoring Andreas Lehner for his outstanding administrative leadership in public education.

H.C.R. 365. House concurrent resolution congratulating the South Burlington Dolphins on winning the 2011 Northern Vermont Youth Football League state championship.

H.C.R. 366. House concurrent resolution designating April as the month of the military child in Vermont.

H.C.R. 367. House concurrent resolution congratulating Blanche Lamore on her 100th birthday.

H.C.R. 368. House concurrent resolution remembering the life of U.S. Army Major Jonathan Kirk Weaver.

H.C.R. 369. House concurrent resolution congratulating the Rochester School winners of the 2012 Vermont aviation art contest.

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

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

S.C.R. 43. Senate concurrent resolution designating May 2012 as Lupus Awareness Month in Vermont.

S.C.R. 44. Senate concurrent resolution congratulating Robert Swartz on being named the 2012 Northeast Kingdom Chamber Citizen of the Year.

S.C.R. 45. Senate concurrent resolution congratulating the 2012 Vermont Prudential Spirit of Community Award winners.

And has adopted the same in concurrence.

Bills Referred

House bills of the following titles were severally read the first time and referred:

H. 533.

An act relating to insurance business transfers.

To the Committee on Rules.

H. 777.

An act relating to licensed midwives and certified nurse midwives.

To the Committee on Rules.

H. 792.

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

To the Committee on Rules.

H. 793.

An act relating to approval of amendments to the charter of the Winooski incorporated school district.

To the Committee on Rules.

H. 794.

An act relating to the management of search and rescue operations.

To the Committee on Rules.

Joint Senate Resolution Adopted on the Part of the Senate

Joint Senate resolution of the following title was offered, read and adopted on the part of the Senate, and is as follows:

By Senators Carris and Mullin,

J.R.S. 59. Joint resolution relating to weekend adjournment.

Resolved by the Senate and House of Representatives:

That when the two Houses adjourn on Thursday, April 26, 2012, or, Friday, April 27, 2012, it be to meet again no later than Tuesday, May 1, 2012.

Committee of Conference Appointed

H. 789.

An act relating to reapportioning the final representative districts of the House of Representatives.

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

Senator White
Senator Sears
Senator Illuzzi

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

Committee of Conference Appointed

H. 770.

An act relating to the state's transportation program.

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

Senator Mazza
Senator Kitchel
Senator Westman

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

Bill Passed in Concurrence

House bill of the following title was read the third time and passed in concurrence:

H. 157. An act relating to restrictions on tanning beds.

Bills Passed in Concurrence with Proposal of Amendment

House bills of the following titles were severally read the third time and passed in concurrence with proposal of amendment:

H. 37. An act relating to telemedicine.

H. 254. An act relating to consumer protection.

H. 496. An act relating to preserving Vermont's working landscape.

H. 627. An act relating to an opioid addiction treatment system.

Proposals of Amendment; Third Reading Ordered

H. 769.

Senator Cummings, for the Committee on Finance, to which was referred House bill entitled:

An act relating to department of environmental conservation fees.

Reported recommending that the Senate propose to the House to amend the bill as follows:

First: In Sec. 1, 3 V.S.A. § 2822(j)(1)(B) by striking out the following: "~~,~~ provided that a plant producing renewable energy as defined in 30 V.S.A. § 8002 shall pay an annual fee not exceeding $64,000.00"

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

Sec. 3. 10 V.S.A. § 1943 is amended to read:

§ 1943. PETROLEUM TANK ASSESSMENT

(a) Each owner of a category one tank used for storage of petroleum products shall remit to the secretary on October 1 of each year ~~beginning October 1, 1988,~~ a fee that shall be deposited in the petroleum cleanup fund established under section 1941 of this title.

(1) For retail gasoline outlets that sell 40,000 gallons or more of motor fuel per month the fee shall be:

(A) $100.00 per double-wall tank~~, which shall be deposited to the petroleum cleanup fund established by section 1941 of this title, except that:~~ system;

(B) $150.00 per combination tank system on October 1, 2012; $250.00 on October 1, 2013; $350.00 on October 1, 2014; and

(C) $200.00 per single-wall tank system on October 1, 2012; $400.00 on October 1, 2013; $600.00 on October 1, 2014.

~~(1)~~(2) ~~The fee shall be $50.00 per tank for~~ For retail gasoline outlets that sell less than 40,000 gallons of motor fuel per month, the fee shall be:

(A) $75.00 per double-wall tank system;

(B) $125.00 per combination tank system on October 1, 2012; $200.00 on October 1, 2013; $275.00 on October 1, 2014; and

(C) $175.00 per single-wall tank system on October 1, 2012; $300.00 on October 1, 2013; $425.00 on October 1, 2014.

~~(2)~~(3) The fee shall be reduced by 50 percent if the owner or permittee provides to the satisfaction of the secretary evidence of financial responsibility to allow the taking of corrective action in the amount of $100,000.00 per occurrence and the compensation of third parties for bodily injury and property damage in the amount of $300,000.00 per occurrence.

~~(3)~~(4) The fee shall be relieved if the owner provides to the satisfaction of the secretary, evidence of financial responsibility to allow the taking of corrective action and the compensation of third parties for bodily injury and property damage each in the amount of $1,000,000.00 per occurrence.

~~(4)~~(5) The fee for retail motor fuel outlets selling 20,000 gallons or less per month ~~shall not exceed $100.00 per year for all tanks at a single location~~ shall be:

(A) $50.00 per double-wall tank system;

(B) $75.00 per combination tank system on October 1, 2012; $125.00 on October 1, 2013; $175.00 on October 1, 2014; and

(C) $100.00 per single-wall tank system on October 1, 2012; $200.00 on October 1, 2013; $300.00 on October 1, 2014.

~~(5)~~(6) ~~The fee shall be $50.00 per tank for~~ For any municipality that uses an annual average of less than ~~an annual average of~~ 40,000 gallons of motor fuel per month, provided that all of the tanks of that municipality meet the requirements of this chapter, the fee shall be:

(A) $50.00 per double-wall tank system;

(B) $100.00 per combination tank system on October 1, 2012; $150.00 on October 1, 2013; $200.00 on October 1, 2014; and

(C) $150.00 per single-wall tank system on October 1, 2012; $250.00 on October 1, 2013; $350.00 on October 1, 2014.

(b) For purposes of this section, an occurrence is an accident, including continuous or repeated exposure to conditions, which results in the release of petroleum from one or more underground storage tanks at the same site.

(c) This tank assessment shall terminate on July 1, 2014.

(d) The secretary shall establish forms and procedures for the payment of the petroleum tank assessment, including a notice of the obligation 30 days prior to being due. Failure to receive notice shall not waive the payment obligation.

Third: In Sec. 4, Petroleum advisory committee report, by adding a new subdivision (5) to read as follows:

(5) Current tank technology and its impact on safety and the rate of current tank fees.

Fourth: By striking out Sec. 8 in its entirety and inserting in lieu thereof a new Sec. 8 to read as follows:

Sec. 8. 10 V.S.A. § 6083a is amended to read:

§ 6083a. ACT 250 FEES

(a) All applicants for a land use permit under section 6086 of this title shall be directly responsible for the costs involved in the publication of notice in a newspaper of general circulation in the area of the proposed development or subdivision and the costs incurred in recording any permit or permit amendment in the land records. In addition, applicants shall be subject to the following fees for the purpose of compensating the state of Vermont for the direct and indirect costs incurred with respect to the administration of the Act 250 program:

* * *

(4) For projects involving the extraction of earth resources, including but not limited to sand, gravel, peat, topsoil, crushed stone, or quarried material, the greater of (a) a fee as determined under subdivision (1) of this subsection or (b) a fee equivalent to the rate of ~~$0.20~~ $0.02 per cubic yard of ~~maximum estimated annual extraction whichever is greater~~ the first million cubic yards of the total volume of earth resources to be extracted over the life of the permit, and $.01 per cubic yard of any such earth resource extraction above one million cubic yards. Extracted material that is not sold or does not otherwise enter the commercial marketplace shall not be subject to the fee. The fee assessed under this subdivision for an amendment to a permit shall be based solely upon any additional volume of earth resources to be extracted under the amendment.

* * *

Fifth: By striking out Secs. 9 and 11 in their entirety

Sixth: By adding seven new sections to be numbered Secs. 12, 13, 14, 15, 16, 17, and 18 to read as follows:

Sec. 12. 3 V.S.A. § 2809 is amended to read:

§ 2809. REIMBURSEMENT OF AGENCY COSTS

(a)(1) The secretary may require an applicant for a permit, license, certification, or order issued under a program that the secretary enforces under 10 V.S.A. § 8003(a) to pay for the cost of research, scientific, or engineering expertise or regulatory services ~~that~~ provided by the agency of natural

resources ~~does not have when such expertise or services are~~ required for the processing of the application for the permit, license, certification, or order.

(2) The secretary may require an applicant under 10 V.S.A. chapter 151 ~~of Title 10~~ to pay for the time of agency of natural resources personnel providing research, scientific, or engineering services or for the cost of expert witnesses when agency personnel or expert witnesses are required for the processing of the permit application.

(3) ~~Except as~~ In addition to the authority set forth under 10 V.S.A. chapters 59 and 159 ~~of Title 10~~ and 10 V.S.A. § 1283, the secretary may require a person who caused the agency to incur expenditures or a person in violation of a permit, license, certification, or order issued by the secretary to pay for the time of agency personnel or the cost of other research, scientific, or engineering services incurred by the agency in response to a threat to public health or the environment presented by an emergency or exigent circumstance.

* * *

(d) The following apply to the authority established under subsection (a) of this section:

(1) ~~The secretary may assess costs under subdivisions (a)(1) and (2) of this section to the applicant or applicants for the permit only with the approval of the governor. Costs assessed under subdivision (a)(3) shall not require approval of the governor.~~

~~(2) The secretary may require reimbursement only of costs in excess of $3,000.00.~~

~~(3)~~ The secretary may revise estimates previously noticed as necessary from time to time during the progress of the work and shall notify the applicant in writing of any revision.

~~(4)~~(2) The secretary shall provide the applicant with a detailed statement of a final assessment under this section showing the total amount of money expended or contracted for in the work and directing the manner and timing of payment by the applicant.

~~(5)~~(3) All funds collected from applicants shall be paid into the state treasury.

* * *

(g) Concerning an application for a permit to discharge stormwater runoff from a telecommunications facility as defined in 30 V.S.A. § 248a that is filed before July 1, 2014~~:~~

~~(1) Under subdivision (a)(1) of this section, the agency shall not require an applicant to pay more than $10,000.00 with respect to a facility.~~

~~(2) The~~, the provisions of subsection (c)(mandatory meeting) of this section shall not apply.

Sec. 13. 24 V.S.A. § 4753(a)(9) is added to read:

(9) The Vermont wastewater and potable water revolving loan fund which shall be used to provide loans to individuals, in accordance with section 4763a of this title, for the design and construction of repairs to or replacement of wastewater systems and potable water supplies when the wastewater system or potable water supply is a failed system or supply as defined in 10 V.S.A. § 1972. The amount of $275,000.00 from the fees collected pursuant to 3 V.S.A. § 2822(j)(4) shall be deposited on an annual basis into this fund.

Sec. 14. 24 V.S.A. § 4763a is added to read:

§ 4763a. LOANS TO INDIVIDUALS FOR FAILED WASTEWATER SYSTEMS AND FAILED POTABLE WATER SUPPLIES

(a) Notwithstanding any other provision of law, when the wastewater system or potable water supply serving only one single-family residence on its own lot meets the definition of a failed supply or system, the secretary of natural resources may lend monies to the owner of the residence from the Vermont wastewater and potable water revolving loan fund established in section 4753 of this title. In such cases, the following conditions shall apply:

(1) loans may only be made to households with an income equal to or less than 200 percent of the state average median household income;

(2) loans may only be made to households where the recipient of the loan resides in the residence on a year-round basis;

(3) loans may only be made if the owner of the residence has been denied financing for the repair, replacement, or construction due to involuntary disconnection by at least two other financing entities;

(4) no construction loan shall be made to an individual under this subsection, nor shall any part of any revolving loan made under this subsection be expended, until all of the following take place:

(A) the secretary of natural resources determines that if a wastewater system and potable water supply permit is necessary for the design and construction of the project to be financed by the loan, the permit has been issued to the owner of the failed system or supply; and

(B) the individual applying for the loan certifies to the secretary of natural resources that the proposed project has secured all state and federal

permits, licenses, and approvals necessary to construct and operate the project to be financed by the loan.

(5) all funds from the repayment of loans made under this section shall be deposited into the Vermont wastewater and potable water revolving loan fund.

(b) The secretary of natural resources shall establish standards, policies, and procedures as necessary for the implementation of this section.

Sec. 15. 24 V.S.A. § 4753a is amended to read:

§ 4753a. AWARDS FROM REVOLVING LOAN FUNDS

(a) Pollution control. The general assembly shall approve all categories of awards made from the special funds established by section 4753 of this title for water pollution control facility construction, in order to assure that such awards conform with state policy on water quality and pollution abatement, and with the state policy that~~, except as provided in subsection (c) of this section,~~ municipal entities shall receive first priority in the award of public monies for such construction, including monies returned to the revolving funds from previous awards. To facilitate this legislative oversight, the secretary of natural resources shall annually no later than January 15 report to the house and senate committees on institutions and on natural resources and energy on all awards made from the relevant special funds during the prior and current fiscal years, and shall report on and seek legislative approval of all the types of projects for which awards are proposed to be made from the relevant special funds during the current or any subsequent fiscal year. Where feasible, the specific projects shall be listed.

(b) Water supply. The secretary of natural resources shall no later than January 15, 2000 recommend to the house ~~and senate committees on institutions and~~ committee on corrections and institutions, the senate committee on institutions, and the house and senate committees on natural resources and energy a procedure for reporting to and seeking the concurrence of the legislature with regard to the special funds established by section 4753 of this title for water supply facility construction.

(c) ~~Notwithstanding other priorities established in law, the secretary may award up to $500,000.00 of the funds from the Vermont environmental protection agency control fund and the Vermont pollution control revolving fund, combined, to a state agency, the Vermont housing finance agency, or a municipality for the administration of loans to households with income equal to or less than 200 percent of the state average median household income for the repair or replacement of failed wastewater systems and failed potable water supplies, as those terms are defined in section 1972 of Title 10. Upon award of~~

~~funds under this section, the state agency, Vermont housing finance agency, or municipality shall agree, pursuant to a memorandum of understanding with the secretary of natural resources, to repay the funds awarded to the special fund from which they were drawn.~~

Sec. 16. ANR REPORT ON ENVIRONMENTAL IMPACT OF GROUNDWATER WITHDRAWALS FOR BOTTLING WATER

(a) On or before January 15, 2013, the secretary of natural resources shall report to the senate and house committees on natural resources and energy, the senate committee on finance, and the house committee on ways and means regarding the impact of groundwater withdrawals by public water systems for the purposes of transfer out of the state for bottling. The report shall include:

(1) An analysis of the environmental effect of withdrawing and transferring out of the state large volumes of groundwater for the purposes of bottling, including the impact of such withdrawals on drinking water supplies, agricultural use, groundwater tables, and surface water recharge.

(2) A summary of the fees charged by other states for the withdrawal of groundwater for bottling or bulk water transfer and a comparison of the fees of other states to the groundwater withdrawal fees charged in Vermont.

(b) In preparing the report required under subsection (a) of this section, the secretary of natural resources shall consult with interested parties, including owners of property in the proximity of public water systems withdrawing groundwater for the purposes of bottling water, public water systems, bottled water companies, environmental groups, and representatives of agriculture.

(c) As used in this section, "public water system" shall be defined as provided in 10 V.S.A. § 1671.

Sec. 17. STUDY; DEPARTMENT OF PUBLIC SAFETY

(a) The department of public safety shall study how it assesses fees or charges for services provided by the department to municipalities, fire departments, and other entities. The study shall also examine how fees or charges can be equitably assessed and what mechanism can be employed to collect fees or charges.

(b) The department shall report its findings and any recommendations to the house committee on ways and means and the senate committee on finance by January 15, 2013.

Sec. 18. REPORT; AGENCY OF NATURAL RESOURCES; AGENCY OF TRANSPORTATION

On or before January 15, 2013, the secretary of natural resources (ANR) and the secretary of transportation (AOT) shall jointly report to the house committee on ways and means and the senate committee on finance with a recommendation as to whether or not agency of natural resources fees and agency of transportation fees should be adjusted so that air pollution fees paid to ANR proportionally reflect the contribution of ANR permittees to state air pollution and so that air-pollution-related fees paid to AOT proportionally reflect the contribution of AOT licensees and permittees to state air pollution. If making adjustments to ANR and AOT fees is recommended for this purpose, the report shall recommend which fees should be adjusted and by what amount.

And by renumbering the sections to be numerically correct

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

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

Third Reading Ordered

H. 272.

Senator Cummings, for the Committee on Judiciary, to which was referred House bill entitled:

An act relating to maintenance of private roads.

Reported that the bill ought to pass in concurrence.

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

Third Reading Ordered

H. 327.

Senator Cummings, for the Committee on Judiciary, to which was referred Senate bill entitled:

An act relating to the uniform principal and income act .

Reported that the bill ought to pass in concurrence.

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

Bill Amended; Third Reading Ordered

S. 233.

Senator Lyons, for the Committee on Education, to which was referred Senate bill entitled:

An act relating to gradually increasing the mandatory age of school attendance.

Reported recommending that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Legal School Age * * *

Sec. 1. 16 V.S.A. § 1121 is amended to read:

§ 1121. ATTENDANCE BY CHILDREN OF SCHOOL AGE REQUIRED

~~A~~ (a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and 16 years, 183 days shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend; ~~or~~

(2) ~~has completed the tenth grade; or~~ has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

(b) A person having the control of a child who is enrolled in a home study program for the academic year in which the child is 15 years old shall not be subject to the provisions of subsection (a) of this section when the child is 16 years old or older.

Sec. 2. 16 V.S.A. § 1121(a) is amended to read:

(a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and ~~16~~ 17 years~~, 183 days~~ shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend;

(2) has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

Sec. 3. 16 V.S.A. § 1121(a) is amended to read:

(a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and 17 years, 183 days shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend;

(2) has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

Sec. 4. 16 V.S.A. § 1121(a) is amended to read:

(a) Except as provided in subsection (b) of this section, a person having the control of a child between the ages of six and ~~17~~ 18 years~~, 183 days~~ shall cause the child to attend a public school, an approved or recognized independent school, an approved education program, or a home study program for the full number of days for which that school is held, unless the child:

(1) is mentally or physically unable so to attend;

(2) has completed all requirements necessary for graduation from secondary school;

(3) is excused by the superintendent or a majority of the school directors as provided in this chapter; or

(4) is enrolled in and attending a postsecondary school, as defined in subdivision 176(b)(1) of this title, which is approved or accredited in Vermont or another state.

* * * Related Provisions * * *

Sec. 5. 16 V.S.A. § 1121a is added to read:

§ 1121a. PUPILS WHO ARE 16 YEARS OLD AND OLDER

(a) A child who is at least 16 years old but is younger than the legal school age established in section 1121 of this title and who is not subject to the exceptions set out in subdivisions (a)(1)–(4) or subsection (b) of that section may terminate his or her secondary education in a public school, an approved or recognized independent school, or an approved education program if the child and at least one of the child's parents or the child's legal guardian personally appear before the superintendent to sign a notice of withdrawal. The notice shall include a statement signed by the student, the parent or guardian, and the principal or headmaster of the school in which the child is enrolled that the child and the parent or guardian attended a final counseling session with the principal, headmaster, or school guidance counselor that included a discussion of alternative educational opportunities available to the child, including workforce development programs eligible to receive funding from the department of labor, and other services available to support the child, including Linking Learning to Life, Inc., Spectrum Youth and Family Services, Inc., Vermont Youth Build, and the Vermont Youth Conservation Corps, Inc.

(b) A school district shall contact each child who has voluntarily withdrawn from school pursuant to subsection (a) of this section within three months after the date of withdrawal to encourage the child to enroll in a public school, an approved or recognized independent school, a home study program, an approved education program, or a workforce development program or to pursue some other alternative educational or training opportunity.

(c) The departments of labor and of education shall publish and update at least annually a list of alternative education and workforce development programs under their respective jurisdictions that would be available to a student who has not completed secondary school.

Sec. 6. 16 V.S.A. § 1122 is amended to read:

§ 1122. PUPILS ~~OVER 16~~ WHO EXCEED THE LEGAL SCHOOL AGE

A person having the control of a child ~~over 16 years of~~ who exceeds the legal school age as established in section 1121 of this title who allows the child to become enrolled in a public school shall cause the child to attend the school continually for the full number of the school days of the term in which he or she is enrolled, unless the child is mentally or physically unable to continue, or is excused in writing by the superintendent or a majority of the school directors. In case of ~~such~~ enrollment, the person, and the teacher, child, superintendent, and school directors shall be under the laws and subject to the

penalties relating to the attendance of children ~~between the ages of six and 16 years~~ of legal school age.

Sec. 7. 16 V.S.A. § 1126 is amended to read:

§ 1126. FAILURE TO ATTEND; NOTICE BY TEACHER

When a pupil ~~between the ages of six and 16 years~~ of legal school age, as established in section 1121 of this title, who is not excused or exempted from school attendance~~,~~ fails to enter school at the beginning ~~thereof~~ of the academic year, or being enrolled, fails to continue to attend ~~the same~~, and when a pupil who ~~has become 16 years of~~ exceeds the legal school age becomes enrolled in a public school and fails to attend, the teacher or principal shall forthwith notify the superintendent or school directors, and the truant officer, unless the teacher or principal is satisfied upon information that the pupil is absent on account of sickness.

Sec. 8. 16 V.S.A. § 1128(a) is amended to read:

(a) A superintendent may and the truant officer shall stop a child ~~between the ages of six and 16 years or a child 16 years of age or over and~~ of legal school age or a child who exceeds the legal school age but is enrolled in public school, wherever found during school hours, and shall, unless ~~such~~ the child is excused or exempted from school attendance, take the child to the school which she or he should attend.

Sec. 9. 16 V.S.A. § 1123(c) is amended to read:

(c) ~~The superintendent with the consent of a majority of the school board of the town in which the pupil resides, may excuse, in writing, a pupil who has reached the age of fifteen years and has completed the work required in the first six years of the elementary school course from further school attendance if his services are needed for the support of those dependent upon him, or for any other sufficient reason.~~ [Repealed.]

* * * Human Services * * *

Sec. 10. 33 V.S.A. § 5102(3) is amended to read:

(3) "Child in need of care or supervision (CHINS)" means a child who:

* * *

(D) is under the age of 16 and is habitually and without justification truant from compulsory school attendance.

* * * Flexible Pathways to Graduation; Dual Enrollment * * *

Sec. 11. 16 V.S.A. chapter 23, subchapter 6 is amended to read:

Subchapter 6. Flexible Pathways to Secondary School Completion; Adult Education and Literacy

§ 1049. ~~PROGRAMS~~ FLEXIBLE PATHWAYS; POLICY; INITIATIVE; GUIDELINES; DEFINITIONS

~~(a) The commissioner of education may provide programs designed to fit the individual needs and circumstances of adult students. Programs authorized under this section shall give priority to those adult persons with the lowest levels of literacy skills.~~

~~(b)(1) Fees for general educational development shall be $3.00 for a transcript.~~

~~(2) The adult diploma program (ADP) means an assessment process administered by the Vermont department of education through which an adult can receive a local high school diploma granted by one of the program's participating high schools.~~

~~(3) General educational development (GED) means a testing program administered jointly by the Vermont department of education, the GED testing service, and approved local testing centers through which an adult can receive a secondary school equivalency certificate based on successful completion of the tests of general educational development.~~

~~(c) Fees collected under this section shall be credited to a special fund established and managed pursuant to chapter 7, subchapter 5 of Title 32, and shall be available to the department to offset the costs of providing those services.~~

(a) Policy. It is the policy of the state:

(1) to take all necessary measures to increase the Vermont secondary school completion rate to 100 percent;

(2) to promote opportunities for every Vermont student to have high-quality educational experiences; and

(3) to create opportunities for every Vermont student to achieve career and college readiness while respecting diverse student goals and personal learning styles and abilities.

(b) Flexible pathways initiative. There is created within the department a flexible pathways initiative:

(1) to promote opportunities for Vermont students to complete secondary school and achieve career and college readiness through high-quality educational experiences that acknowledge individual goals, learning styles, and abilities; and

(2) to encourage and support the creativity of school districts as they develop or expand high-quality alternative educational experiences that advance the policies set forth in subsection (a) of this section.

(c) Flexible pathways guidance. The commissioner of education shall develop, publish, and regularly update guidance, in the form of technical assistance, sharing of best practices, legal interpretations, and other support, designed to encourage and assist school districts:

(1) to identify and support elementary and secondary students who require additional assistance to succeed in school, including individual students identified under subsection 2902(c) of this title, or who would otherwise benefit from flexible pathways to graduation;

(2) to encourage movement toward development of a personalized learning plan by every student, in consultation with a representative of the school and the student's parents or legal guardian;

(3) to implement strategies and flexible pathways components such as:

(A) the provision of targeted assistance, including individual tutoring, evidence-based literacy instruction, alternative and extended scheduling, and the provision of a variety of opportunities to earn credits or demonstrate proficiency necessary to earn a high school diploma;

(B) the assignment of one or more adults from within the school community to provide continuity to the student;

(C) the opportunity to acquire knowledge and skills through applied or work-based learning opportunities, including those that foster appropriate social interactions with adults and other students;

(D) the opportunity to participate in dual enrollment courses with tutorial support provided as needed;

(E) assessments that allow the student to demonstrate proficiency by applying his or her knowledge and skills to tasks that are of interest to that student; and

(4) to oversee implementation of publicly funded components of flexible pathways established in this subchapter, including:

(A) the high school completion program as set forth in section 1049a:

(B) the dual enrollment program as set forth in section 1049b;

(C) other innovative components as set forth in section 1049c; and

(D) the adult diploma and general educational development programs as set forth in section 1049d.

(d) Definitions. In this title:

(1) "Approved provider" means an entity approved by the commissioner to provide educational services that may be awarded credits or used to determine proficiency necessary for a high school diploma.

(2) "Career and college readiness" means the ability to enter the workforce or pursue postsecondary education or training without the need for remediation.

(3) "Contracting agency" means an entity that enters into a contract with the department to provide "flexible pathways to graduation" services itself or in conjunction with one or more approved providers in Vermont.

(4) "Dual enrollment" means enrollment by a secondary student in a course offered by an accredited postsecondary institution as defined in section 913 of this title and for which, upon successful completion of the course, the student will receive:

(A) credit toward graduation from the secondary school in which the student is enrolled; and

(B) postsecondary credit from the institution that offered the course if the course is a credit-bearing course at that institution.

(5) "Flexible pathways to graduation" means any combination of high-quality academic and experiential components leading to secondary school completion and career and college readiness.

(6) "Personalized learning plan" means a written document developed by a student, a representative of the school, and, if the student is a minor, the student's parents or legal guardian that describes a flexible pathway to graduation that is unique to the individual student. The plan shall define the scope and rigor of services necessary for the student to attain a high school diploma and may describe educational services to be provided by a public school, an approved independent school, an approved provider, a contracting agency, or a combination of these.

(e) Other initiatives. Nothing in this subchapter shall be construed as limiting the authority of any school district to develop or continue to provide alternative educational opportunities for its students that are otherwise permitted, including participation in dual enrollment programs with

out-of-state postsecondary institutions or the provision of advanced placement courses.

(f) Scope. No individual entitlement or private right of action is created by this section.

§ 1049a. HIGH SCHOOL COMPLETION PROGRAM

(a) ~~In this section:~~

~~(1) "Graduation education plan" means a written plan leading to a high school diploma for a person who is 16 to 22 years of age and has not received a high school diploma, who may or may not be enrolled in a public or approved independent school. The plan shall define the scope and rigor of services necessary for the student to attain a high school diploma, and may describe educational services to be provided by a public high school, an approved independent high school, an approved provider, or a combination of these.~~

~~(2) "Approved provider" means an entity approved by the commissioner to provide educational services which may be counted for credit toward a high school diploma.~~

~~(3) "Contracting agency" means an agency that has entered into a contract with the department of education to provide adult education services in Vermont.~~ There is created a high school completion program to be a potential component of a flexible pathway for any student who is at least 16 years old, who has not received a high school diploma, and who may or may not be enrolled in a public or approved independent school.

(b) If a person who wishes to work on a ~~graduation education~~ personalized learning plan leading to graduation through the high school completion program is not enrolled in a public or approved independent school, then the commissioner shall assign the prospective student to a high school district, which shall be the district of residence whenever possible. The school district in which a student is enrolled or to which a non-enrolled student is assigned shall work with the contracting agency and the student to develop a ~~graduation education~~ personalized learning plan. The school district shall award a high school diploma upon successful completion of the plan.

(c) The commissioner shall reimburse, and net cash payments where possible, a school district that has agreed to a ~~graduation education~~ personalized learning plan under this section in an amount:

(1) established by the commissioner for development of the ~~graduation education~~ personalized learning plan and for other educational services typically provided by the assigned district or an approved independent school pursuant to the plan, such as counseling, health services, participation in

cocurricular activities, and participation in academic or other courses, provided this amount shall not be available to a district that provides services under this section to an enrolled student; and

(2) negotiated by the commissioner and the contracting agency, with the approved provider, for services and outcomes purchased from the approved provider on behalf of the student pursuant to the ~~graduation education~~ personalized learning plan.

§ 1049b. DUAL ENROLLMENT PROGRAM

(a) Program created. There is created a statewide dual enrollment program to be a potential component of a student's flexible pathway and through which a Vermont secondary student who is enrolled in a Vermont public school or a Vermont approved independent school at public expense or who is assigned to a public school through the high school completion program may enroll in up to four postsecondary courses for which the program shall pay tuition.

(b) Courses. The dual enrollment program shall include college courses offered on the campus of an accredited postsecondary institution and college courses offered by an accredited postsecondary institution on the campus of a secondary school. The program may include online college courses or components. Provided, however, a personalized learning plan that includes a dual enrollment course offered by an accredited postsecondary institution that is not approved pursuant to section 176 or 176a of this title shall be submitted to the program manager for review prior to enrollment in the course. The program manager may approve enrollment if it determines that the institution meets quality standards established by the manager or state board rule, that the student does not have access to the same or a comparable course offered by an institution approved pursuant to section 176 or 176a of this title, and that enrollment is in the best interest of the student. A student may appeal a decision of the program manager to the commissioner, whose decision shall be final.

(c) Postsecondary institutions.

(1) Vermont's public postsecondary institutions shall work together to ensure that dual enrollment opportunities are available throughout the state. Other nonprofit accredited postsecondary institutions may participate in the dual enrollment program pursuant to criteria established by this section, the state board, and the program manager.

(2) Each participating postsecondary institution shall:

(A) define how it will determine whether a student is sufficiently prepared to succeed academically in a dual enrollment course;

(B) develop the curriculum and select instructors for dual enrollment courses;

(C) maintain the postsecondary academic record of each participating student and provide transcripts on request;

(D) agree to accept as full payment for a dual enrollment course the tuition set forth in subsection (f) of this section; and

(E) to the extent permitted under the Family Educational Rights and Privacy Act, collect and send data related to student participation and success to the student's secondary school and the commissioner.

(d) Secondary schools. A public secondary school, regional technical center as defined in section 1522 of this title, and approved independent secondary school that receives publicly funded tuition dollars shall:

(1) provide access for eligible students to participate in dual enrollment courses offered on the campus of the secondary school;

(2) accept postsecondary credit awarded for dual enrollment courses as meeting secondary school graduation requirements;

(3) collect enrollment data as prescribed by the department for longitudinal review and evaluation;

(4) identify and provide necessary support for participating students and continue to provide services for students with disabilities; and

(5) provide support for a seamless transition to postsecondary enrollment upon graduation.

(e) Students.

(1) A Vermont resident in any flexible pathway who has completed grade 10 but has not received a high school diploma is eligible to participate in the dual enrollment program if:

(A) the student is enrolled in a Vermont public school or a Vermont approved independent school at public expense or is assigned to a public school through the high school completion program;

(B) dual enrollment is an element included within the student's personalized learning plan; and

(C) the secondary school and the postsecondary institution have determined that the student is sufficiently prepared to succeed in a dual enrollment course, which can be determined in part by the assessment tool or tools identified by the participating postsecondary institution.

(2) An eligible student may enroll in up to four dual enrollment courses prior to completion of secondary school for which the dual enrollment program will pay tuition. A student may enroll in courses offered while secondary school is in session and during the summer.

(3) A student's personalized learning plan shall include provisions for support services, including transitional support for students with disabilities and including academic, emotional, and other support services as appropriate.

(f) Tuition.

(1) For any course for which the postsecondary institution pays the instructor, the commissioner shall reimburse a secondary school district the full amount of tuition paid to the postsecondary institution, which shall not exceed the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(2) For any course that is taught by an instructor who is paid as part of employment by a secondary school, the commissioner shall reimburse a secondary school district the full amount of tuition paid to the postsecondary institution, which shall not exceed 50 percent of the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(g) Program management**.** The department shall manage or may contract for the management of the dual enrollment program in Vermont by:

(1) coordinating secondary and postsecondary partners to ensure success of the programs, including assisting partners to develop memoranda of understanding;

(2) marketing of the dual enrollment program to students and their families throughout the state;

(3) evaluating all aspects of the dual enrollment program;

(4) coordinating with secondary and postsecondary partners to understand and define student academic readiness;

(5) assessing what is needed to support student success;

(6) reviewing program costs;

(7) managing distribution of tuition funds;

(8) coordinating the use of technology to ensure access and coordination of the program;

(9) ensuring overall quality and accountability;

(10) convening regular meetings of interested parties to explore and develop improved student support services; and

(11) performing other necessary or related duties.

(h) Annually in January, the commissioner and program manager shall report to the house and senate committees on education regarding the dual enrollment program, including data relating to student demographics, levels of participation, and program success.

§ 1049c. INNOVATIVE COMPONENTS OF FLEXIBLE PATHWAYS

(a) The commissioner may use sums appropriated for the high school completion program to support other innovative components of a flexible pathway that are available to a student instead of or in addition to the high school completion program by reimbursing or awarding grants to Vermont public schools, Vermont career and technical education centers, Vermont supervisory unions, approved providers, and contracting agencies for activities that create opportunities for Vermont students to have high-quality educational experiences and achieve career and college readiness while respecting diverse student goals and personal learning styles and abilities, including:

(1) implementation of innovative, comprehensive programs offered by and within a school; and

(2) implementation of innovative, comprehensive programs offered through the school by entities other than the school or offered at a location other than the school campus, including work-based learning, virtual or blended learning, career and technical education, dual enrollment, and programs operated by the Vermont Youth Conservation Corps, Inc.

(b) Money awarded by the commissioner under this section shall be pursuant to criteria established in rule by the state board.

§ 1049d. ADULT DIPLOMA PROGRAM; GENERAL EDUCATIONAL DEVELOPMENT PROGRAM

(a) The department shall maintain an adult diploma program ("ADP"), which shall be an assessment process administered by the department through which an individual who is at least 20 years old can receive a local high school diploma granted by one of the program's participating high schools.

(b) The department shall maintain a general educational development ("GED") program, which it shall administer jointly with the GED testing service and approved local testing centers and through which an individual who is at least 16 years old and who is not enrolled in secondary school can receive a secondary school equivalency certificate based on successful completion of the GED tests.

(c) The commissioner of education may provide additional programs designed to address the individual needs and circumstances of adult students, particularly students with the lowest levels of literacy skills.

Sec. 12. APPROPRIATION

The sum of $1,200,000.00 is appropriated from the education fund in fiscal year 2013 to be used for the purposes of paying tuition under Sec. 11, 16 V.S.A. §§ 1049b (dual enrollment) of this act.

Sec. 13. EFFECTIVE DATES

(a) Sec. 1 of this act shall take effect on July 1, 2013, but shall not apply to a child who lawfully stopped attending school prior to that date.

(b) Sec. 2 of this act shall take effect on July 1, 2014, but shall not apply to a child who lawfully stopped attending school prior to that date.

(c) Sec. 3 of this act shall take effect on July 1, 2015, but shall not apply to a child who lawfully stopped attending school prior to that date.

(d) Sec. 4 of this act shall take effect on July 1, 2016, but shall not apply to a child who lawfully stopped attending school prior to that date.

(e) This section and Secs. 5 through 12 of this act shall take effect on July 1, 2012.

(f) The commissioner of education shall ensure that both new and updated guidance documents required by this act are published no later than July 1, 2012.

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

An act relating to the mandatory age of school attendance and creating flexible pathways to high school completion.

And that when so amended the bill ought to pass.

Senator Kitchel, for the Committee on Appropriations, to which the bill was referred reported recommending that the bill be amended as recommended by the Committee on Education with the following amendments thereto:

First: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (a) in its entirety and inserting in lieu thereof a new subsection (a) to read as follows:

(a) Program created. There is created a statewide dual enrollment program to be a potential component of a student's flexible pathway and through which a Vermont secondary student who is enrolled in a Vermont public school or a Vermont-approved independent school at public expense or who is assigned to a public school through the high school completion program may enroll in

postsecondary courses for which neither the student nor the student's parent or guardian shall be required to pay tuition.

Second: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, § 1049b, in subsection (e), by striking out subdivision (2) in its entirety and inserting in lieu thereof a new subdivision (2) to read as follows:

(2) Subject to available funding, an eligible student may enroll in up to four dual enrollment courses prior to completion of secondary school for which neither the student nor the student's parent or guardian shall be required to pay tuition. A student may enroll in courses offered while secondary school is in session and during the summer.

Third: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (f) in its entirety and inserting in lieu thereof a new subsection (f) to read as follows:

(f) Tuition.

(1) For any course for which the postsecondary institution pays the instructor, tuition shall not exceed the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(2) For any course that is taught by an instructor who is paid as part of employment by a secondary school, tuition shall not exceed 50 percent of the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

Fourth: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, by striking out § 1049c (innovative components of flexible pathways) in its entirety, redesignating § 1049d as § 1049c, and inserting a new § 1049d to read as follows:

§ 1049d. REPORT

Notwithstanding provisions of 2 V.S.A. § 20(d) to the contrary, the prekindergarten–16 council created in section 2905 of this title shall report annually in January to the senate and house committees on appropriations and on education, the senate committee on finance, and the house committee on ways and means regarding the flexible pathways initiative and its potential components as set forth in this subchapter 6, including detailed data regarding and analysis of:

(1) the annual expenditures from the education fund for dual enrollment courses and other alternative programs under this subchapter, including a breakdown of the amount spent for each program statewide and by each participating secondary school;

(2) the annual number of students accessing dual enrollment and alternative programs, including a breakdown by secondary school of:

(A) the total number of students eligible to participate;

(B) the number of students accessing each program;

(C) the per-student tuition and other costs paid for each program;

(3) the geographic areas of the state that are underserved or unable to access dual enrollment programs and each other type of alternative program; and

(4) whether participation in dual enrollment and other alternative programs has improved high school completion rates, student aspiration, college and career readiness, and completion of college or other postsecondary education or training.

Fifth: By striking out Sec. 12 (appropriation) in its entirety and inserting in lieu thereof a new Sec. 12 to read as follows:

Sec. 12. 16 V.S.A. § 2885(c) and (g) are amended to read:

(c) In August of each fiscal year~~, beginning in the year 2000~~, the state treasurer shall withdraw and divide an amount equal to five percent of the assets equally among the University of Vermont, the Vermont ~~state colleges~~ State Colleges, and the Vermont ~~student assistance corporation~~ Student Assistance Corporation. In this subsection, "assets" means the average of the fund's market values at the end of each quarter for the most recent 12 quarters, or all quarters of operation, whichever is less. Therefore, up to five percent of the fund assets are hereby annually allocated pursuant to this section, provided that the amount allocated shall not exceed an amount which would bring the fund balance below the initial funding made in fiscal year 2000 plus any additional contributions to the principal. The University of Vermont and the Vermont ~~state colleges~~ State Colleges shall use the funds to provide nonloan financial aid to Vermont students attending their institutions; the Vermont ~~student assistance corporation~~ Student Assistance Corporation shall use the funds to provide nonloan financial aid to Vermont students attending a Vermont postsecondary institution. For purposes of this section, "nonloan financial aid" includes tuition paid for financially needy Vermont students and Vermont students whose parents have not pursued higher education for:

(1) early college and dual enrollment programs; and

(2) Science, Technology, Engineering, and Mathematics ("STEM") programs.

(g) The University of Vermont, the Vermont State Colleges, and the Vermont Student Assistance Corporation shall review expenditures made from the fund, evaluate the impact of the expenditures on higher education in Vermont, and report this information to the state treasurer each year in January. In addition, in November of each year, the three entities shall report to the joint fiscal committee regarding expenditures made in connection with early college, dual enrollment, and STEM programs.

And that when so amended the bill ought to pass.

Thereupon, pending the question, Shall the proposal of amendment of the Committee on Education be amended as recommended by the Committee on Appropriations, Senator Kitchel?, Senator Kitchel, on behalf of the Committee on Appropriations, moved to substitute a recommendation of amendment for the recommendation of amendment of the Committee on Appropriations, as follows:

First: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (a) in its entirety and inserting in lieu thereof a new subsection (a) to read as follows:

(a) Program created. There is created a statewide dual enrollment program to be a potential component of a student's flexible pathway and through which a Vermont secondary student who is enrolled in a Vermont public school or a Vermont-approved independent school at public expense or who is assigned to a public school through the high school completion program may enroll in postsecondary courses for which neither the student nor the student's parent or guardian shall be required to pay tuition.

Second: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, § 1049b, in subsection (e), by striking out subdivision (2) in its entirety and inserting in lieu thereof a new subdivision (2) to read as follows:

(2) Subject to available funding, an eligible student may enroll in up to four dual enrollment courses under this section prior to completion of secondary school for which neither the student nor the student's parent or guardian shall be required to pay tuition. A student may enroll in courses offered while secondary school is in session and during the summer.

Third: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, in § 1049b, by striking out subsection (f) in its entirety and inserting in lieu thereof a new subsection (f) to read as folows:

(f) Tuition.

(1) For any course for which the postsecondary institution pays the instructor, tuition shall not exceed the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

(2) For any course that is taught by an instructor who is paid as part of employment by a secondary school, tuition shall not exceed 50 percent of the Community College of Vermont tuition rate charged at the time the dual enrollment course is offered.

Fourth: In Sec. 11, 16 V.S.A. chapter 23, subchapter 6, by inserting a new § 1049f to read as follows:

§ 1049f. REPORT

Notwithstanding provisions of 2 V.S.A. § 20(d) to the contrary, the prekindergarten–16 council created in section 2905 of this title, in cooperation with the department of education, shall report annually in January to the senate and house committees on appropriations and on education, the senate committee on finance, and the house committee on ways and means regarding the flexible pathways initiative and its potential components as set forth in this subchapter 6, including detailed data regarding and analysis of:

(1) the annual expenditures from the education fund for dual enrollment courses and other alternative programs under this subchapter, including a breakdown of the amount spent for each program statewide and by each participating secondary school;

(2) the annual number of students accessing dual enrollment and alternative programs including, to the extent permitted by the Federal Educational Rights and Privacy Act, a breakdown by secondary school of:

(A) the total number of students eligible to participate;

(B) the number of students accessing each program;

(C) the per-student tuition and other costs paid for each program;

(D) the number of students in the school who are eligible for free and reduced-price lunch and, of those, the number of students accessing each program;

(E) the number of students in the school whose parents have not completed a postsecondary degree and, of those, the number of students accessing each program;

(3) the geographic areas of the state that are underserved or unable to access dual enrollment programs and each other type of alternative program; and

(4) whether participation in dual enrollment and other alternative programs has improved high school completion rates, student aspiration, college and career readiness, and completion of college or other postsecondary education or training.

Fifth: By striking out Sec. 12 (appropriation) in its entirety and inserting in lieu thereof a new Sec. 12 to read as follows:

Sec. 12. 16 V.S.A. § 2885(c) and (g) are amended to read:

(c) In August of each fiscal year~~, beginning in the year 2000~~, the state treasurer shall withdraw and divide an amount equal to five percent of the assets equally among the University of Vermont, the Vermont ~~state colleges~~ State Colleges, and the Vermont ~~student assistance corporation~~ Student Assistance Corporation. In this subsection, "assets" means the average of the fund's market values at the end of each quarter for the most recent 12 quarters, or all quarters of operation, whichever is less. Therefore, up to five percent of the fund assets are hereby annually allocated pursuant to this section, provided that the amount allocated shall not exceed an amount which would bring the fund balance below the initial funding made in fiscal year 2000 plus any additional contributions to the principal. The University of Vermont and the Vermont ~~state colleges~~ State Colleges shall use the funds to provide nonloan financial aid to Vermont students attending their institutions; the Vermont ~~student assistance corporation~~ Student Assistance Corporation shall use the funds to provide nonloan financial aid to Vermont students attending a Vermont postsecondary institution. For purposes of this section, "nonloan financial aid" includes tuition paid for financially needy Vermont students to access early college and dual enrollment programs.

(g) The University of Vermont, the Vermont State Colleges, and the Vermont Student Assistance Corporation shall review expenditures made from the fund, evaluate the impact of the expenditures on higher education in Vermont, and report this information to the state treasurer each year in January. In addition, in November of each year, the three entities shall report to the joint fiscal committee regarding expenditures made in connection with early college and dual enrollment programs.

Which was agreed to.

Thereupon, the bill was read the second time by title only pursuant to Rule 43, and the recommendation of amendment of the Committee on Education was amended as recommended by the Committee on Appropriations, as substituted.

Thereupon, the pending question, Shall the bill be amended as recommended by the Committee on Education, as amended?, was decided in the affirmative.

Thereupon, third reading of the bill was ordered.

Ordered to Lie

H. 699.

Senator Carris, for the Committee on Economic Development, Housing and General Affairs, to which was referred House bill entitled:

An act relating to scrap metal processors.

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. 9 V.S.A. chapter 82 is amended to read:

CHAPTER 82. SCRAP METAL PROCESSORS

§ 3021. DEFINITIONS

As used in this chapter:

(1) ~~"Authorized scrap seller" means a licensed plumber, electrician, HVAC contractor, building or construction contractor, demolition contractor, construction and demolition debris contractor, public utility, transportation company, licensed peddler or broker, an industrial and manufacturing company; marine, automobile, or aircraft salvage and wrecking company, or a government entity.~~ [Repealed.]

* * *

(7) "Scrap metal processor" means:

(A) a salvage yard, as defined in 24 V.S.A. § 2241(7); or

(B) a person ~~authorized to conduct a business that processes and manufactures scrap metal into prepared grades for sale as raw material to mills, foundries, and other manufacturing facilities~~ engaged in the business of purchasing ferrous scrap, nonferrous scrap, metal articles, or proprietary articles, whether for resale or for processing into raw material products consisting of prepared grades.

(C) "Scrap metal processor" does not include:

(i) a salvage yard described in 24 V.S.A. § 2248(e); or

(ii) a salvage yard or salvage dealer that only accepts or dismantles motor vehicles and flattens or crushes the motor vehicles for transportation to a scrap metal processor.

§ 3022. PURCHASE OF NONFERROUS SCRAP, METAL ARTICLES, AND PROPRIETARY ARTICLES

(a) ~~A scrap metal processor may purchase nonferrous scrap, metal articles, and proprietary articles directly from an authorized scrap metal seller or the seller's authorized agent or employee~~. [Repealed.]

(b) A scrap metal processor may purchase nonferrous scrap, metal articles, and proprietary articles ~~from a person who is not an authorized scrap metal seller or the seller's authorized agent or employee, provided~~ only if the scrap metal processor complies with all the following procedures:

(1) At the time of sale, the processor:

(A) ~~requires~~ Requires the seller to provide a current government-issued photographic identification that indicates the seller's full name, current address, and date of birth, and records in a permanent ledger the identification information of the seller, the time and date of the transaction, the license number of the seller's vehicle, and a description of the items received from the seller. ~~This information shall be retained for at least five years at the processor's normal place of business or other readily accessible and secure location. On request, this information shall be made available to any law enforcement official or authorized security agent of a governmental entity who provides official credentials at the scrap metal processor's business location during regular business hours.~~

~~(2)~~(B) Requests and, if available, collects documentation from the seller of the items offered for sale, such as a bill of sale, receipt, letter of authorization, or similar evidence that establishes that the seller lawfully owns the items to be sold.

~~(3)~~(2) After purchasing an item from a person who fails to provide documentation pursuant to subdivision ~~(2)~~(1)(B) of this subsection ~~(b) of this section~~, the processor:

(A) ~~submits~~ Submits to the ~~local law enforcement agency~~ department of public safety no later than the close of the following business day a report that describes the item and the seller's identifying information required in subdivision (1)(A) of this subsection~~, and~~.

(B) ~~holds~~ Holds the proprietary article for at least ~~15~~ 30 days following purchase.

(c) The information collected by a scrap metal processor pursuant to this section shall be retained for at least five years at the processor's normal place of business or other readily accessible and secure location. On request, this information shall be made available to any law enforcement official or authorized security agent of a governmental entity who provides official credentials at the scrap metal processor's business location during regular business hours.

§ 3023. PENALTIES

(a) A scrap metal processor who violates any provision of this chapter for the first time may be assessed a civil penalty not to exceed $1,000.00 for each transaction.

(b) A scrap metal processor who violates any provision of this chapter for a second or subsequent time shall be fined not more than $25,000.00 for each transaction.

Sec. 2. REPORTING SCRAP METAL SALES

The department of public safety, in collaboration with the department of environmental conservation, shall develop:

(1) a uniform form for the report required for purchases pursuant to 9 V.S.A. § 3022(b)(2)(A);

(2) an electronic form and reporting system through which scrap metal processors may submit to the department of public safety the report required for purchases pursuant to 9 V.S.A. § 3022(b)(2)(A); and

(3) an implementation and public outreach process to inform scrap metal processors that the electronic form and reporting system are available for use.

Sec. 3. 13 V.S.A. § 2561 is amended to read:

§ 2561. PENALTY FOR RECEIVING STOLEN PROPERTY; VENUE

~~(a)~~ A person who ~~is a dealer in property who~~ knowingly or recklessly buys, receives, sells, possesses ~~unless with the intent to restore to the owner~~, or aids in the concealment of stolen property~~, knowing or believing the property to be stolen~~ without the intent to restore the property to the rightful owner shall be punished the same as for the stealing of ~~such~~ the property. A prosecution under this section may be brought where the stolen item is recovered or in the location from where it was stolen.

~~(b) A person who buys, receives, sells, possesses unless with the intent to restore to the owner, or aids in the concealment of stolen property, knowing the same to be stolen, shall be punished the same as for the stealing of such property.~~

~~(c) A buyer, receiver, seller, possessor, or concealer under subsection (a) or (b) of this section may be prosecuted and punished in the criminal division of the superior court in the unit where the person stealing the property might be prosecuted, although such property is bought, received, or concealed in another county or unit.~~

Sec. 4. 9 V.S.A. § 3865 is amended to read:

§ 3865. ~~PAWNBROKER'S RECORD BOOK~~ RECORDS OF A PAWNBROKER OR SECONDHAND DEALER

(a) A pawnbroker or a secondhand dealer shall keep ~~a book in which shall be fairly written in the English language, at the time of making a loan, an account and description of the goods, articles or things pawned or pledged, the amount of money loaned thereon, the time of pledging the same, the rate of interest to be paid on such loan, and the name and residence of the person pawning or pledging such property~~ the following records together for each transaction:

(1) a legible statement written at the time of making the loan describing the items pawned, pledged, or sold, and the amount of money lent or paid thereon, the time of the transaction, and the rate of interest to be paid on the loan, as applicable;

(2) a legible statement of the name, current address, telephone number, and vehicle license number of the person pawning, pledging, or selling the items;

(3) a photograph of the items pawned, pledged, or sold; and

(4) a photocopy of a government-issued identification card issued to the person pawning, pledging, or selling the items. If the seller does not have a government-issued identification card, the purchaser shall take and retain a photograph of the seller's face.

(b) At all reasonable times, ~~such book~~ the records required under subsection (a) of this section shall be open to the inspection of ~~the town or city authorities, all courts, the chief of police, or of any person who is duly authorized in writing for that purpose by such authority, court, or chief of police and who exhibits such written authority to such pawnbroker~~ law enforcement.

(c) In this section:

(1) "Precious metal" means gold, silver, platinum, or palladium.

(2) "Secondhand dealer" means a person in the business of purchasing used or estate precious metal, coins, or jewelry for the purpose of sale to consumers or for scrap.

Sec. 5. 9 V.S.A. § 3872 is added to read:

§ 3872. SECONDHAND DEALERS; RETENTION OF GOODS

A pawnbroker or secondhand dealer, as defined in section 3865 of this title, shall retain property pawned, pledged, or purchased for no fewer than 30 days before offering it for sale or for scrap.

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

An act relating to scrap metal processors, pawnbrokers, and secondhand dealers.

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 pending the question, Shall the bill be amended as recommended by the Committee on Economic Development, Housing and General Affairs?, Senator Sears moved to amend the proposal of amendment of the Committee on Economic Development, Housing and General Affairs as follows:

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

Sec. 3. POSSESSION OF STOLEN PROPERTY; STUDY; NONVIOLENT MISDEMEANOR SENTENCE REVIEW COMMITTEE

The nonviolent misdemeanor sentence review committee created by Sec. 4 of No. 41 of the Acts of 2011 shall study the feasibility and advisability of broadening the scope of Vermont's possession and receipt of stolen property statute, 13 V.S.A. § 2561. The study shall consider the practical and policy implications of amending 13 V.S.A. § 2561 to apply to reckless conduct or of otherwise amending state stolen property law to limit the likelihood that stolen property will be purchased and resold by pawnbrokers and other persons engaged in the business of reselling property.

Which was agreed to.

Thereupon, the pending question, Shall the Senate propose to the House to amend the bill as proposed by the Committee on Economic Development, Housing and General Affairs?, was disagreed to on a division of the Senate, Yeas 8, Nays 16.

Thereupon, on motion of Senator Sears, the bill was ordered to lie.

Proposal of Amendment; Third Reading Ordered

H. 559.

Senator Ayer, for the Committee on Health and Welfare, to which was referred House bill entitled:

An act relating to health care reform implementation.

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. 33 V.S.A. § 1802 is amended to read:

§ 1802. DEFINITIONS

For purposes of this subchapter:

* * *

(5) "Qualified employer" ~~means an employer that~~:

(A) means an entity which employed an average of not more than 50 employees on working days during the preceding calendar year and which:

(i) 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)~~(ii) elects to provide coverage through the Vermont health benefit exchange for all of its eligible employees who are principally employed in this state.

(B) on and after January 1, 2016, shall include an entity which:

(i) employed an average of not more than 100 employees on working days during the preceding calendar year; and

(ii) meets the requirements of subdivisions (A)(i) and (A)(ii) of this subdivision (5).

(C) on and after January 1, 2017, shall include all employers meeting the requirements of subdivisions (A)(i) and (ii) of this subdivision (5), regardless of size.

* * *

Sec. 2. 33 V.S.A. § 1804 is amended to read:

§ 1804. QUALIFIED EMPLOYERS

~~[Reserved.]~~

(a)(1) Until January 1, 2016, a qualified employer shall be an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employed at least one and no more than 50 employees, and the term "qualified employer" includes self-employed persons. Calculation of the number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week.

(2) An employer with 50 or fewer employees that offers a qualified health benefit plan to its employees through the Vermont health benefit exchange may continue to participate in the exchange even if the employer's size grows beyond 50 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

(b)(1) From January 1, 2016 until January 1, 2017, a qualified employer shall be an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employed at least one and no more than 100 employees, and the term "qualified employer" includes self-employed persons. Calculation of the number of employees of a qualified employer shall not include a part-time employee who works fewer than 30 hours per week.

(2) An employer with 100 or fewer employees that offers a qualified health benefit plan to its employees through the Vermont health benefit exchange may continue to participate in the exchange even if the employer's size grows beyond 100 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health exchange available to its employees.

(c) On and after January 1, 2017, a qualified employer shall be an employer of any size which elects to make all of its full-time employees eligible for one or more qualified health plans offered in the Vermont health benefit exchange, and the term "qualified employer" includes self-employed persons. A full-time employee shall be an employee who works more than 30 hours per week.

Sec. 2a. 33 V.S.A. § 1806(b) is amended to read:

(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. Said plans may include child-only policies or family policies. If permitted under federal law, a qualified health benefit plan offered in conjunction with a stand-alone dental plan providing pediatric dental benefits meeting the requirements of Section 1302(b)(1)(J) of the Affordable Care Act shall be deemed to meet the requirements of this subsection.

(2) At least the ~~silver~~ bronze 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.

* * *

Sec. 2b. 33 V.S.A. § 1807(b) is amended to read:

(b) Navigators shall have the following duties:

* * *

(7) Provide information about and facilitate employers' establishment of cafeteria or premium-only plans under Section 125 of the Internal Revenue Code that allow employees to pay for health insurance premiums with pretax dollars.

Sec. 2c. EXCHANGE OPTIONS

In approving benefit packages for the Vermont health benefit exchange pursuant to 18 V.S.A. § 9375(b)(7), the Green Mountain Care board shall approve a full range of cost-sharing structures for each level of actuarial value. To the extent permitted under federal law, the board shall also allow health insurers to establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by an insured to programs of

health promotion and disease prevention pursuant to 33 V.S.A. § 1811(f)(2)(B).

Sec. 2d. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

The Vermont health benefit exchange shall have the following duties and responsibilities consistent with the Affordable Care Act:

* * *

(17) Establishing procedures that allow licensed insurance agents and brokers to:

(A) enroll qualified individuals and qualified employers in any qualified health plan offered through the exchange for which the individual or employer is eligible and to be appropriately compensated for doing so; and

(B) assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health benefit plans purchased through the exchange.

Sec. 2e. 33 V.S.A. § 1806(e)(1) is amended to read:

(e)(1) A health insurer offering a qualified health benefit plan shall comply with the following insurance and consumer information requirements:

* * *

(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, the compensation paid to licensed insurance brokers and agents for enrollments made through the exchange, 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.

* * *

Sec. 3. 33 V.S.A. § 1811 is added to read:

§ 1811. HEALTH BENEFIT PLANS FOR INDIVIDUALS AND SMALL EMPLOYERS

(a) As used in this section:

(1) "Health benefit plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered through the Vermont health benefit exchange and issued to an individual or to an employee of a small employer. The 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 in which 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.

(2) "Registered carrier" means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a health benefit plan and who has a registration in effect with the commissioner of banking, insurance, securities, and health care administration as required by this section.

(3)(A) Until January 1, 2016, "small employer" means an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 50 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. An employer may continue to participate in the exchange even if the employer's size grows beyond 50 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

(B) Beginning on January 1, 2016, "small employer" means an employer which, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 100 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. An employer may continue to participate in the exchange even if the employer's size grows beyond 100 employees as long as the employer continuously makes qualified health benefit plans in the Vermont health benefit exchange available to its employees.

(b) No person may provide a health benefit plan to an individual or small employer unless the plan is offered through the Vermont health benefit exchange and complies with the provisions of this subchapter.

(c) No person may provide a health benefit plan to an individual or small employer unless such person is a registered carrier. The commissioner of banking, insurance, securities, and health care administration shall establish, by rule, the minimum financial, marketing, service and other requirements for registration. Such registration shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(d) A registered carrier shall guarantee acceptance of all individuals, small employers, and employees of small employers, and each dependent of such individuals and employees, for any health benefit plan offered by the carrier.

(e) A registered carrier shall offer a health benefit plan rate structure which at least differentiates between single person, two person, and family rates.

(f)(1) A registered carrier shall use a community rating method acceptable to the commissioner of banking, insurance, securities, and health care administration for determining premiums for health benefit plans. Except as provided in subdivision (2) of this subsection, the following risk classification factors are prohibited from use in rating individuals, small employers, or employees of small employers, or the dependents of such individuals or employees:

(A) demographic rating, including age and gender rating;

(B) geographic area rating;

(C) industry rating;

(D) medical underwriting and screening;

(E) experience rating;

(F) tier rating; or

(G) durational rating.

(2)(A) The commissioner shall, by rule, adopt standards and a process for permitting registered carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than

20 percent and provided further that the commissioner's rules may not permit any medical underwriting and screening and shall give due consideration to the need for affordability and accessibility of health insurance.

(B) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health, the director of the Blueprint for Health, and the commissioner of Vermont health access in the development of health promotion and disease prevention rules that are consistent with the Blueprint for Health. Such rules shall:

(i) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (A) of this subdivision (2) does not exceed 30 percent;

(ii) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(iii) provide that the reward under the program is available to all similarly situated individuals and shall comply with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act of 1996; and

(iv) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(C) The commissioner's rules shall include:

(i) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(ii) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(iii) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (2).

(D) The commissioner may require a registered carrier to identify that percentage of a requested premium increase which is attributed to the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall occur at the time a rate increase is sought and shall be in the manner and form directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

(g) A registered carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this section. The requirements for certification shall be as the commissioner prescribes by rule.

(h) A registered carrier shall provide, on forms prescribed by the commissioner, full disclosure to a small employer of all premium rates and any risk classification formulas or factors prior to acceptance of a plan by the small employer.

(i) A registered carrier shall guarantee the rates on a health benefit plan for a minimum of 12 months.

(j) The commissioner shall disapprove any rates filed by any registered carrier, whether initial or revised, for insurance policies unless the anticipated medical loss ratios for the entire period for which rates are computed are at least 80 percent, as required by the Patient Protection and Affordable Care Act (Public Law 111-148).

(k) The guaranteed acceptance provision of subsection (d) of this section shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

Sec. 4. 8 V.S.A. § 4080g is added to read:

§ 4080g. GRANDFATHERED PLANS

(a) Application. Notwithstanding the provisions of 33 V.S.A. § 1811, on and after January 1, 2014, the provisions of this section shall apply to an individual, small group, or association plan that qualifies as a grandfathered health plan under Section 1251 of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) ("Affordable Care Act"). In the event that a plan no longer qualifies as a grandfathered health plan under

the Affordable Care Act, the provisions of this section shall not apply and the provisions of 33 V.S.A. § 1811 shall govern the plan.

(b) Small group plans.

(1) Definitions. As used in this subsection:

(A) "Small employer" means an employer who, on at least 50 percent of its working days during the preceding calendar quarter, employs at least one and no more than 50 employees. The term includes self-employed persons. Calculation of the number of employees of a small employer shall not include a part-time employee who works fewer than 30 hours per week. The provisions of this subsection shall continue to apply until the plan anniversary date following the date that the employer no longer meets the requirements of this subdivision.

(B) "Small group" means:

(i) a small employer; or

(ii) an association, trust, or other group issued a health insurance policy subject to regulation by the commissioner under subdivision 4079(2), (3), or (4) of this title.

(C) "Small group plan" means a group health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered or issued to a small group, including but not limited to common health care plans approved by the commissioner under subdivision (5) of this subsection. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, dental policies, policies that supplement the Civilian Health and Medical Program of the Uniformed Services, or Medicare supplemental policies.

(D) "Registered small group carrier" means any person except an insurance agent, broker, appraiser, or adjuster who issues a small group plan and who has a registration in effect with the commissioner as required by this subsection.

(2) No person may provide a small group plan unless the plan complies with the provisions of this subsection.

(3) No person may provide a small group plan unless such person is a registered small group carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service and other requirements for registration. Such registration shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for

cause or until withdrawn by the carrier. A small group carrier may withdraw its registration upon at least six months prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(4)(A) A registered small group carrier shall guarantee acceptance of all small groups for any small group plan offered by the carrier. A registered small group carrier shall also guarantee acceptance of all employees or members of a small group and each dependent of such employees or members for any small group plan it offers.

(B) Notwithstanding subdivision (A) of this subdivision (b)(4), a health maintenance organization shall not be required to cover:

(i) a small employer which is not physically located in the health maintenance organization's approved service area; or

(ii) a small employer or an employee or member of the small group located or residing within the health maintenance organization's approved service area for which the health maintenance organization:

(I) is not providing coverage; and

(II) reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its network of providers to deliver adequate service because of its existing group contract obligations, including contract obligations subject to the provisions of this subsection and any other group contract obligations.

(5) A registered small group carrier shall offer one or more common health care plans approved by the commissioner. The commissioner, by rule, shall adopt standards and a process for approval of common health care plans that ensure that consumers may compare the costs of plans offered by carriers and that ensure the development of an affordable common health care plan, providing for deductibles, coinsurance arrangements, managed care, cost containment provisions, and any other term, not inconsistent with the provisions of this title, deemed useful in making the plan affordable. A health maintenance organization may add limitations to a common health care plan if the commissioner finds that the limitations do not unreasonably restrict the insured from access to the benefits covered by the plans.

(6) A registered small group carrier shall offer a small group plan rate structure which at least differentiates between single-person, two-person and family rates.

(7)(A) A registered small group carrier shall use a community rating method acceptable to the commissioner for determining premiums for small group plans. Except as provided in subdivision (B) of this subdivision (7), the following risk classification factors are prohibited from use in rating small groups, employees or members of such groups, and dependents of such employees or members:

(i) demographic rating, including age and gender rating;

(ii) geographic area rating;

(iii) industry rating;

(iv) medical underwriting and screening;

(v) experience rating;

(vi) tier rating; or

(vii) durational rating.

(B)(i) The commissioner shall, by rule, adopt standards and a process for permitting registered small group carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent and provided further that the commissioner's rules may not permit any medical underwriting and screening.

(ii) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, split benefit designs, rebates, or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health, the director of the Blueprint for Health, and the commissioner of Vermont health access in the development of health promotion and disease prevention rules that are consistent with the Blueprint for Health. Such rules shall:

(I) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (i) of this subdivision (7)(B) does not exceed 30 percent;

(II) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(III) provide that the reward under the program is available to all similarly situated individuals and complies with the nondiscrimination provisions of the federal Health Insurance Portability and Accountability Act of 1996; and

(IV) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(iii) The commissioner's rules shall include:

(I) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(II) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(III) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (7)(B).

(C) The commissioner may require a registered small group carrier to identify that percentage of a requested premium increase which is attributed to the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall occur at the time a rate increase is sought and shall be in the manner and form as directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

(D) The commissioner may exempt from the requirements of this subsection an association as defined in subdivision 4079(2) of this title which:

(i) offers a small group plan to a member small employer which is community rated in accordance with the provisions of subdivisions (A) and (B) of this subdivision (b)(7). The plan may include risk classifications in accordance with subdivision (B) of this subdivision (7);

(ii) offers a small group plan that guarantees acceptance of all persons within the association and their dependents; and

(iii) offers one or more of the common health care plans approved by the commissioner under subdivision (5) of this subsection.

(E) The commissioner may revoke or deny the exemption set forth in subdivision (D) of this subdivision (7) if the commissioner determines that:

(i) because of the nature, size, or other characteristics of the association and its members, the employees or members are in need of the protections provided by this subsection; or

(ii) the association exemption has or would have a substantial adverse effect on the small group market.

(8) A registered small group carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this subsection. The requirements for certification shall be as the commissioner by rule prescribes.

(9) A registered small group carrier shall provide, on forms prescribed by the commissioner, full disclosure to a small group of all premium rates and any risk classification formulas or factors prior to acceptance of a small group plan by the group.

(10) A registered small group carrier shall guarantee the rates on a small group plan for a minimum of six months.

(11)(A) A registered small group carrier may require that 75 percent or less of the employees or members of a small group with more than 10 employees participate in the carrier's plan. A registered small group carrier may require that 50 percent or less of the employees or members of a small group with 10 or fewer employees or members participate in the carrier's plan. A small group carrier's rules established pursuant to this subdivision shall be applied to all small groups participating in the carrier's plans in a consistent and nondiscriminatory manner.

(B) For purposes of the requirements set forth in subdivision (A) of this subdivision (11), a registered small group carrier shall not include in its calculation an employee or member who is already covered by another group health benefit plan as a spouse or dependent or who is enrolled in Catamount Health, Medicaid, the Vermont health access plan, or Medicare. Employees or members of a small group who are enrolled in the employer's plan and receiving premium assistance under 33 V.S.A. chapter 19 shall be considered to be participating in the plan for purposes of this subsection. If the small group is an association, trust, or other substantially similar group, the participation requirements shall be calculated on an employer-by-employer basis.

(C) A small group carrier may not require recertification of compliance with the participation requirements set forth in this subdivision (11) more often than annually at the time of renewal. If, during the

recertification process, a small group is found not to be in compliance with the participation requirements, the small group shall have 120 days to become compliant prior to termination of the plan.

(12) This subsection shall apply to the provisions of small group plans. This subsection shall not be construed to prevent any person from issuing or obtaining a bona fide individual health insurance policy; provided that no person may offer a health benefit plan or insurance policy to individual employees or members of a small group as a means of circumventing the requirements of this subsection. The commissioner shall adopt, by rule, standards and a process to carry out the provisions of this subsection.

(13) The guaranteed acceptance provision of subdivision (4) of this subsection shall not be construed to limit an employer's discretion in contracting with his or her employees for insurance coverage.

(14) Registered small group carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring small group risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this subsection. Failure or delay in the formation of a reinsurance pool under this subsection shall not delay implementation of this subdivision. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis.

(c) Nongroup health benefit plans.

(1) Definitions. As used in this subsection:

(A) "Individual" means a person who is not eligible for coverage by group health insurance as defined by section 4079 of this title.

(B) "Nongroup plan" means a health insurance policy, a nonprofit hospital or medical service corporation service contract, or a health maintenance organization health benefit plan offered or issued to an individual, including but not limited to common health care plans approved by the commissioner under subdivision (5) of this subsection. The term does not include disability insurance policies, accident indemnity or expense policies, long-term care insurance policies, student or athletic expense or indemnity policies, Medicare supplemental policies, and dental policies. The term also does not include hospital indemnity policies or specified disease indemnity or expense policies, provided such policies are sold only as supplemental

coverage when a common health care plan or other comprehensive health care policy is in effect.

(C) "Registered nongroup carrier" means any person, except an insurance agent, broker, appraiser, or adjuster, who issues a nongroup plan and who has a registration in effect with the commissioner as required by this subsection.

(2) No person may provide a nongroup plan unless the plan complies with the provisions of this subsection.

(3) No person may provide a nongroup plan unless such person is a registered nongroup carrier. The commissioner, by rule, shall establish the minimum financial, marketing, service, and other requirements for registration. Registration under this subsection shall be effective upon approval by the commissioner and shall remain in effect until revoked or suspended by the commissioner for cause or until withdrawn by the carrier. A nongroup carrier may withdraw its registration upon at least six months' prior written notice to the commissioner. A registration filed with the commissioner shall be deemed to be approved unless it is disapproved by the commissioner within 30 days of filing.

(4)(A) A registered nongroup carrier shall guarantee acceptance of any individual for any nongroup plan offered by the carrier. A registered nongroup carrier shall also guarantee acceptance of each dependent of such individual for any nongroup plan it offers.

(B) Notwithstanding subdivision (A) of this subdivision, a health maintenance organization shall not be required to cover:

(i) an individual who is not physically located in the health maintenance organization's approved service area; or

(ii) an individual residing within the health maintenance organization's approved service area for which the health maintenance organization:

(I) is not providing coverage; and

(II) reasonably anticipates and demonstrates to the satisfaction of the commissioner that it will not have the capacity within its network of providers to deliver adequate service because of its existing contract obligations, including contract obligations subject to the provisions of this subsection and any other group contract obligations.

(5) A registered nongroup carrier shall offer two or more common health care plans approved by the commissioner. The commissioner, by rule, shall adopt standards and a process for approval of common health care plans

that ensure that consumers may compare the cost of plans offered by carriers. At least one plan shall be a low-cost common health care plan that may provide for deductibles, coinsurance arrangements, managed care, cost-containment provisions, and any other term not inconsistent with the provisions of this title that are deemed useful in making the plan affordable.

A health maintenance organization may add limitations to a common health care plan if the commissioner finds that the limitations do not unreasonably restrict the insured from access to the benefits covered by the plan.

(6) A registered nongroup carrier shall offer a nongroup plan rate structure which at least differentiates between single-person, two-person and family rates.

(7) For a 12-month period from the effective date of coverage, a registered nongroup carrier may limit coverage of preexisting conditions which exist during the 12-month period before the effective date of coverage; provided that a registered nongroup carrier shall waive any preexisting condition provisions for all individuals and their dependents who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to the carrier's common health care plan approved by the commissioner. If an individual has a preexisting condition excluded under a subsequent policy, such exclusion shall not continue longer than the period required under the original contract or 12 months, whichever is less. Credit shall be given for prior coverage that occurred without a break in coverage of 63 days or more. For an eligible individual as such term is defined in Section 2741 of Title XXVII of the Public Health Service Act, a registered nongroup carrier shall not limit coverage of preexisting conditions.

(8)(A) A registered nongroup carrier shall use a community rating method acceptable to the commissioner for determining premiums for nongroup plans. Except as provided in subdivision (B) of this subsection, the following risk classification factors are prohibited from use in rating individuals and their dependents:

(i) demographic rating, including age and gender rating;

(ii) geographic area rating;

(iii) industry rating;

(iv) medical underwriting and screening;

(v) experience rating;

(vi) tier rating; or

(vii) durational rating.

(B)(i) The commissioner shall, by rule, adopt standards and a process for permitting registered nongroup carriers to use one or more risk classifications in their community rating method, provided that the premium charged shall not deviate above or below the community rate filed by the carrier by more than 20 percent and provided further that the commissioner's rules may not permit any medical underwriting and screening and shall give due consideration to the need for affordability and accessibility of health insurance.

(ii) The commissioner's rules shall permit a carrier, including a hospital or medical service corporation and a health maintenance organization, to establish rewards, premium discounts, and rebates or otherwise waive or modify applicable co-payments, deductibles, or other cost-sharing amounts in return for adherence by a member or subscriber to programs of health promotion and disease prevention. The commissioner shall consult with the commissioner of health and the commissioner of Vermont health access in the development of health promotion and disease prevention rules. Such rules shall:

(I) limit any reward, discount, rebate, or waiver or modification of cost-sharing amounts to not more than a total of 15 percent of the cost of the premium for the applicable coverage tier, provided that the sum of any rate deviations under subdivision (B)(i) of this subdivision (8) does not exceed 30 percent;

(II) be designed to promote good health or prevent disease for individuals in the program and not be used as a subterfuge for imposing higher costs on an individual based on a health factor;

(III) provide that the reward under the program is available to all similarly situated individuals; and

(IV) provide a reasonable alternative standard to obtain the reward to any individual for whom it is unreasonably difficult due to a medical condition or other reasonable mitigating circumstance to satisfy the otherwise applicable standard for the discount and disclose in all plan materials that describe the discount program the availability of a reasonable alternative standard.

(iii) The commissioner's rules shall include:

(I) standards and procedures for health promotion and disease prevention programs based on the best scientific, evidence-based medical practices as recommended by the commissioner of health;

(II) standards and procedures for evaluating an individual's adherence to programs of health promotion and disease prevention; and

(III) any other standards and procedures necessary or desirable to carry out the purposes of this subdivision (8)(B).

(iv) The commissioner may require a registered nongroup carrier to identify that percentage of a requested premium increase which is attributed to the following categories: hospital inpatient costs, hospital outpatient costs, pharmacy costs, primary care, other medical costs, administrative costs, and projected reserves or profit. Reporting of this information shall occur at the time a rate increase is sought and shall be in the manner and form directed by the commissioner. Such information shall be made available to the public in a manner that is easy to understand.

(9) Notwithstanding subdivision (8)(B) of this subsection, the commissioner shall not grant rate increases, including increases for medical inflation, for individuals covered pursuant to the provisions of this subsection that exceed 20 percent in any one year; provided that the commissioner may grant an increase that exceeds 20 percent if the commissioner determines that the 20 percent limitation will have a substantial adverse effect on the financial safety and soundness of the insurer. In the event that this limitation prevents implementation of community rating to the full extent provided for in subdivision (8) of this subsection, the commissioner may permit insurers to limit community rating provisions accordingly as applicable to individuals who would otherwise be entitled to rate reductions.

(10) A registered nongroup carrier shall file with the commissioner an annual certification by a member of the American Academy of Actuaries of the carrier's compliance with this subsection. The requirements for certification shall be as the commissioner by rule prescribes.

(11) A registered nongroup carrier shall guarantee the rates on a nongroup plan for a minimum of 12 months.

(12) Registered nongroup carriers, except nonprofit medical and hospital service organizations and nonprofit health maintenance organizations, shall form a reinsurance pool for the purpose of reinsuring nongroup risks. This pool shall not become operative until the commissioner has approved a plan of operation. The commissioner shall not approve any plan which he or she determines may be inconsistent with any other provision of this subsection. Failure or delay in the formation of a reinsurance pool under this subsection shall not delay implementation of this subdivision. The participants in the plan of operation of the pool shall guarantee, without limitation, the solvency of the pool, and such guarantee shall constitute a permanent financial obligation of each participant, on a pro rata basis.

(13) The commissioner shall disapprove any rates filed by any registered nongroup carrier, whether initial or revised, for nongroup insurance

policies unless the anticipated loss ratios for the entire period for which rates are computed are at least 70 percent. For the purpose of this subdivision, "anticipated loss ratio" shall mean a comparison of earned premiums to losses incurred plus a factor for industry trend where the methodology for calculating trend shall be determined by the commissioner by rule.

* * * Green Mountain Care Board * * *

Sec. 5. 18 V.S.A. § 9374 is amended to read:

§ 9374. BOARD MEMBERSHIP; AUTHORITY

* * *

(g) The chair of the board or designee may apply for grant funding, if available, to advance or support any responsibility within the board's jurisdiction.

(h)(1) Expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the board shall be borne as follows:

(A) 40 percent by the state from state monies;

(B) 15 percent by the hospitals;

(C) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125;

(D) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101; and

(E) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

(2) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the board to perform its duties, the chair of the board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the chair

may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however, any person subject to the board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the chair upon properly being ordered to do so may be assessed an administrative penalty by the chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

Sec. 5a. BILL-BACK REPORT

No later than February 1, 2013, the department of banking, insurance, securities, and health care administration and the Green Mountain Care board shall report to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance regarding the allocation of expenses among hospitals and health insurers to finance the department's and the board's regulatory activities pursuant to 18 V.S.A. §§ 9374(h) and 9415. The report shall address the basis for the formula and how it is applied and shall contain the department's and the board's recommendations for alternate expense allocation formulas or models.

* * * Unified Health Care Budget * * *

Sec. 6. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

* * *

(14) "Unified health care budget" means the budget established in accordance with section 9375a of this title.

(15) "Wellness services" means health services, programs, or activities that focus on the promotion or maintenance of good health.

Sec. 7. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

* * *

(15) ~~"Unified health care budget" means the budget established in accordance with section 9406 of this title.~~ [Deleted.]

* * *

Sec. 8. 18 V.S.A. § 9403 is amended to read:

§ 9403. DIVISION OF HEALTH CARE ADMINISTRATION; PURPOSES

The division of health care administration is created in the department of banking, insurance, securities, and health care administration. The division shall assist the commissioner in carrying out the policies of the state regarding health care delivery, cost, and quality, by providing oversight of health care quality and expenditures through the ~~certificate of need program and the unified health care budget for the state or with respect to Vermont residents~~, establishment and maintenance of consumer protection functions, and oversight of quality assurance within the health care system. The division shall also establish and maintain a data base with information needed to carry out the commissioner's duties and obligations under this chapter and Title 8.

Sec. 9. 18 V.S.A. § 9405(b) is amended to read:

(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.

(1) The plan shall include:

* * *

(C) Consistent with the principles set forth in subdivision (A) of this subdivision (1), recommendations for the appropriate supply and distribution of resources, programs, and services identified in subdivision (B) of this subdivision (1), options for implementing such recommendations and mechanisms which will encourage the appropriate integration of these services on a local or regional basis. To arrive at such recommendations, the commissioner shall consider at least the following factors: the values and goals reflected in the state health plan; the needs of the population on a statewide basis; the needs of particular geographic areas of the state, as identified in the state health plan; the needs of uninsured and underinsured populations; the use of Vermont facilities by out-of-state residents; the use of out-of-state facilities by Vermont residents; the needs of populations with special health care needs; the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners; the cost impact of these resource requirements on health care expenditures; the services appropriate for the four categories of hospitals described in subdivision 9402(12) of this title; the overall quality and use of health care services as reported by the Vermont program for quality in health care and the

Vermont ethics network; the overall quality and cost of services as reported in the annual hospital community reports; individual hospital four-year capital budget projections; ~~the unified health care budget;~~ and the four-year projection of health care expenditures prepared by the division.

* * *

Sec. 10. 18 V.S.A. § 9406 is amended to read:

~~§ 9406. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET~~

~~(a) Annually, the commissioner shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in section 9401 of this title.~~

~~(1) The budget shall:~~

~~(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.~~

~~(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont, and for all health care services provided to residents of this state.~~

~~(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.~~

~~(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.~~

~~(2) The commissioner shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.~~

~~(b)(1) Annually the division shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the commissioner under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:~~

~~(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organizations, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and~~

~~(B) expenditures for Medicare, all self insured employers, and all other health insurance.~~

~~(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the division's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year, and an evaluation of the efficacy of any cost containment efforts the plan has made.~~

~~(3) The division's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.~~

~~(4) The division shall prepare a report of the final projections made under this subsection, and file the report with the general assembly on or before January 15 of each year.~~ [Repealed.]

Sec. 11. 18 V.S.A. 9375a is added to read:

§ 9375a. EXPENDITURE ANALYSIS; UNIFIED HEALTH CARE BUDGET

(a) Annually, the board shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in sections 9371 and 9372 of this title.

(1) The budget shall:

(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.

(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont and for all health care services provided to residents of this state.

(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.

(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

(2) The board shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.

(b)(1) Annually the board shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the board under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:

(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organization, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and

(B) expenditures for Medicare, all self-insured employers, and all other health insurance.

(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the board's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year and an evaluation of the efficacy of any cost containment efforts the plan has made.

(3) The board's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department of banking, insurance, securities, and health care administration, and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.

(4) The board shall prepare a report of the final projections made under this subsection and file the report with the general assembly on or before January 15 of each year.

* * * Claims Edit Standards * * *

Sec. 11a. 18 V.S.A. § 9418a is amended to read:

§ 9418a. PROCESSING CLAIMS, DOWNCODING, AND ADHERENCE TO CODING RULES

(a) Health plans, contracting entities, covered entities, and payers shall accept and initiate the processing of all health care claims submitted by a health care provider pursuant to and consistent with the current version of the American Medical Association's Current Procedural Terminology (CPT)

codes, reporting guidelines, and conventions; the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System (HCPCS); American Society of Anesthesiologists; the National Correct Coding Initiative (NCCI); the National Council for Prescription Drug Programs coding; or other appropriate nationally recognized standards, guidelines, or conventions approved by the commissioner.

(b) When editing claims, health plans, contracting entities, covered entities, and payers shall adhere to edit standards ~~that are no more restrictive than the following,~~ except as provided in subsection (c) of this section:

(1) The CPT, HCPCS, and NCCI;

(2) National specialty society edit standards; or

(3) Other appropriate nationally recognized edit standards, guidelines, or conventions approved by the commissioner.

(c) Adherence to the edit standards in subdivision (b)(1) or (2) of this section is not required:

(1) When necessary to comply with state or federal laws, rules, regulations, or coverage mandates; or

(2) For ~~services not addressed by NCCI standards or national specialty society edit standards~~ edits that the payer determines are more favorable to providers than the edit standards in subdivisions (b)(1) through (3) of this section or to address new codes not yet incorporated by a payer's edit management software, provided the edit standards are developed with input from the relevant Vermont provider community and national provider organizations and provided the edits are available to providers on the plan's websites and in their newsletters.

(d) Nothing in this section shall preclude a health plan, contracting entity, covered entity, or payer from determining that any such claim is not eligible for payment in full or in part, based on a determination that:

(1) The claim is contested as defined in subdivision 9418(a)(2) of this title;

(2) The service provided is not a covered benefit under the contract, including a determination that such service is not medically necessary or is experimental or investigational;

(3) The insured did not obtain a referral, prior authorization, or precertification, or satisfy any other condition precedent to receiving covered benefits from the health care provider;

(4) The covered benefit exceeds the benefit limits of the contract;

(5) The person is not eligible for coverage or is otherwise not compliant with the terms and conditions of his or her coverage agreement;

(6) The health plan has a reasonable belief that fraud or other intentional misconduct has occurred; or

(7) The health plan, contracting entity, covered entity, or payer determines through coordination of benefits that another entity is liable for the claim.

(e) Nothing in this section shall be deemed to require a health plan, contracting entity, covered entity, or payer to pay or reimburse a claim, in full or in part, or to dictate the amount of a claim to be paid by a health plan, contracting entity, covered entity, or payer to a health care provider.

(f) No health plan, contracting entity, covered entity, or payer shall automatically reassign or reduce the code level of evaluation and management codes billed for covered services (downcoding), except that a health plan, contracting entity, covered entity, or payer may reassign a new patient visit code to an established patient visit code based solely on CPT codes, CPT guidelines, and CPT conventions.

(g) Notwithstanding the provisions of subsection (d) of this section, and other than the edits contained in the conventions in subsections (a) and (b) of this section, health plans, contracting entities, covered entities, and payers shall continue to have the right to deny, pend, or adjust claims for services on other bases and shall have the right to reassign or reduce the code level for selected claims for services based on a review of the clinical information provided at the time the service was rendered for the particular claim or a review of the information derived from a health plan's fraud or abuse billing detection programs that create a reasonable belief of fraudulent or abusive billing practices, provided that the decision to reassign or reduce is based primarily on a review of clinical information.

(h) Every health plan, contracting entity, covered entity, and payer shall publish on its provider website and in its provider newsletter if applicable:

(1) The name of any commercially available claims editing software product that the health plan, contracting entity, covered entity, or payer utilizes;

(2) The standard or standards, pursuant to subsection (b) of this section, that the entity uses for claim edits;

(3) The payment percentages for modifiers; and

(4) Any significant edits, as determined by the health plan, contracting entity, covered entity, or payer, added to the claims software product after the

effective date of this section, which are made at the request of the health plan, contracting entity, covered entity, or payer.

(i) Upon written request, the health plan, contracting entity, covered entity, or payer shall also directly provide the information in subsection (h) of this section to a health care provider who is a participating member in the health plan's, contracting entity's, covered entity's, or payer's provider network.

(j) For purposes of this section, "health plan" includes a workers' compensation policy of a casualty insurer licensed to do business in Vermont.

(k) ~~Prior to the effective date of subsections (b) and (c) of this section, MVP Healthcare is requested to convene~~ Blue Cross and Blue Shield of Vermont and the Vermont Medical Society are requested to continue convening a work group consisting of health plans, health care providers, state agencies, and other interested parties to study the edit standards in subsection (b) of this section, the edit standards in national class action settlements, and edit standards and edit transparency standards established by other states to determine the most appropriate way to ensure that health care providers can access information about the edit standards applicable to the health care services they provide. ~~No later than January 1, 2012, the~~ The work group is requested to ~~report its findings and recommendations, including any recommendations for legislative changes to subsections (b) and (c) of this section,~~ provide an annual progress report to the house committee on health care and the senate ~~committee~~ committees on health and welfare and on finance.

(l) With respect to the work group established under subsection (k) of this section and to the extent required to avoid violations of federal antitrust laws, the department shall facilitate and supervise the participation of members of the work group.

* * * Mental Health and Substance Abuse * * *

Sec. 11b. 18 V.S.A. chapter 221, subchapter 8 is added to read:

Subchapter 8. Mental Health and Substance Abuse Treatment Quality Assurance

§ 9461. QUALITY INDICATORS

(a) The department of banking, insurance, securities, and health care administration shall develop performance quality indicators to evaluate and ensure that health insurers, including managed care organizations that contract with health insurers to administer the insurers' mental health benefits, comply with the provisions of 8 V.S.A. § 4089b and related rules.

(b) The departments of health and of mental health shall develop clinical and performance quality measures to evaluate and ensure that health care professionals and health care facilities in Vermont provide high quality mental health and substance abuse treatment services to their patients.

§ 9462. QUALITY IMPROVEMENT PROJECTS

In addition to reviewing mental health and substance abuse treatment data pursuant to subdivision 9375(b)(12) of this title, the Green Mountain Care board shall consider the results of any quality improvement projects not otherwise confidential or privileged undertaken by managed care organizations for mental health and substance abuse care and treatment pursuant to 8 V.S.A. § 4089b(d)(1)(B)(vii) and subsection 9414(i) of this title.

Sec. 11c. 8 V.S.A. § 4089b(c) is amended to read:

(c) A health insurance plan shall provide coverage for treatment of a mental health condition and shall:

(1) not establish any rate, term, or condition that places a greater burden on an insured for access to treatment for a mental health condition than for access to treatment for other health conditions, including no greater co-payment for primary mental health care or services than the co-payment applicable to care or services provided by a primary care provider under an insured's policy and no greater co-payment for specialty mental health care or services than the co-payment applicable to care or services provided by a specialist provider under an insured's policy;

* * *

Sec. 11d. PARITY FOR PRIMARY MENTAL HEALTH CARE SERVICES; RULEMAKING

To carry out the purposes of Sec. 11c of this act, the commissioner of banking, insurance, securities, and health care administration shall adopt rules pursuant to 3 V.S.A. chapter 25, distinguishing between primary and specialty mental health services, taking into consideration factors such as mental health care providers' scope of practice and patterns of patient visitation.

Sec. 11e. 18 V.S.A. § 7259 is added to chapter 174 to read:

§ 7259. MENTAL HEALTH CARE OMBUDSMAN

(a) The department of mental health shall establish the office of the mental health care ombudsman within the agency designated by the governor as the protection and advocacy system for the state pursuant to 42 U.S.C. § 10801 et seq. The agency may execute the duties of the office of the mental health

care ombudsman, including authority to assist individuals with mental health conditions and to advocate for policy issues on their behalf.

(b) The agency may provide a report annually to the general assembly regarding the implementation of this section.

(c) In the event the protection and advocacy system ceases to provide federal funding to the agency for the purposes described in this section, the general assembly may allocate sufficient funds to maintain the office of the mental health care ombudsman.

* * * Prior Authorization * * *

Sec. 11f. 18 V.S.A. § 9418b is amended to read:

§ 9418b. PRIOR AUTHORIZATION

* * *

(g)(1) Notwithstanding any provision of law to the contrary, on and after March 1, 2014, a health plan shall accept only the uniform prior authorization forms developed pursuant to subdivision (3) of this subsection when requiring prior authorization of prescription drugs, medical procedures, and medical tests. If a health plan fails to utilize or accept a uniform prior authorization form, or fails to respond within two business days of receipt of a completed prior authorization request from a prescribing health care provider, the prior authorization request shall be deemed to have been granted.

(2) No later than September 1, 2013, the department of banking, insurance, securities, and health care administration shall develop two uniform prior authorization forms. One form shall be used for prior authorization requests for prescription drugs, and one form shall be used for prior authorization requests for medical procedures and medical tests. Notwithstanding any provision of law to the contrary, beginning March 1, 2014, each prescribing health care provider licensed to practice in Vermont shall use the applicable uniform prior authorization forms to request prior authorization for coverage of prescription drugs, medical procedures, and medical tests, and each health plan licensed to do business in Vermont shall accept the uniform prior authorization forms as sufficient to request prior authorization for the applicable benefits.

(3) To the extent consistent with federal law, each uniform prior authorization form developed pursuant to subdivision (2) of this subsection shall meet the following criteria:

(A) The form shall not exceed two pages.

(B) The form shall be made available electronically by the department and by the health plan.

(C) The completed form may be submitted electronically from the prescribing health care provider to the health plan.

(D) The department shall develop the form with input from interested parties from at least one public meeting.

(E) In developing the uniform prior authorization form, the department shall take into consideration the following:

(i) existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services, by the department of Vermont health access, and by insurance and Medicaid departments and agencies in other states; and

(ii) national standards related to electronic prior authorization, if available.

* * * Certificate of Need * * *

Sec. 12. 18 V.S.A. § 9375(b) is amended to read:

(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 this chapter ~~13, subchapter 2 of this title~~ are consistent with such reforms.

* * *

(6) ~~Review and approve recommendations from the commissioner of banking, insurance, securities, and health care administration, within 10 business~~ Approve or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of ~~such recommendations and~~ a request for approval from the commissioner of banking, insurance, securities, and health care administration, 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)~~(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012~~; and~~.

~~(C)~~(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning ~~July 1, 2012~~ January 1, 2013.

~~(7)~~(9) 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)~~(10) Develop and maintain a method for evaluating systemwide performance and quality, including identification of the appropriate process and outcome measures:

* * *

(11) Develop the unified health care budget pursuant to section 9375a of this title.

(12) Review data regarding mental health and substance abuse treatment reported to the department of banking, insurance, securities, and health care administration pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the mental health technical advisory group established pursuant to subdivision 9374(e)(2) of this title.

Sec. 13. 18 V.S.A. § 9402 is amended to read:

§ 9402. DEFINITIONS

As used in this chapter, unless otherwise indicated:

* * *

(5) "Expenditure analysis" means the expenditure analysis developed pursuant to section ~~9406~~ 9375a of this title.

(6) "Health care facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient, or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision ~~9432(10)~~ 9432(8) of this title, except health maintenance organizations.

* * *

(10) "Health resource allocation plan" means the plan adopted by the commissioner of banking, insurance, securities, and health care administration under section 9405 of this title.

* * *

(15) "Unified health care budget" means the budget established in accordance with section ~~9406~~ 9375a of this title.

(16) "State health plan" means the plan developed under section 9405 of this title.

(17) "Green Mountain Care board" or "board" means the Green Mountain Care board established in chapter 220 of this title.

Sec. 14. 18 V.S.A. § 9412 is amended to read:

§ 9412. ENFORCEMENT

(a) In order to carry out the duties under this chapter, ~~the commissioner,~~ in addition to the powers provided in this chapter, in chapter 220 of this title, and in Title 8, the commissioner and the board may examine the books, accounts, and papers of health insurers, health care providers, health care facilities, health plans, contracting entities, covered entities, and payers, as defined in section 9418 of this title, and may administer oaths and may issue subpoenas to a person to appear and testify or to produce documents or things.

* * *

Sec. 14a. 18 V.S.A. § 9431(b) is amended to read:

(b) In order to carry out the policy goals of this subchapter, the ~~department~~ board shall adopt by rule by ~~October 1, 2005~~ January 1, 2013, certificate of need procedural guidelines to assist in its decision-making. The guidelines shall be consistent with the state health plan and the health resource allocation plan.

Sec. 15. 18 V.S.A. § 9433 is amended to read:

§ 9433. ADMINISTRATION

(a) The ~~commissioner~~ board shall exercise such duties and powers as shall be necessary for the implementation of the certificate of need program as provided by and consistent with this subchapter. The ~~commissioner~~ board shall issue or deny certificates of need.

(b) The ~~commissioner~~ board may adopt rules governing the review of certificate of need applications consistent with and necessary to the proper administration of this subchapter. All rules shall be adopted pursuant to 3 V.S.A. chapter 25 ~~of Title 3~~.

(c) The ~~commissioner~~ board shall consult with hospitals, nursing homes and professional associations and societies, the secretary of human services, and other interested parties in matters of policy affecting the administration of this subchapter.

(d) The ~~commissioner~~ board shall administer the certificate of need program.

Sec. 16. 18 V.S.A. § 9434 is amended to read:

§ 9434. CERTIFICATE OF NEED; GENERAL RULES

(a) A health care facility other than a hospital shall not develop, or have developed on its behalf a new health care project without issuance of a certificate of need by the ~~commissioner~~ board. For purposes of this subsection, a "new health care project" includes the following:

* * *

(3) The offering of any home health service, or the transfer or conveyance of more than a 50 percent ownership interest ~~of a home health agency~~ in a health care facility other than a hospital.

(4) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. For purposes of this subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision ~~9432(7)(B)~~9432(8)(B) of this title, as determined by the ~~commissioner~~ board, shall be considered together in calculating the amount of an expenditure. The ~~commissioner's~~ board's determination of functional interdependence of items of equipment under this subdivision shall have the effect of a final decision and is subject to appeal under ~~this subchapter~~ section 9381 of this title.

* * *

(b) A hospital shall not develop or have developed on its behalf a new health care project without issuance of a certificate of need by the ~~commissioner~~ board. For purposes of this subsection, a "new health care project" includes the following:

* * *

(2) The purchase, lease, or other comparable arrangement of a single piece of diagnostic and therapeutic equipment for which the cost, or in the case of a donation the value, is in excess of $1,000,000.00. For purposes of this

subdivision, the purchase or lease of one or more articles of diagnostic or therapeutic equipment which are necessarily interdependent in the performance of their ordinary functions or which would constitute any health care facility included under subdivision ~~9432(7)(B)~~9432(8)(B) of this title, as determined by the ~~commissioner~~ board, shall be considered together in calculating the amount of an expenditure. The ~~commissioner's~~ board's determination of functional interdependence of items of equipment under this subdivision shall have the effect of a final decision and is subject to appeal under ~~this subchapter~~ section 9381 of this title.

* * *

(c) In the case of a project which requires a certificate of need under this section, expenditures for which are anticipated to be in excess of $30,000,000.00, the applicant first shall secure a conceptual development phase certificate of need, in accordance with the standards and procedures established in this subchapter, which permits the applicant to make expenditures for architectural services, engineering design services, or any other planning services, as defined by the ~~commissioner~~ board, needed in connection with the project. Upon completion of the conceptual development phase of the project, and before offering or further developing the project, the applicant shall secure a final certificate of need, in accordance with the standards and procedures established in this subchapter. Applicants shall not be subject to sanctions for failure to comply with the provisions of this subsection if such failure is solely the result of good faith reliance on verified project cost estimates issued by qualified persons, which cost estimates would have led a reasonable person to conclude the project was not anticipated to be in excess of $30,000,000.00 and therefore not subject to this subsection. The provisions of this subsection notwithstanding, expenditures may be made in preparation for obtaining a conceptual development phase certificate of need, which expenditures shall not exceed $1,500,000.00 for non-hospitals or $3,000,000.00 for hospitals.

(d) If the ~~commissioner~~ board determines that a person required to obtain a certificate of need under this subchapter has separated a single project into components in order to avoid cost thresholds or other requirements under this subchapter, the person shall be required to submit an application for a certificate of need for the entire project, and the ~~commissioner~~ board may proceed under section 9445 of this title. The ~~commissioner's~~ board's determination under this subsection shall have the effect of a final decision and is subject to appeal under ~~this subchapter~~ section 9381 of this title.

(e) Beginning January 1, ~~2005~~ 2013, and biannually thereafter, the ~~commissioner~~ board may by rule adjust the monetary jurisdictional thresholds

contained in this section. In doing so, the ~~commissioner~~ board shall reflect the same categories of health care facilities, services, and programs recognized in this section. Any adjustment by the ~~commissioner~~ board shall not exceed the consumer price index rate of inflation.

Sec. 16a. 18 V.S.A. § 9435 is amended to read:

§ 9435. EXCLUSIONS

* * *

(b) Excluded from this subchapter are community mental health or developmental disability center health care projects proposed by a designated agency and supervised by the commissioner of mental health or the commissioner of disabilities, aging, and independent living, or both, depending on the circumstances and subject matter of the project, provided the appropriate commissioner or commissioners make a written approval of the proposed health care project. The designated agency shall submit a copy of the approval with a letter of intent to the ~~commissioner~~ board.

* * *

(e) Upon request under 8 V.S.A. § 5102(f) by a Program for All-Inclusive Care for the Elderly (PACE) authorized under federal Medicare law, or by a Prepaid Inpatient Health Plan (PIHP) or Prepaid Ambulatory Health Plan (PAHP) established in accordance with federal Medicare or Medicaid laws and regulations, the ~~commissioner~~ board may approve the exemption of the PACE program, PIHP, or PAHP from the provisions of this subchapter and from any other provisions of this chapter if the ~~commissioner~~ board determines that the purposes of this subchapter and the purposes of any other provision of this chapter will not be materially and adversely affected by the exemption. In approving an exemption, the ~~commissioner~~ board may prescribe such terms and conditions as the ~~commissioner~~ board deems necessary to carry out the purposes of this subchapter and this chapter.

Sec. 17. 18 V.S.A. § 9437 is amended to read:

§ 9437. CRITERIA

A certificate of need shall be granted if the applicant demonstrates and the ~~commissioner~~ board finds that:

(1) the application is consistent with the health resource allocation plan;

(2) the cost of the project is reasonable, because:

(A) the applicant's financial condition will sustain any financial burden likely to result from completion of the project;

(B) the project will not result in an undue increase in the costs of medical care. In making a finding under this subdivision, the ~~commissioner~~ board shall consider and weigh relevant factors, including:

* * *

Sec. 18. 18 V.S.A. § 9439 is amended to read:

§ 9439. COMPETING APPLICATIONS

(a) The ~~commissioner~~ board shall provide by rule a process by which any person wishing to offer or develop a new health care project may submit a competing application when a substantially similar application is pending. The competing application must be filed and completed in a timely manner, and the original application and all competing applications shall be reviewed concurrently. A competing applicant shall have the same standing for administrative and judicial review under this subchapter as the original applicant.

(b) When a letter of intent to compete has been filed, the review process is suspended and the time within which a decision must be made as provided in subdivision 9440(d)(4) of this title is stayed until the competing application has been ruled complete or for a period of 55 days from the date of notification under subdivision 9440(c)(8) as to the original application, whichever is shorter.

(c) Nothing in this subchapter shall be construed to restrict the ~~commissioner~~ board to granting a certificate of need to only one applicant for a new health care project.

(d) The ~~commissioner~~ board may, by rule, establish regular review cycles for the addition of beds for skilled nursing or intermediate care.

(e) In the case of proposals for the addition of beds for skilled nursing or intermediate care, the ~~commissioner~~ board shall identify in advance of the review the number of additional beds to be considered in that cycle or the maximum additional financial obligation to be incurred by the agencies of the state responsible for financing long-term care. The number of beds shall be consistent with the number of beds determined to be necessary by the health resource management plan or state health plan, whichever applies, and shall take into account the number of beds needed to develop a new, efficient facility.

(f) Unless an application meets the requirements of subsection 9440(e) of this title, the ~~commissioner~~ board shall consider disapproving a certificate of need application for a hospital if a project was not identified prospectively as needed at least two years prior to the time of filing in the hospital's four-year

capital plan required under subdivision 9454(a)(6) of this title. The ~~commissioner~~ board shall review all hospital four-year capital plans as part of the review under subdivision 9437(2)(B) of this title.

Sec. 19. 18 V.S.A. § 9440 is amended to read:

§ 9440. PROCEDURES

(a) Notwithstanding 3 V.S.A. chapter 25 ~~of Title 3~~, a certificate of need application shall be in accordance with the procedures of this section.

(b)(1) The application shall be in such form and contain such information as the ~~commissioner~~ board establishes. In addition, the ~~commissioner~~ board may require of an applicant any or all of the following information that the ~~commissioner~~ board deems necessary:

(A) institutional utilization data, including an explanation of the unique character of services and a description of case mix;

(B) a population based description of the institution's service area;

(C) the applicant's financial statements;

(D) third party reimbursement data;

(E) copies of feasibility studies, surveys, designs, plans, working drawings, or specifications developed in relation to the proposed project;

(F) annual reports and four-year long range plans;

(G) leases, contracts, or agreements of any kind that might affect quality of care or the nature of services provided;

(H) the status of all certificates issued to the applicant under this subchapter during the three years preceding the date of the application. As a condition to deeming an application complete under this section, the ~~commissioner~~ board may require that an applicant meet with the ~~commissioner~~ board to discuss the resolution of the applicant's compliance with those prior certificates; and

(I) additional information as needed by the ~~commissioner~~ board, including information from affiliated corporations or other persons in the control of or controlled by the applicant.

(2) In addition to the information required for submission, an applicant may submit, and the ~~commissioner~~ board shall consider, any other information relevant to the application or the review criteria.

(c) The application process shall be as follows:

(1) Applications shall be accepted only at such times as the ~~commissioner~~ board shall establish by rule.

(2)(A) Prior to filing an application for a certificate of need, an applicant shall file an adequate letter of intent with the ~~commissioner~~ board no less than 30 days or, in the case of review cycle applications under section 9439 of this title, no less than 45 days prior to the date on which the application is to be filed. The letter of intent shall form the basis for determining the applicability of this subchapter to the proposed expenditure or action. A letter of intent shall become invalid if an application is not filed within six months of the date that the letter of intent is received or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule. Except for requests for expedited review under subdivision (5) of this subsection, public notice of such letters of intent shall be provided in newspapers having general circulation in the region of the state affected by the letter of intent. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application or petition to intervene must be filed. In addition, a copy of the public notice shall be sent to the clerk of the municipality in which the health care facility is located. Upon receipt, the clerk shall post the notice in or near the clerk's office and in at least two other public places in the municipality.

(B) Applicants who agree that their proposals are subject to jurisdiction pursuant to section 9434 of this title shall not be required to file a letter of intent pursuant to subdivision (A) of this subdivision (2) and may file an application without further process. Public notice of the application shall be provided upon filing as provided for in subdivision (A) of this subdivision (2) for letters of intent.

(3) The ~~commissioner~~ board shall review each letter of intent and, if the letter contains the information required for letters of intent as established by the ~~commissioner~~ board by rule, within 30 days, determine whether the project described in the letter will require a certificate of need. If the ~~commissioner~~ board determines that a certificate of need is required for a proposed expenditure or action, an application for a certificate of need shall be filed before development of the project begins.

(4) Within 90 days of receipt of an application, the ~~commissioner~~ board 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~~ board 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~~ board's notice that additional information is required shall not be included within the maximum review period permitted under this subsection. The ~~commissioner~~ board 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.

(5) An applicant seeking expedited review of a certificate of need application may simultaneously file a letter of intent and an application with the ~~commissioner~~ board. Upon making a determination that the proposed project may be uncontested and does not substantially alter services, as defined by rule, or upon making a determination that the application relates to a health care facility affected by bankruptcy proceedings, the ~~commissioner~~ board shall issue public notice of the application and the request for expedited review and identify a date by which a competing application or petition for interested party status must be filed. If a competing application is not filed and no person opposing the application is granted interested party status, the ~~commissioner~~ board may formally declare the application uncontested and may issue a certificate of need without further process, or with such abbreviated process as the ~~commissioner~~ board deems appropriate. If a competing application is filed or a person opposing the application is granted interested party status, the applicant shall follow the certificate of need standards and procedures in this section, except that in the case of a health care facility affected by bankruptcy proceedings, the ~~commissioner~~ board after notice and an opportunity to be heard may issue a certificate of need with such abbreviated process as the ~~commissioner~~ board deems appropriate, notwithstanding the contested nature of the application.

(6) If an applicant fails to respond to an information request under subdivision (4) of this subsection within six months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule, the application will be deemed inactive unless the applicant, within six months, requests in writing that the application be reactivated and the ~~commissioner~~ board grants the request. If an applicant fails to respond to an information request within 12 months or, in the case of review cycle applications under section 9439 of this title, within such time limits as the ~~commissioner~~ board shall establish by rule, the application will become invalid unless the applicant requests, and the ~~commissioner~~ board grants, an extension.

(7) For purposes of this section, "interested party" status shall be granted to persons or organizations representing the interests of persons who demonstrate that they will be substantially and directly affected by the new health care project under review. Persons able to render material assistance to the ~~commissioner~~ board by providing nonduplicative evidence relevant to the

determination may be admitted in an amicus curiae capacity but shall not be considered parties. A petition seeking party or amicus curiae status must be filed within 20 days following public notice of the letter of intent, or within 20 days following public notice that the application is complete. The ~~commissioner~~ board shall grant or deny a petition to intervene under this subdivision within 15 days after the petition is filed. The ~~commissioner~~ board shall grant or deny the petition within an additional 30 days upon finding that good cause exists for the extension. Once interested party status is granted, the ~~commissioner~~ board shall provide the information necessary to enable the party to participate in the review process~~. Such information includes~~, including information about procedures, copies of all written correspondence, and copies of all entries in the application record.

(8) Once an application has been deemed to be complete, public notice of the application ~~will~~ shall be provided in newspapers having general circulation in the region of the state affected by the application. The notice shall identify the applicant, the proposed new health care project, and the date by which a competing application under section 9439 of this title or a petition to intervene must be filed.

(9) The health care ombudsman's office established under 8 V.S.A. chapter 107, subchapter ~~1A of chapter 107 of Title 8~~ or, in the case of nursing homes, the long-term care ombudsman's office established under 33 V.S.A. § 7502, is authorized but not required to participate in any administrative or judicial review of an application under this subchapter and shall be considered an interested party in such proceedings upon filing a notice of intervention with the ~~commissioner~~ board.

(d) The review process shall be as follows:

(1) The ~~commissioner~~ board shall review:

(A) The application materials provided by the applicant.

(B) Any information, evidence, or arguments raised by interested parties or amicus curiae, and any other public input.

(2) ~~The department~~ Except as otherwise provided in subdivision (c)(5) and subsection (e) of this section, the board shall hold a public hearing during the course of a review.

(3) The ~~commissioner~~ board 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~~ board 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.

(4) After reviewing each application, the ~~commissioner~~ board 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~~ board may impose in furtherance of the purposes of this subchapter, or a denial. In granting a partial approval or a conditional approval the ~~commissioner~~ board 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.

(5) If the ~~commissioner~~ board proposes to render a final decision denying an application in whole or in part, or approving a contested application, the ~~commissioner~~ board 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~~ board. The ~~commissioner~~ board may also permit the parties to present additional evidence.

(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.

(7) The ~~commissioner~~ board shall establish rules governing the compilation of the record used by the ~~commissioner~~ board in connection with decisions made on applications filed and certificates issued under this subchapter.

(e) The ~~commissioner~~ board 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~~ board 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~~ board 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~~ board under this section may appeal ~~the decision to the supreme court~~ pursuant to the provisions of section 9381 of this title.

(g) If the ~~commissioner~~ board has reason to believe that the applicant has violated a provision of this subchapter, a rule adopted pursuant to this

subchapter, or the terms or conditions of a prior certificate of need, the ~~commissioner~~ board may take into consideration such violation in determining whether to approve, deny, or approve the application subject to conditions. The applicant shall be provided an opportunity to contest whether such violation occurred, unless such an opportunity has already been provided. The ~~commissioner~~ board may impose as a condition of approval of the application that a violation be corrected or remediated before the certificate may take effect.

Sec. 20. 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~~ board, and any testimony taken before the ~~commissioner~~ board or a hearing officer appointed by the ~~commissioner~~ board shall be submitted or taken under oath. The form and manner of the submission shall be prescribed by the ~~commissioner~~ board. The authority granted to the ~~commissioner~~ board under this section is in addition to any other authority granted to the ~~commissioner~~ board 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~~ board 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~~ board or a hearing officer appointed by the ~~commissioner~~ board or who knowingly testifies falsely in any proceeding before the ~~commissioner~~ board or a hearing officer appointed by the ~~commissioner~~ board shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

Sec. 20a. 18 V.S.A. § 9440b is amended to read:

§ 9440b. INFORMATION TECHNOLOGY; REVIEW PROCEDURES

Notwithstanding the procedures in section 9440 of this title, upon approval by the general assembly of the health information technology plan developed under section 9351 of this title, the ~~commissioner~~ board shall establish by rule standards and expedited procedures for reviewing applications for the purchase or lease of health care information technology that otherwise would be subject to review under this subchapter. Such applications may not be granted or approved unless they are consistent with the health information technology

plan and the health resource allocation plan. The ~~commissioner's~~ board's rules may include a provision requiring that applications be reviewed by the health information advisory group authorized under section 9352 of this title. The advisory group shall make written findings and a recommendation to the ~~commissioner~~ board in favor of or against each application.

Sec. 20b. 18 V.S.A. § 9441 is amended to read:

§ 9441. FEES

(a) The ~~commissioner~~ board shall charge a fee for the filing of certificate of need applications. The fee shall be calculated at the rate of 0.125 percent of project costs.

(b) The maximum fee shall not exceed $20,000.00 and the minimum filing fee is $250.00 regardless of project cost. No fee shall be charged on projects amended as part of the review process.

(c) The ~~commissioner~~ board may retain such additional professional or other staff as needed to assist in particular proceedings under this subchapter and may assess and collect the reasonable expenses for such additional staff from the applicant. The ~~commissioner~~ board, on petition by the applicant and opportunity for hearing, may reduce such assessment upon a proper showing by the applicant that such expenses were excessive or unnecessary. The authority granted to the ~~commissioner~~ board under this section is in addition to any other authority granted to the ~~commissioner~~ board under law.

Sec. 20c. 18 V.S.A. § 9442 is amended to read:

§ 9442. BONDS

In any circumstance in which bonds are to be or may be issued in connection with a new health care project subject to the provisions of this subchapter, the certificate of need shall include the requirement that all information required to be provided to the bonding agency shall be provided also to the ~~commissioner~~ board within a reasonable period of time. The ~~commissioner~~ board shall be authorized to obtain any information from the bonding agency deemed necessary to carry out the duties of monitoring and oversight of a certificate of need. The bonding agency shall consider the recommendations of the ~~commissioner~~ board in connection with any such proposed authorization.

Sec. 20d. 18 V.S.A. § 9443 is amended to read:

§ 9443. EXPIRATION OF CERTIFICATES OF NEED

(a) Unless otherwise specified in the certificate of need, a project shall be implemented within five years or the certificate shall be invalid.

(b) No later than 180 days before the expiration date of a certificate of need, an applicant that has not yet implemented the project approved in the certificate of need may petition the ~~commissioner~~ board for an extension of the implementation period. The ~~commissioner~~ board may grant an extension in ~~his or her~~ its discretion.

(c) Certificates of need shall expire on the date the ~~commissioner~~ board accepts the final implementation report filed in connection with the project implemented pursuant to the certificate.

* * *

Sec. 21. 18 V.S.A. § 9444 is amended to read:

§ 9444. REVOCATION OF CERTIFICATES; MATERIAL CHANGE

(a) The ~~commissioner~~ board may revoke a certificate of need for substantial noncompliance with the scope of the project as designated in the application, or for failure to comply with the conditions set forth in the certificate of need granted by the ~~commissioner~~ board.

(b)(1) In the event that after a project has been approved, its proponent wishes to materially change the approved project, all such changes are subject to review under this subchapter.

(2) Applicants shall notify the ~~commissioner~~ board of a nonmaterial change to the approved project. If the ~~commissioner~~ board decides to review a nonmaterial change, ~~he or she~~ the board may provide for any necessary process, including a public hearing, before approval. Where the ~~commissioner~~ board decides not to review a change, such change will be deemed to have been granted a certificate of need.

Sec. 21a. 18 V.S.A. § 9445 is amended to read:

§ 9445. ENFORCEMENT

(a) Any person who offers or develops any new health care project within the meaning of this subchapter without first obtaining a certificate of need as required herein, or who otherwise violates any of the provisions of this subchapter, may be subject to the following administrative sanctions by the ~~commissioner~~ board, after notice and an opportunity to be heard:

(1) The ~~commissioner~~ board may order that no license or certificate permitted to be issued by the department or any other state agency may be issued to any health care facility to operate, offer, or develop any new health care project for a specified period of time, or that remedial conditions be attached to the issuance of such licenses or certificates.

(2) The ~~commissioner~~ board may order that payments or reimbursements to the entity for claims made under any health insurance policy, subscriber contract, or health benefit plan offered or administered by any public or private health insurer, including the Medicaid program and any other health benefit program administered by the state be denied, reduced, or limited, and in the case of a hospital that the hospital's annual budget approved under subchapter 7 of this chapter be adjusted, modified, or reduced.

(b) In addition to all other sanctions, if any person offers or develops any new health care project without first having been issued a certificate of need or certificate of exemption therefore, or violates any other provision of this subchapter or any lawful rule or regulation promulgated thereunder, the board, the commissioner, the state health care ombudsman, the state long-term care ombudsman, and health care providers ~~or~~ and consumers located in the state shall have standing to maintain a civil action in the superior court of the county wherein such alleged violation has occurred, or wherein such person may be found, to enjoin, restrain, or prevent such violation. Upon written request by the ~~commissioner~~ board, it shall be the duty of the attorney general of the state to furnish appropriate legal services and to prosecute an action for injunctive relief to an appropriate conclusion, which shall not be reimbursed under subdivision (2) of this subsection.

(c) After notice and an opportunity for hearing, the ~~commissioner~~ board may impose on a person who knowingly violates a provision of this subchapter, or a rule or order adopted pursuant to this subchapter or 8 V.S.A. § 15, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the health care facility, whichever is greater, which shall not be reimbursed under subdivision (a)(2) of this section, and the ~~commissioner~~ board may order the entity to cease and desist from further violations, and to take such other actions necessary to remediate a violation. A person aggrieved by a decision of the ~~commissioner~~ board under this subdivision may appeal ~~the commissioner's decision to the supreme court~~ under section 9381 of this title.

(d) The ~~commissioner~~ board shall adopt by rule criteria for assessing the circumstances in which a violation of a provision of this subchapter, a rule adopted pursuant to this subchapter, or the terms or conditions of a certificate of need require that a penalty under this section shall be imposed, and criteria for assessing the circumstances in which a penalty under this section may be imposed.

Sec. 22. 18 V.S.A. § 9446 is amended to read:

§ 9446. HOME HEALTH AGENCIES; GEOGRAPHIC SERVICE AREAS

The terms of a certificate of need relating to the boundaries of the geographic service area of a home health agency may be modified by the ~~commissioner~~ board, in consultation with the commissioner of aging and independent living, after notice and opportunity for hearing, or upon written application to the ~~commissioner~~ board by the affected home health agencies or consumers, demonstrating a substantial need therefor. Service area boundaries may be modified by the ~~commissioner~~ board to take account of natural or physical barriers that may make the provision of existing services uneconomical or impractical, to prevent or minimize unnecessary duplication of services or facilities, or otherwise to promote the public interest. The ~~commissioner~~ board shall issue an order granting such application only upon a finding that the granting of such application is consistent with the purposes of 33 V.S.A. chapter 63, subchapter 1A ~~of chapter 63 of Title 33~~ and the health resource allocation plan established under section 9405 of this title and after notice and an opportunity to participate on the record by all interested persons, including affected local governments, pursuant to rules adopted by the ~~commissioner~~ board.

* * * Hospital Budgets * * *

Sec. 23. 18 V.S.A. chapter 221, subchapter 7 is amended to read:

Subchapter 7. Hospital Budget Review

* * *

§ 9453. POWERS AND DUTIES

(a) The ~~commissioner~~ board shall:

* * *

(b) To effectuate the purposes of this subchapter the ~~commissioner~~ board may adopt rules under 3 V.S.A. chapter 25 ~~of Title 3~~.

§ 9454. HOSPITALS; DUTIES

(a) Hospitals shall file the following information at the time and place and in the manner established by the ~~commissioner~~ board:

* * *

(7) such other information as the ~~commissioner~~ board may require.

* * *

§ 9456. BUDGET REVIEW

(a) The ~~commissioner~~ board shall conduct reviews of each hospital's proposed budget based on the information provided pursuant to this subchapter, and in accordance with a schedule established by the ~~commissioner~~ board. The ~~commissioner~~ board shall require the submission of documentation certifying that the hospital is participating in the Blueprint for Health if required by section 708 of this title.

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

* * *

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

(c) Individual hospital budgets established under this section shall:

(1) be consistent with the health resource allocation plan;

(2) take into consideration national, regional, or instate peer group norms, according to indicators, ratios, and statistics established by the ~~commissioner~~ board;

* * *

(d)(1) Annually, the ~~commissioner~~ board shall establish a budget for each hospital by September 15, followed by a written decision by October 1. Each hospital shall operate within the budget established under this section.

(2)(A) It is the general assembly's intent that hospital cost containment conduct is afforded state action immunity under applicable federal and state antitrust laws, if:

(i) the ~~commissioner~~ board requires or authorizes the conduct in any hospital budget established by the ~~commissioner~~ board under this section;

(ii) the conduct is in accordance with standards and procedures prescribed by the ~~commissioner~~ board; and

(iii) the conduct is actively supervised by the ~~commissioner~~ board.

(B) A hospital's violation of the ~~commissioner's~~ board's standards and procedures shall be subject to enforcement pursuant to subsection (h) of this section.

(e) The ~~commissioner~~ board may establish~~, by rule,~~ a process to define, on an annual basis, criteria for hospitals to meet, such as utilization and inflation benchmarks. The ~~commissioner~~ board may waive one or more of the review processes listed in subsection (b) of this section.

(f) The ~~commissioner~~ board may, upon application, adjust a budget established under this section upon a showing of need based upon exceptional or unforeseen circumstances in accordance with the criteria and processes established under section 9405 of this title.

(g) The ~~commissioner~~ board may request, and a hospital shall provide, information determined by the ~~commissioner~~ board to be necessary to determine whether the hospital is operating within a budget established under this section. For purposes of this subsection, subsection (h) of this section, and subdivision 9454(a)(7) of this title, the ~~commissioner's~~ board's authority shall extend to an affiliated corporation or other person in the control of or controlled by the hospital to the extent that such authority is necessary to carry out the purposes of this subsection, subsection (h) of this section, or subdivision 9454(a)(7) of this title. As used in this subsection, a rebuttable presumption of "control" is created if the entity, hospital, or other person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing 20 percent or more of the voting securities or membership interest or other governing interest of the hospital or other controlled entity.

(h)(1) If a hospital violates a provision of this section, the ~~commissioner~~ board may maintain an action in the superior court of the county in which the hospital is located to enjoin, restrain or prevent such violation.

(2)(A) After notice and an opportunity for hearing, the ~~commissioner~~ board may impose on a person who knowingly violates a provision of this subchapter, or a rule adopted pursuant to this subchapter, a civil administrative penalty of no more than $40,000.00, or in the case of a continuing violation, a civil administrative penalty of no more than $100,000.00 or one-tenth of one percent of the gross annual revenues of the hospital, whichever is greater. This subdivision shall not apply to violations of subsection (d) of this section caused by exceptional or unforeseen circumstances.

(B)(i) The ~~commissioner~~ board may order a hospital to:

(I)(aa) cease material violations of this subchapter or of a regulation or order issued pursuant to this subchapter; or

(bb) cease operating contrary to the budget established for the hospital under this section, provided such a deviation from the budget is material; and

(II) take such corrective measures as are necessary to remediate the violation or deviation and to carry out the purposes of this subchapter.

(ii) Orders issued under this subdivision (2)(B) shall be issued after notice and an opportunity to be heard, except where the ~~commissioner~~ board finds that a hospital's financial or other emergency circumstances pose

an immediate threat of harm to the public or to the financial condition of the hospital. Where there is an immediate threat, the ~~commissioner~~ board may issue orders under this subdivision (2)(B) without written or oral notice to the hospital. Where an order is issued without notice, the hospital shall be notified of the right to a hearing at the time the order is issued. The hearing shall be held within 30 days of receipt of the hospital's request for a hearing, and a decision shall be issued within 30 days after conclusion of the hearing. The ~~commissioner~~ board may increase the time to hold the hearing or to render the decision for good cause shown. Hospitals may appeal any decision in this subsection to superior court. Appeal shall be on the record as developed by the ~~commissioner~~ board in the administrative proceeding and the standard of review shall be as provided in 8 V.S.A. § 16.

(3)(A) The ~~commissioner~~ board 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~~ board and required pursuant to this subchapter. The authority granted to the ~~commissioner~~ board under this subsection is in addition to any other authority granted to the ~~commissioner~~ board under law.

(B) A person who knowingly makes a false statement under oath or who knowingly submits false information under oath to the ~~commissioner~~ board or to a hearing officer appointed by the ~~commissioner~~ board or who knowingly testifies falsely in any proceeding before the ~~commissioner~~ board or a hearing officer appointed by the ~~commissioner~~ board shall be guilty of perjury and punished as provided in 13 V.S.A. § 2901.

* * *

* * * Provider Bargaining Groups * * *

Sec. 24. 18 V.S.A. § 9409 is amended to read:

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

(a) The commissioner may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. A bargaining group is authorized to negotiate~~,~~ on behalf of all participating providers with the commissioner, the secretary of administration, the secretary of human services, the Green Mountain Care Board, or the commissioner of labor with respect to any matter in this chapter; chapter 13, 219, 220, or 222 of this title; ~~chapters~~ 21 V.S.A. chapter 9 ~~and 11 of Title 21~~; and ~~chapter~~ 33 V.S.A. chapters 18 and 19 ~~of Title 33, in regard~~ with respect to provider regulation, provider reimbursement, administrative simplification, information technology, workforce planning, or quality of health care.

* * *

(c) The rules relating to negotiations shall include a nonbinding arbitration process to assist in the resolution of disputes. Nothing in this section shall be construed to limit the authority of the commissioner, the commissioner of labor, the secretary of administration, the Green Mountain Care board, or the secretary of human services to reject the recommendation or decision of the arbiter.

* * * Medical Malpractice Reform * * *

Sec. 24a. 12 V.S.A. § 1051 is added to read:

§ 1051. CERTIFICATE OF MERIT

(a) No civil action shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after February 1, 2013, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action files a certificate of merit simultaneously with the filing of the complaint. In the certificate of merit, the attorney or plaintiff shall certify that he or she has consulted with a health care provider qualified pursuant to the requirements of Rule 702 of the Vermont Rules of Evidence and any other applicable standard, and that, based on the information reasonably available at the time the opinion is rendered, the health care provider has:

(1) Described the applicable standard of care;

(2) Indicated that based on reasonably available evidence, there is a reasonable likelihood that the plaintiff will be able to show that the defendant failed to meet that standard of care; and

(3) Indicated that there is a reasonable likelihood that the plaintiff will be able to show that the defendant's failure to meet the standard of care caused the plaintiff's injury.

(b) A plaintiff may satisfy this requirement through multiple consultations that collectively meet the requirements of subsection (a) of this section.

(c) A plaintiff must certify to having consulted with a health care provider as set forth in subsection (a) of this section with respect to each defendant identified in the complaint.

(d) Upon petition to the clerk of the court where the civil action will be filed, an automatic 90-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by this section.

(e) The failure to file the certificate of merit as required by this section shall be grounds for dismissal of the action without prejudice, except in the

rare instances in which a court determines that expert testimony is not required to establish a case for medical malpractice.

(f) The requirements set forth in this section shall not apply to claims where the sole allegation against the health care provider is failure to obtain informed consent.

Sec. 24b. SORRY WORKS! PILOT PROGRAM

(a) For purposes of this section:

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

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

(b) The Sorry Works! pilot program is established under the oversight of the commissioner. Any hospital that voluntarily chooses to participate shall be eligible for the program beginning on February 1, 2013. Hospitals may participate only with the approval of the hospital administration and the hospital's medical staff.

(c)(1) Under the program, participating hospitals and physicians shall promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements. If a settlement is accepted, further litigation with respect to the mistake shall be prohibited.

(2) Participating hospitals shall provide to the patient written notification of the patient's right to legal counsel. The notification shall include an affirmative declaration that no action was taken to dissuade a patient from using counsel for the negotiations.

(3) A communication between parties engaged in negotiation pursuant to this program is privileged and is not subject to discovery or admissible in evidence in any civil or administrative proceeding. Evidence or information that is otherwise admissible or subject to discovery does not become inadmissible or protected from discovery solely by reason of its disclosure or use in negotiations pursuant to this program.

(4) Participation in Sorry Works! shall toll the applicable statute of limitations in cases where such negotiations are unsuccessful. The commissioner shall establish guidelines for determining when negotiations under the Sorry Works! program begin and end for purposes of tolling the statute of limitations.

(d) Participating hospitals shall report to the department their total costs for medical malpractice verdicts, settlements, and defense litigation for the

preceding five years to enable the department to determine average costs for that hospital during that period. The department shall develop standards and protocols to compare costs for cases handled by traditional means and cases handled under the Sorry Works! program for purposes of reporting to the general assembly as to the financial impact of the program.

(e) The commissioner shall establish criteria for the program, including the criteria under which hospitals shall be selected to participate. A program participant may withdraw from the program by notifying the commissioner. Any mistakes in patient care that result in harm that occurred prior to the program participant notifying the commissioner shall continue to be subject to this section and the terms of the program.

(f) In consultation with hospitals, providers, and other interested parties, the department shall adopt rules to implement the pilot program no later than October 1, 2012.

(g) The department shall initiate a dialogue with insurers and encourage them to participate in the Sorry Works! pilot program with any hospital that is willing to commit to the program.

Sec. 24c. 12 V.S.A. chapter 215, subchapter 2 is added to read:

Subchapter 2. Mediation Prior to Filing a Complaint of Malpractice

§ 7011. PURPOSE

The purpose of mediation prior to filing a medical malpractice case is to identify and resolve meritorious claims and reduce areas of dispute prior to litigation, which will reduce the litigation costs, reduce the time necessary to resolve claims, provide fair compensation for meritorious claims, and reduce malpractice-related costs throughout the system.

§ 7012. PRE-SUIT MEDIATION; SERVICE

(a) A potential plaintiff may serve upon each known potential defendant a request to participate in pre-suit mediation prior to filing a civil action in tort or in contract alleging that an injury or death resulted from the negligence of a health care provider and to recover damages resulting from the personal injury or wrongful death.

(b) Service of the request required in subsection (a) of this section shall be in letter form and shall be served on all known potential defendants by certified mail. The date of mailing such request shall toll all applicable statutes of limitations.

(c) The request to participate in pre-suit mediation shall name all known potential defendants, contain a brief statement of the facts that the potential

plaintiff believes are grounds for relief, and be accompanied by a certificate of merit in accordance with section 1051 of this title, and may include other documents or information supporting the potential plaintiff's claim.

(d) Nothing in this chapter precludes potential plaintiffs and defendants from pre-suit negotiation or other pre-suit dispute resolution to settle potential claims.

§ 7013. MEDIATION RESPONSE

(a) Within 60 days of service of the request to participate in pre-suit mediation, each potential defendant shall accept or reject the potential plaintiff's request for pre-suit mediation by mailing a certified letter to counsel or if the party is unrepresented to the potential plaintiff.

(b) If the potential defendant agrees to participate, within 60 days of the service of the request to participate in pre-suit mediation, each potential defendant shall serve a responsive certificate on the potential plaintiff by mailing a certified letter indicating that he or she, or his or her counsel, has consulted with a qualified expert within the meaning of section 1643 of this title and that expert is of the opinion that there are reasonable grounds to defend the potential plaintiff's claims of medical negligence. Notwithstanding the potential defendant's acceptance of the request to participate, if the potential defendant does not serve such a responsive certificate within the 60-day period, then the potential plaintiff need not participate in the pre-suit mediation under this title and may file suit. If the potential defendant is willing to participate, pre-suit mediation may take place without a responsive certificate of merit from the potential defendant at the plaintiff's election.

§ 7014. PROCESS; TIME FRAMES

(a) The mediation shall take place within 60 days of the service of all potential defendants' acceptance of the request to participate in pre-suit mediation. The parties may agree to an extension of time. If in good faith the mediation cannot be scheduled within the 60-day time period, the potential plaintiff need not participate and may proceed to file suit.

(b) If pre-suit mediation is not agreed to, the mediator certifies that mediation is not appropriate, or mediation is unsuccessful, the potential plaintiff may initiate a civil action as provided in the Vermont Rules of Civil Procedure. The action shall be filed:

(1) within 90 days of the potential plaintiff's receipt of the potential defendant's letter refusing mediation, the failure of the potential defendant to file a responsive certificate of merit within the specified time period, or the mediator's signed letter certifying that mediation was not appropriate or that the process was complete; or

(2) prior to the expiration of the applicable statute of limitations, whichever is later.

(c) If pre-suit mediation is attempted unsuccessfully, the parties shall not be required to participate in mandatory mediation under Rule 16.3 of the Vermont Rules of Civil Procedure.

§ 7015. CONFIDENTIALITY

All written and oral communications made in connection with or during the mediation process set forth in this chapter shall be confidential. The mediation process shall be treated as a settlement negotiation under Rule 408 of the Vermont Rules of Evidence.

Sec. 24d. SUNSET

12 V.S.A. chapter 215, subchapter 2 shall be repealed on February 1, 2015.

Sec. 24e. REPORT

On or before September 1, 2014, the secretary of administration or designee shall report to the senate committees on health and welfare and on judiciary and the house committees on health care and on judiciary on the impacts of Secs. 24a (certificate of merit), 24b (Sorry Works! pilot program), and 24c (pre-suit mediation) of this act. The report shall address the impacts that these reforms have had on:

(1) consumers, physicians, and the provision of health care services;

(2) the rights of consumers to due process of law and to access to the court system; and

(3) any other service, right, or benefit that was or may have been affected by the establishment of the medical malpractice reforms in Secs. 24a, 24b, and 24c of this act.

Sec. 24f. 18 V.S.A. § 1919 is amended to read:

§ 1919. INCLUSION OF DATA IN HOSPITAL COMMUNITY REPORTS

The commissioner shall consult with the commissioner of banking, insurance, securities, and health care administration, and with patient safety experts, hospitals, health care professionals, and members of the public and shall make recommendations to the commissioner of banking, insurance, securities, and health care administration concerning which data should be included in the hospital community reports required by section 9405b of this title. Beginning in 2013, the community reports shall include at a minimum data from all Vermont hospitals of reportable adverse events aggregated in a manner that protects the privacy of the patients involved and does not identify the individual hospitals in which an event occurred together with analysis and

explanatory comments about the information contained in the report to facilitate the public's understanding of the data. The commissioner shall make such recommendations no more than 18 months after data collection is initiated.

Sec. 24g. LEGISLATIVE INTENT; FEASIBILITY ANALYSIS

(a) The general assembly recognizes the need to balance the rights of consumers to due process of law and to access the court system with the importance of reducing costs to the health care system created by the practice of defensive medicine.

(b) No later than January 15, 2013, the secretary of administration or designee shall report to the house committees on health care and on judiciary and the senate committees on health and welfare and on judiciary with an analysis of the feasibility of implementing a pretrial screening process for medical malpractice claims without jeopardizing patients' due process rights or their ability to access the courts. In addition to the feasibility analysis, the report shall also include recommendations designed to reduce the practice of defensive medicine without jeopardizing patient care.

* * * Insurance Rate Reviews * * *

Sec. 25. 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 filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, health maintenance organization, or a managed care organization and 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) 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~~ and

(B) a decision by the Green Mountain Care board has been applied by the commissioner as provided ~~herein, unless the commissioner shall sooner give his or her written approval thereto~~ in subdivision (2) of this subsection.

(2)(A) Prior to approving a rate ~~increase~~ pursuant to this subsection, the commissioner shall seek approval for such rate ~~increase~~ from the Green Mountain Care board established in 18 V.S.A. chapter 220~~, which~~. The

commissioner shall make a recommendation to the Green Mountain Care board about whether to approve or disapprove the rate within 30 days of receipt of a completed application from an insurer. In the event that the commissioner does not make a recommendation to the board within the 30-day period, the commissioner shall be deemed to have recommended approval of the rate, and the Green Mountain Care board shall review the rate request pursuant to subdivision (B) of this subsection.

(B) The Green Mountain Care board shall review rate requests forwarded by the commissioner pursuant to subdivision (A) of this subsection and shall approve or disapprove ~~the~~ a rate ~~increase~~ request within ~~10 business~~ 30 days of receipt of the commissioner's recommendation or, in the absence of a recommendation from the commissioner, the expiration of the 30-day period following the department's receipt of the completed application. In the event that the board does not approve or disapprove a rate within 30 days, the board shall be deemed to have approved the rate request.

(C) The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board within five business days of the board's decision.

~~(2)~~(3) 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 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. The board may, in its discretion, conduct a hearing on the premium rate jointly with any such hearing before the commissioner.

~~(3) After the expiration of the review period provided herein or at any time after having given written approval~~

(b) At any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section, the commissioner may, after a hearing of which at least 20 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)~~(c) 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)~~ (d) of this section. In addition, the insurer shall post the summaries on its website.

~~(c)~~(d)(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 rate 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~~ submitting the policy or rate for the Green Mountain Care board's approval 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~~ rates.

~~(d)~~(e)(1) The following provisions of this section shall not apply to policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, or other limited benefit coverage~~, but shall apply to long-term care policies~~:

(A) the requirement in ~~subdivision~~ subdivisions (a)(1) and (2) for the Green Mountain Care board's approval ~~for any~~ on rate ~~increase~~ requests;

(B) the review standards in subdivision ~~(a)(2)~~ (a)(3) 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) and (d) 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.

(3) Medicare supplemental insurance policies shall be exempt only from the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests and shall be subject to the remaining provisions of this section.

Sec. 26. 18 V.S.A. § 9381 is amended to read:

§ 9381. APPEALS

(a)(1) 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.

(2) Only decisions by the board shall be appealable under this subsection. Recommendations to the board by the commissioner of banking, insurance, securities, and health care administration pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.

* * *

(c) If an appeal or other petition for judicial review of a final order is not filed in connection with an order of the Green Mountain Care board pursuant to subsection (b) of this section, the chair may file a certified copy of the final order with the clerk of a court of competent jurisdiction. The order so filed has the same effect as a judgment of the court and may be recorded, enforced, or satisfied in the same manner as a judgment of the court.

Sec. 26a. HEALTH CARE OMBUDSMAN REPORT

No later than January 15, 2013, the state health care ombudsman, in collaboration with the department of banking, insurance, securities, and health care administration and the agency of human services, shall report to the house committee on health care and the senate committees on health and welfare and on finance regarding the ombudsman's current and projected funding and resource needs, suggestions for funding mechanisms to meet those needs, and recommendations on how best to coordinate, consolidate, or both the consumer protection efforts of the ombudsman's office, the department, and the agency.

* * * Payment Reform Pilots * * *

Sec. 27. 18 V.S.A. § 9377 is amended to read:

§ 9377. PAYMENT REFORM; PILOTS

* * *

(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~~ this section.

(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:

* * *

~~(4)~~(3) In addition to the objectives identified in subdivision ~~(a)(3)~~ (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

* * *

(e) The board or designee 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 board in developing and implementing the pilot projects and to advise the Green Mountain Care board in setting overall policy goals.

(f) The first pilot project shall become operational no later than July 1, 2012, and two or more additional pilot projects shall become operational no later than October 1, 2012.

(g)(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.

(3) 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.

(4) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.

* * * Blueprint for Health * * *

Sec. 28. 18 V.S.A. § 702 is amended to read:

§ 702. BLUEPRINT FOR HEALTH; STRATEGIC PLAN

(a)(1) The department of Vermont health access shall be responsible for the Blueprint for Health.

(2) The director of the Blueprint, in collaboration with the ~~commissioner~~ commissioners of health, of mental health, ~~and the commissioner~~ of Vermont health access, and of disabilities, aging, and independent living, shall oversee the development and implementation of the Blueprint for Health, including a strategic plan describing the initiatives and implementation time lines and strategies. Whenever private health insurers are concerned, the director shall collaborate with the commissioner of banking, insurance, securities, and health care administration and the chair of the Green Mountain Care board.

(b)(1)(A) The commissioner of Vermont health access shall establish an executive committee to advise the director of the Blueprint on creating and implementing a strategic plan for the development of the statewide system of chronic care and prevention as described under this section. The executive committee shall include the commissioner of health; the commissioner of mental health; a representative from the ~~department of banking, insurance,~~

~~securities, and health care administration~~ Green Mountain Care board; a representative from the department of Vermont health access; an individual appointed jointly by the president pro tempore of the senate and the speaker of the house of representatives; a representative from the Vermont medical society; a representative from the Vermont nurse practitioners association; a representative from a statewide quality assurance organization; a representative from the Vermont association of hospitals and health systems; two representatives of private health insurers; a consumer; a representative of the complementary and alternative medicine professions; a primary care professional serving low income or uninsured Vermonters; a licensed mental health professional with clinical experience in Vermont; a representative of the Vermont assembly of home health agencies who has clinical experience; a representative from a self-insured employer who offers a health benefit plan to its employees; and a representative of the state employees' health plan, who shall be designated by the commissioner of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan.

* * *

Sec. 28a. BLUEPRINT PARTICIPATION; LEGISLATIVE INTENT

It is the intent of the general assembly that:

(1) Health insurer and Medicaid payments for a community health team and access by patients and medical practices to the team should begin at least six months prior to the scheduled date to score a medical practice for Blueprint recognition.

(2) The director of the Blueprint use the statutory discretion afforded by 18 V.S.A. § 706(c)(2) to increase payments to medical home practices in recognition of the efforts needed to satisfy the updated National Committee for Quality Assurance scoring requirements.

(3) To the extent permitted under federal law, all health insurance plans, including the multistate plans, will be active participants in the Blueprint for Health.

* * * HMO Reporting Requirement * * *

Sec. 29. 8 V.S.A. § 5106(a) is amended to read:

(a) Every organization subject to this chapter, annually, within ~~120~~ 90 days of the close of its fiscal year, shall file a report with the commissioner, said report verified by an appropriate official of the organization, showing its financial condition on the last day of the preceding fiscal year. The report shall be prepared in accordance with the National Association of Insurance

Commissioners' Accounting Practices and Procedures Manual for health maintenance organizations and shall be in such general form and context, as approved by, and shall contain any other information required by the National Association of Insurance Commissioners together with any useful or necessary modifications or adaptations thereof required, approved or accepted by the commissioner for the type of organization to be reported upon, and as supplemented by additional information required by the commissioner.

* * * Vermont Program for Quality in Health Care * * *

Sec. 30. 18 V.S.A. § 9416 is amended to read:

§ 9416. VERMONT PROGRAM FOR QUALITY IN HEALTH CARE

(a) The commissioner of health shall contract with the Vermont Program for Quality in Health Care, Inc. to implement and maintain a statewide quality assurance system to evaluate and improve the quality of health care services rendered by health care providers of health care facilities, including managed care organizations, to determine that health care services rendered were professionally indicated or were performed in compliance with the applicable standard of care, and that the cost of health care rendered was considered reasonable by the providers of professional health services in that area. The commissioner of health shall ensure that the information technology components of the quality assurance system ~~are incorporated into and~~ comply with, and the commissioner of Vermont health access shall ensure such components are incorporated into, the statewide health information technology plan developed under section 9351 of this title and any other information technology initiatives coordinated by the secretary of administration pursuant to 3 V.S.A. § 2222a.

(b) The Vermont Program for Quality in Health Care, Inc. shall file an annual report with the commissioner of health. The report shall include an assessment of progress in the areas designated by the commissioner of health, including comparative studies on the provision and outcomes of health care and professional accountability.

* * *

* * * Discretionary Clauses * * *

Sec. 31. 8 V.S.A. § 4062f is added to read:

§ 4062f. DISCRETIONARY CLAUSES PROHIBITED

(a) The purpose of this section is to ensure that health insurance benefits, disability income protection coverage, and life insurance benefits are contractually guaranteed and to avoid the conflict of interest that may occur when the carrier responsible for providing benefits has discretionary authority

to decide what benefits are due. Nothing in this section shall be construed to impose any requirement or duty on any person other than a health insurer or an insurer offering disability income protection coverage or life insurance.

(b) As used in this section:

(1) "Disability income protection coverage" means a policy, contract, certificate, or agreement that provides for weekly, monthly, or other periodic payments for a specified period during the continuance of disability resulting from illness, injury, or a combination of illness and injury.

(2) "Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

(3) "Health insurer" means an insurance company that provides health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, a managed care organization, a health maintenance organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by a public or private entity; as well as entities offering policies for specific disease, accident, injury, hospital indemnity, dental care, disability income, long-term care, and other limited benefit coverage.

(4) "Life insurance" means a policy, contract, certificate, or agreement that provides life insurance as defined in subdivision 3301(a)(1) of this title.

(c) No policy, contract, certificate, or agreement offered or issued in this state by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services may contain a provision purporting to reserve discretion to the health insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

(d) No policy, contract, certificate, or agreement offered or issued in this state providing for disability income protection coverage may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

(e) No policy, contract, certificate, or agreement of life insurance offered or issued in this state may contain a provision purporting to reserve discretion to the insurer to interpret the terms of the contract or to provide standards of interpretation or review that are inconsistent with the laws of this state, and any such provision in a policy, contract, certificate, or agreement shall be null and void.

* * * Prescription Drug Cost-Sharing * * *

Sec. 32. 8 V.S.A. § 4089i is amended to read:

§ 4089i. PRESCRIPTION DRUG COVERAGE

(a) A health insurance or other health benefit plan offered by a health insurer shall provide coverage for prescription drugs purchased in Canada, and used in Canada or reimported legally or purchased through the I-SaveRx program on the same benefit terms and conditions as prescription drugs purchased in this country. For drugs purchased by mail or through the internet, the plan may require accreditation by the Internet and Mailorder Pharmacy Accreditation Commission (IMPAC/tm) or similar organization.

(b) A health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall not include an annual dollar limit on prescription drug benefits.

(c) A health insurance or other health benefit plan offered by a health insurer or pharmacy benefit manager shall limit a beneficiary's out-of-pocket expenditures for prescription drugs, including specialty drugs, to no more for self-only and family coverage per year than the minimum dollar amounts in effect under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively.

(d) For prescription drugs benefits offered in conjunction with a high-deductible health plan (HDHP), the plan may not provide prescription drug benefits until the expenditures applicable to the deductible under the HDHP have met the amount of the minimum annual deductibles in effect for self-only and family coverage under Section 223(c)(2)(A)(i) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively. Once the foregoing expenditure amount has been met under the HDHP, coverage for prescription drug benefits shall begin, and the limit on out-of-pocket expenditures for prescription drug benefits shall be as specified in subsection (c) of this section.

(e) As used in this section:

(1) "Health insurer" shall have the same meaning as in 18 V.S.A. § 9402.

(2) "Out-of-pocket expenditure" means a co-payment, coinsurance, deductible, or other cost-sharing mechanism.

(3) "Pharmacy benefit manager" shall have the same meaning as in section 4089j of this title.

(f) The department of banking, insurance, securities, and health care administration shall enforce this section and may adopt rules as necessary to carry out the purposes of this section.

Sec. 32a. 18 V.S.A. § 4631a is amended to read:

§ 4631a. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

(a) As used in this section:

* * *

(12) "Prescribed product" means a drug or device as defined in section 201 of the federal Food, Drug and Cosmetic Act, 21 U.S.C. § 321, a compound drug or drugs, ~~or~~ a biological product as defined in section 351 of the Public Health Service Act, 42 U.S.C. § 262, for human use, or a combination product as defined in 21 C.F.R. § 3.2(e), but shall not include prescription eyeglasses, prescription sunglasses, or other prescription eyewear.

* * *

(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.

(2) The prohibition set forth in subdivision (1) of this subsection shall not apply to any of the following:

(A) Samples of a prescribed product or reasonable quantities of an over-the-counter drug, a nonprescription medical device, ~~or~~ an item of nonprescription durable medical equipment, an item of medical food as defined in the federal Orphan Drug Act, as amended, 21 U.S.C. § 360ee(b)(3), or infant formula as defined in Section 201(z) of the federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 321, provided to a health care provider for free distribution to patients.

* * *

(H) The provision ~~of free prescription drugs or over-the-counter drugs, medical devices, biological products, medical equipment or supplies, or financial donations~~ to a free clinic of financial donations or of free:

(i) prescription drugs;

(ii) over-the-counter drugs;

(iii) medical devices;

(iv) biological products;

(v) combination products;

(vi) medical food;

(vii) infant formula; or

(viii) medical equipment or supplies.

* * *

(d) The attorney general may bring an action in ~~Washington superior court~~ the civil division of the Washington unit of the superior court for injunctive relief, costs, and attorney's fees and may impose on a manufacturer that violates this section a civil penalty of no more than $10,000.00 per violation. Each unlawful gift shall constitute a separate violation. In any action brought pursuant to this section, the attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Fraud Act, 9 V.S.A. chapter 63.

Sec. 32b. 18 V.S.A. § 4632 is amended to read:

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

(a)(1)(A) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year the value, nature, purpose, and recipient information of any allowable expenditure or gift 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:

* * *

(B) Annually on or before April 1 of each year, every manufacturer of prescribed products shall disclose to the office of the attorney general for the preceding calendar year if the manufacturer is reporting other allowable expenditures or permitted gifts pursuant to subdivision (a)(1)(A) of this section, the product, dosage, number of units, and recipient information of over-the-counter drugs, nonprescription medical devices, and items of nonprescription durable medical equipment provided to a health care provider for free distribution to patients pursuant to subdivision 4631a(b)(2)(A) of this title; provided that any public reporting of such information shall not include information that allows for the identification of individual recipients of ~~samples~~ such products or connects individual recipients with the monetary value of the ~~samples~~ products provided.

* * *

(D) Any public reporting of the provision of free prescription or over-the-counter drugs, medical devices, biological products, medical equipment, combination products, medical food, infant formula, or supplies to a free clinic shall not include information that allows for the identification of individual recipients of such products or that connects individual recipients with the monetary value of the products provided.

(2)(A)(i) Subject to the provisions of subdivision (B) of this subdivision (a)(2) and to the extent allowed under federal law, annually on or before April 1 of each year beginning in 2012, each manufacturer of prescribed products shall disclose to the office of the attorney general all samples ~~of prescribed products~~ provided to health care providers during the preceding calendar year, identifying for each sample the product, recipient, number of units, and dosage.

* * *

(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 October 1. The report shall include:

(A) Information on allowable expenditures and permitted gifts required to be disclosed under this section, which shall present information in aggregate form 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. In accordance with subdivisions (1)(B), (1)(D), and (2)(A) of this subsection, information on samples and donations to free clinics of prescribed products and of over-the-counter drugs, nonprescription medical devices, and items of nonprescription durable medical equipment shall be presented in aggregate form.

* * *

(c) The attorney general may bring an action in ~~Washington superior court~~ the civil division of the Washington unit of the superior court for injunctive relief, costs, and attorney's fees, and to impose on a manufacturer of prescribed products that fails to disclose as required by subsection (a) of this section a civil penalty of no more than $10,000.00 per violation. Each unlawful failure to disclose shall constitute a separate violation. In any action brought pursuant to this section, the attorney general shall have the same authority to investigate and to obtain remedies as if the action were brought under the Consumer Fraud Act, 9 V.S.A. chapter 63.

(d) The terms used in this section shall have the same meanings as they do in section 4631a of this title.

* * * Medicaid Waiver Approval * * *

Sec. 33. DUAL ELIGIBLE PROJECT PROPOSAL

(a) It is the intent of the general assembly to provide the agency of human services with the authority to enter into negotiations with the Centers for Medicare and Medicaid Services (CMS) to seek waivers as needed to operate an integrated system of coverage for individuals who are eligible for Medicare and Medicaid, and to provide the agency of human services with the authority to implement the program approved by CMS. Any waivers sought pursuant to this section shall promote the health care reform goals established in No. 48 of the Acts of 2011, including universal coverage; integration of health, mental health, and substance abuse treatment; administrative simplification; and payment reform.

(b)(1) The agency of human services may seek a waiver or waivers from CMS to enable the agency to better serve individuals who are eligible for both Medicare and Medicaid ("dual eligibles") through a consolidated program operated by the agency of human services or by a department of the agency of human services. The waiver or waivers sought pursuant to this section may be consolidated with or filed in conjunction with Vermont's Medicaid Section 1115 Global Commitment to Health waiver renewal, any Choices for Care waiver modifications, or a state children's health insurance program (SCHIP) waiver. Any modifications of the Choices for Care waiver shall be consistent with No. 56 of the Acts of 2005.

(2) The agency may seek permission to serve the dual eligibles population as a public managed care organization or through another administrative mechanism that enables the agency to integrate services for the dual eligibles, pursue administrative flexibility and simplification, or otherwise align health coverage programs. The agency shall seek permission to implement payment mechanisms that ensure the health coverage provided under the waiver or waivers is consistent with and supportive of the payment reform initiatives established by the Green Mountain Care board.

(3) The agency shall seek a waiver to create a consolidated program which:

(A) includes eligibility standards, methodologies, and procedures that are neither more restrictive than the standards, methodologies, and procedures in effect as of January 1, 2012 nor more restrictive than the standards, methodologies, and procedures for dual eligible individuals who are not enrolled in this consolidated program.

(B) does not reduce the amount, duration, or scope of services covered by Medicaid and Medicare or impose limits on enrollment or access to services.

(C) ensures that an individual in the consolidated program receives a level of service that is equivalent to or greater than the individual would have received if he or she were not in the consolidated program.

(D) provides reasonable opportunity for an individual to disenroll from the consolidated program and transition to traditional Medicaid and Medicare coverage.

(E) as provided in the terms and conditions for the Choices for Care Section 1115 waiver, includes an independent advocacy system for all participants and applicants in the consolidated program which includes, at a minimum, access to area agency on aging advocacy, legal services, and the long-term care and health care ombudsmen.

(F) if the agency contracts with an integrated service provider (ISP) then, at a minimum, as required under 42 U.S.C. § 1395a(a), guarantees individuals a choice of health care providers who offer the same service or services within the individual's ISP and a choice of providers for services that are not offered through the individual's ISP.

(G) unless otherwise appropriated by the general assembly, invests at least 50 percent of the remaining funds at the end of the state fiscal year to enhance the consolidated program.

(H) maintains state provider payment rates in the consolidated program that:

(i) permit providers to deliver services, on a solvent basis, that are consistent with efficiency, economy, access, and quality of care; and

(ii) are at least comparable to the average weighted payment rates that eligible providers would have received from Medicaid and Medicare in the absence of the consolidated program, subject to modifications as a result of:

(I) changes to federal Medicare rates;

(II) provider rates set by the Green Mountain Care board pursuant to 18 V.S.A. § 9376; or

(III) rate negotiations between the providers in an ISP and the agency of human services.

(4) The agency of human services shall enter into a waiver only if it provides individuals enrolled in the consolidated program who become ineligible for Medicaid or Medicare or who choose to opt out of the program

with a seamless transition process between coverage provided by the consolidated program and traditional Medicaid coverage, Medicare coverage, or both to ensure that the process does not result in a reduction or loss of services during the transition.

(5) If the agency of human services contracts with an ISP, the agency or designee shall include the following provisions in its ISP contracts:

(A) A broad range of services for individuals, to be provided by the ISP or through contracts between the ISP and other service providers, and coordination between the ISP and other service or health care providers who are not participants in the ISP, as appropriate. Examples of entities that are unlikely to be part of an ISP include the individual's medical home and the Blueprint for Health community health teams.

(B) An enforcement mechanism to ensure that the ISP and any subcontractors provide integrated services as required by the waiver and the contract provisions.

(C) Transparent quality assurance measures for evaluating the performance of the ISP and any subcontractors and a method for making the measures public.

(6) The agency of human services shall provide dual eligible individuals with meaningful information about their care options, including services through Medicaid, Medicare, and the consolidated program established in this section. The agency shall develop enrollee materials and notices that are accessible and understandable to those individuals who will be enrolled in the consolidated program, including individuals with disabilities, speech and vision limitations, or limited English proficiency.

(7) The agency of human services shall establish by rule a comprehensive and accessible appeals process, including an opportunity for an individual to request an independent clinical assessment of medical or functional limitations when appealing an eligibility determination, a denial in services, or a reduction in services.

(c)(1) The agency of human services shall implement the program approved by CMS by rule.

(2) Prior to filing proposed rules, the agency shall seek input on the proposed rules from a workgroup that includes providers, beneficiaries, and advocates for beneficiaries.

Sec. 34. GLOBAL COMMITMENT; CHOICES FOR CARE; SCHIP

(a) It is the intent of the general assembly to provide the agency of human services with the authority to renew and implement Vermont's Medicaid

Section 1115 Global Commitment to Health ("Global Commitment") waiver or to request a new waiver from the Centers for Medicare and Medicaid Services (CMS) with similar terms and conditions as Global Commitment. It is also the intent of the general assembly to provide the agency with the authority to modify or renew the Choices for Care waiver consistent with the provisions of No. 56 of the Acts of 2005 and to seek a state children's health insurance program (SCHIP) waiver to allow for greater administrative flexibility and simplification, as well as to seek advantageous financial terms similar to those in the Global Commitment waiver. Any waivers sought pursuant to this section shall promote the health care reform goals established in No. 48 of the Acts of 2011, including universal coverage; administrative simplification; integration of health, mental health, and substance abuse; and payment reform.

(b) The secretary of human services or designee shall seek to renew the Global Commitment waiver, seek a new Medicaid or SCHIP waiver, modify the Choices for Care waiver, or a combination thereof, to enable the agency to:

(1) Maintain the public managed care entity structure, financial provisions, and flexibility provided in the Global Commitment terms and conditions and extend these provisions and flexibility to the Choices for Care and Dr. Dynasaur programs.

(2) Maintain the waiver terms for special demonstration populations, such as individuals with traumatic brain injury and others currently provided for in Global Commitment, as well as for any special demonstration populations covered and services provided to eligible individuals under Choices for Care.

(3) Eliminate terms and conditions which are outdated or for which state options are now available.

(4) Eliminate Catamount Health Assistance in order to comply with the insurance provisions in this act and in the federal Affordable Care Act.

(5) Obtain federal matching funds for any state financial assistance provided to individuals purchasing insurance through the Vermont health benefit exchange in order to promote seamless health coverage for eligible individuals and to achieve universal coverage, affordability, and administrative simplification. The secretary or designee shall analyze the impacts of offering state financial assistance to individuals with incomes below 350 percent of the federal poverty level.

(6) Ensure a streamlined transition between Medicaid and the Vermont health benefit exchange.

(7) Modify payment mechanisms to ensure that the health coverage provided under any waiver program is consistent with and supportive of the payment reform initiatives established by the Green Mountain Care board.

(8) Ensure affordable coverage for individuals who are eligible for Medicare but who are responsible for paying the full cost of Medicare coverage due to inadequate work history or for another reason. The agency shall align the upper income eligibility limitation with other populations, such as individuals receiving state assistance in the Vermont health benefit exchange or individuals receiving coverage as part of a Medicaid expansion population.

(c) Any waiver or waivers sought pursuant to this section may be consolidated or filed in conjunction with Vermont's Global Commitment to Health waiver renewal, Choices for Care waiver modifications, SCHIP waiver, or combination thereof. The secretary of human services or designee shall implement the program or programs approved by CMS by rule.

Sec. 34a. Sec. 17 of No. 128 of the Acts of the 2009 Adj. Sess. (2010) is amended to read:

Sec. 17. FEDERAL HEALTH CARE REFORM; DEMONSTRATION PROGRAMS

(a)(1) Medicare waivers. Upon establishment by the secretary of the U.S. Department of Health and Human Services (HHS) of an advanced practice primary care medical home demonstration program or a community health team demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, the secretary of human services may apply to the secretary of HHS to enable Vermont to include Medicare as a participant in the Blueprint for Health as described in 18 V.S.A. chapter 13 ~~of Title 18~~.

(2) Upon establishment by the secretary of HHS of a shared savings program pursuant to Sec. 3022 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 or other federal authority established to allow for payment and delivery system reform, the secretary of human services may apply to the secretary of HHS to enable ~~Vermont~~ the state's Medicaid and SCHIP programs, including any waiver programs under Global Commitment to Health or Choices for Care, to ~~participate in the program by establishing~~ engage in payment reform ~~pilot projects as provided for by Sec. 14 of this act~~ activities consistent with the payment reform initiatives established by the Green Mountain Care board pursuant to 18 V.S.A. chapter 220. The chair of the Green Mountain Care board or

designee may apply to the secretary of HHS to enable Vermont to advance the payment reform goals established in No. 48 of the Acts of 2011 and consistent with the board's authority.

(b)(1) Medicaid waivers. The intent of this section is to provide the secretary of human services with the authority to pursue Medicaid and SCHIP participation in the Blueprint for Health and new payment reform initiatives established by the Green Mountain Care board through any existing or new waiver.

(2) Upon establishment by the secretary of HHS of a health home demonstration program pursuant to Sec. 3502 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152; Section 1115 or 2107 of the Social Security Act; or other federal authority, the secretary of human services may apply to the secretary of HHS to include Medicaid or SCHIP as a participant in the Blueprint for Health as described in 18 V.S.A. chapter 13 ~~of Title 18~~ and other payment reform initiatives established by the Green Mountain Care board pursuant to 18 V.S.A. chapter 220. ~~In the alternative, under Section 1115 of the Social Security Act, the secretary of human services may apply for an amendment to an existing Section 1115 waiver or may include in the renegotiation of the Global Commitment for Health Section 1115 waiver a request to include Medicaid as a participant in the Blueprint for Health as described in chapter 13 of Title 18.~~

Sec. 35. WAIVER UPDATES AND INFORMATION

(a) The secretary of human services or designee shall present information and updates on the waiver proposal and transition planning to the house committees on appropriations, on human services, and on health care and the senate committees on appropriations and on health and welfare as requested, no later than January 30, 2013. When the general assembly is not in session, the secretary or designee shall present information and updates to the health access oversight committee upon request. The secretary or designee shall be available to the health access oversight committee on a monthly basis to provide an update in person or by telephone on the status of the waiver and transition planning, applications, and negotiations, including updates on the substantive provisions and issues provided for in Secs. 33–35a of this act. If the health access oversight committee elects not to meet in person or by telephone during any one month, the secretary or designee shall provide a monthly update by telephone conference call to interested parties and stakeholders, including a time for questions from the public. In addition, the secretary or designee shall provide updates at each meeting of the Medicaid and exchange advisory board and to other advisory committees upon request.

(b) The secretary of human services or designee shall present a transition plan for individuals eligible for or enrolled in the Vermont health access plan, the employer-sponsored insurance premium assistance program, and Catamount Health to the house committees on appropriations, on human services, and on health care and the senate committees on appropriations and on health and welfare by January 15, 2013.

Sec. 35a. WAIVERS AND TRANSITION PLANNING; INTENT

(a) It is the intent of the general assembly to ensure continued legislative oversight after adjournment through the health access oversight committee and the committees of jurisdiction of the transition from Vermont's current Medicaid expansion programs to new coverage options, including the Vermont health benefit exchange, for individuals and families in 2014. Because of federal time lines and the need to negotiate a waiver with the Centers for Medicare and Medicaid Services, continued development of the transition plan by the administration is expected during the summer and fall of 2012. It is the intent of the general assembly that the secretary of human services or designee not implement a basic health program without the approval of the general assembly. It is also the intent of the general assembly to continue to oversee the development of the transition plan during the 2013 legislative session.

(b) It is the intent of the general assembly that the transition from Catamount Health and the Vermont health access plan to the Vermont health benefit exchange should be accomplished in such a way that it minimizes the financial exposure of low income Vermonters, including the amounts of their premiums and out-of-pocket costs; ensures that health care providers receive compensation that is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably; and recognizes the need to limit the financial exposure of the state of Vermont.

(c) The department of Vermont health access, in consultation with the Medicaid and exchange advisory committee established by 33 V.S.A. § 402, shall evaluate the options available under Section 1115 of the Social Security Act and under the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), for ensuring affordable coverage for individuals above 133 percent of the federal poverty level. The department shall consider financial implications to Vermonters, health care providers, and the state; administrative simplification of health care; continuity of coverage and reduction of churn; consistency with and promotion of other state health care reform efforts; and the likelihood of receiving approval from the U.S. Department of Health and Human Services, where necessary.

Sec. 35b. 33 V.S.A. § 402(b) is amended to read:

(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 at least 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, health insurance brokers and agents, 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.

* * *

Sec. 35c. EXCHANGE IMPLEMENTATION AND TRANSITION PLANNING; UPDATES

(a) The house committee on health care and the senate committee on health and welfare shall meet while the legislature is not in session during 2012 to receive updates on issues related to health care reform, including waivers, transition planning, health information technology, the Vermont Information Technology Leaders, Inc., and implementation of the Vermont health benefit exchange. The committees may meet up to four times, at the call of the chairs of both committees, or more often with the approval of the speaker of the house of representatives and the president pro tempore of the senate; provided, however, that the committees shall meet no less frequently than once every 90 days. To the extent practicable, such meetings shall coincide with scheduled meetings of the health access oversight committee.

(b) If the secretary of human services or designee receives the results of the federal government's review of Vermont's plan to implement its health benefit

exchange while the general assembly is not in session, the members of the administration team responsible for exchange implementation shall present the results to the health access oversight committee and to a joint meeting of the standing committees pursuant to subsection (a) of this section. If the secretary or designee receives the results of the federal review when the general assembly is in session, the members of the administration team shall present the results to the house committees on health care and on appropriations and the senate committees on health and welfare, on finance, and on appropriations.

(c) No later than February 1, 2013, the administration team responsible for exchange implementation shall present to the house committees on health care and on appropriations and the senate committees on health and welfare, on finance, and on appropriations the exchange certification application the secretary of human services or designee submitted to the federal government.

* * * Health Access Eligibility Unit * * *

Sec. 36. 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.

* * * Preconditions for Green Mountain Care * * *

Sec. 36a. 33 V.S.A. § 1822 is amended to read:

§ 1822. IMPLEMENTATION; WAIVER

(a) Green Mountain Care shall be implemented 90 days following the last to occur of:

* * *

(5) A determination by the Green Mountain Care ~~Board~~ board, as the result of a detailed and transparent analysis, 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. This determination shall include an analysis of the impact of implementation on economic growth.

(C) The financing for Green Mountain Care is sustainable. In this analysis, the board shall consider at least a five-year revenue forecast using the consensus process established in 32 V.S.A. § 305a, projections of federal and other funds available to support Green Mountain Care, and estimated expenses for Green Mountain Care for an equivalent time period.

(D) Administrative expenses borne by health care providers, health insurers, and the state of Vermont will be reduced below 2011 levels, adjusted for inflation and other factors as necessary to reflect the present value of 2011 dollars at the time of the analysis.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending without reducing access to necessary care or resulting in excessive wait times for services.

(F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

* * *

(c) The Green Mountain Care board's analysis prepared pursuant to subdivision (a)(5) of this section shall be made available to the general assembly and the public and shall include:

(1) a complete fiscal projection of revenues and expenses, as described in subdivision (a)(5) of this section, including reserves, if recommended, and other costs in addition to the cost of services, over at least a five-year period for a public-private universal health care system providing benefits with an actuarial value of 80 percent or greater;

(2) the financing plans provided to the general assembly in January 2013 pursuant to Sec. 9 of No. 48 of the Acts of 2011;

(3) an analysis of how implementing Green Mountain Care will further the principles of health care reform expressed in 18 V.S.A. § 9371 beyond the reforms established through the Blueprint for Health; and

(4) a comparison of best practices for reducing health care costs in self-funded plans, if available.

Sec. 36b. JOINT FISCAL OFFICE REVIEW

(a) Within 90 days following a determination by the Green Mountain Care board pursuant to 33 V.S.A. § 1822 that the preconditions for Green Mountain Care have been met, the joint fiscal committee shall direct the legislative joint fiscal office to prepare a review of the board's findings, including an evaluation of the assumptions that formed the basis for the board's analysis. The joint fiscal office shall present its review to the house committees on

health care and on appropriations, the senate committees on health and welfare and on appropriations, the governor, and the Green Mountain Care board; provided, however, that if the general assembly is not in session at the time the office completes its review, the office shall present the review to the joint fiscal committee in lieu of the committees of jurisdiction.

(b) The joint fiscal office may hire consultants as necessary to carry out its duties under this section.

* * * Technical and Clarifying Changes * * *

Sec. 37. 18 V.S.A. § 701 is amended to read:

§ 701. DEFINITIONS

For the purposes of this chapter:

* * *

(8) "Health benefit plan" shall have the same meaning as health insurance plan in 8 V.S.A. § 4088h.

* * *

(11) "Hospital" shall have the same meaning as in section ~~9456~~ 9451 of this title.

* * *

Sec. 38. 18 V.S.A. § 9391 is amended to read:

§ 9391. NOMINATION AND APPOINTMENT PROCESS

* * *

(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 and the name of any incumbent who declares that he or she wishes to be a candidate to succeed himself or herself.

(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. The names of candidates submitted and not selected shall remain confidential.

* * *

Sec. 39. Sec. 31(a) of No. 48 of the Acts of 2011 is amended to read:

(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, as provided in 3 V.S.A. § 259.

* * * Sports Injuries * * *

Sec. 39a. 16 V.S.A. § 1431(d) is amended to read:

(d) Participation in athletic activity.

(1) A coach shall not permit a youth athlete to continue to participate in any training session or competition associated with a school athletic team if the coach has reason to believe that the athlete has sustained a concussion or other head injury during the training session or competition.

(2) A coach shall not permit a youth athlete who has been prohibited from training or competing pursuant to subdivision (1) of this subsection to train or compete with a school athletic team ~~if the athlete has been removed or prohibited from participating in a training session or competition associated with the 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 health care provider licensed pursuant to Title 26 and trained in the evaluation and management of concussions and other head injuries.

* * * Rulemaking Authority * * *

Sec. 40. HOSPITAL BUDGET REVIEW RULES

For the purposes of hospital budget reviews pursuant to 18 V.S.A. chapter 221, subchapter 7, the Green Mountain Care board shall apply Rule 7.500 of the department of banking, insurance, securities, and health care administration, as that rule exists on the effective date of this section, until March 1, 2013 or the board's adoption of a permanent rule on hospital budget reviews pursuant to Sec. 40a of this act, whichever is earlier.

Sec. 40a. RULEMAKING

No later than January 1, 2013, the Green Mountain Care board shall adopt rules pursuant to 3 V.S.A. chapter 25 implementing the amendments in this act to 8 V.S.A. § 4062 (insurance rate review) and to 18 V.S.A. chapter 221, subchapters 5 (certificate of need) and 7 (hospital budget review).

* * * Position Transfer * * *

Sec. 40b. TRANSFER OF POSITION

On or before January 1, 2013, one health care administrator position shall be transferred from the department of banking, insurance, securities, and health care administration to the Green Mountain Care board.

* * * Maximizing Federal Funds * * *

Sec. 40c. MAXIMIZING PREMIUM TAX CREDITS AND COST-SHARING SUBSIDIES

No later than January 15, 2013, the secretary of administration or designee shall recommend to the house committees on health care and on ways and means and the senate committees on health and welfare and on finance strategies for maximizing the number of Vermont residents who will be eligible to receive federal premium tax credits or cost-sharing subsidies, or both, in the Vermont health benefit exchange and for maximizing the amount of the federal credits and subsidies that eligible Vermonters will receive.

* * * Health Access Oversight Committee * * *

Sec. 40d. 2 V.S.A. § 852 is amended to read:

§ 852. FUNCTIONS AND DUTIES

(a) The health access oversight committee shall ~~carry on~~ monitor, oversee, and provide a continuing review of ~~the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs~~ health care and human services programs in Vermont when the general assembly is not in session.

(b) In conducting its ~~review~~ oversight and in order to fulfill its duties, the committee ~~shall~~ may consult the following:

(1) Consumers and advocacy groups ~~regarding their satisfaction and complaints~~.

(2) Health care providers ~~regarding their satisfaction and complaints~~.

(3) The department of Vermont health access.

(4) The department of banking, insurance, securities, and health care administration.

(5) The department of health.

(6) The department for children and families.

(7) The department of disabilities, aging, and independent living.

(8) The department of mental health.

(9) The agency of human services.

(10) The agency of administration.

(11) The Green Mountain Care board.

(12) The director of health care reform.

~~(6)~~(13) The attorney general.

~~(7)~~(14) The health care ombudsman.

(15) The long-term care ombudsman.

~~(8)~~(16) The Vermont program for quality in health care.

~~(9)~~(17) Any other person or entity as determined by the committee.

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to ~~the state Medicaid program and other state~~ health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the general assembly.

* * * Repeals * * *

Sec. 41. REPEALS

(a) 8 V.S.A. § 4089b(h) (insurance quality task force) is repealed July , 012.

(b) 18 V.S.A. § 9409a (provider reimbursement survey) is repealed on passage.

(c) 8 V.S.A. § 4080c (safety net) is repealed January 1, 2014, except that plans issued or renewed in 2013 shall remain in effect until their anniversary date in calendar year 2014 to the extent consistent with the provisions of the Affordable Care Act and related guidance and regulations.

(d) Sec. 6 (health access eligibility unit transfer) of No. 48 of the Acts of 2011 is repealed on passage.

(e) 33 V.S.A. chapter 13, subchapter 2 (payment reform pilots) is repealed on passage.

(f) 18 V.S.A. § 4632(a)(7) (DVHA prescribed product report) is repealed on passage.

(g) No. 2 of the Acts of 2005 (I-SaveRx prescription drug program) is repealed on passage. Notwithstanding any provision of Sec. 2 of No. 2 of the Acts of 2005 to the contrary, repeal of such act shall constitute Vermont's withdrawal from the I-SaveRx agreement and terminate its related cooperative relationship with the state of Illinois.

(h) 33 V.S.A. chapter 19, subchapter 3 (Vermont Health Access Plan; employer-sponsored insurance assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage by the department of Vermont health access as authorized by the Centers on Medicare and Medicaid Services.

(i) 8 V.S.A. §§ 4080a (small group market) and 4080b (nongroup market) are repealed January 1, 2014, except that plans issued or renewed in 2013 shall remain in effect until their anniversary date in calendar year 2014 to the extent consistent with the provisions of the Affordable Care Act and related guidance and regulations.

(j) 8 V.S.A. § 4062d (market security trust is repealed July 1, 2012.

Sec. 41a. TRANSITIONAL PROVISIONS; IMPLEMENTATION

(a) Except as otherwise provided in subsection (c) of this section, small employers may enroll in health insurance plans offered though the Vermont health benefit exchange beginning at the earliest on October 1, 2013 and at the latest on the renewal date of any small group plan the employer purchased prior to January 1, 2014.

(b) Except as otherwise provided in subsections (c) and (d) of this section, individuals in the nongroup market may enroll in health insurance plans offered though the Vermont health benefit exchange beginning at the earliest on October 1, 2013 and at the latest on March 31, 2014, pursuant to federal law.

(c) Notwithstanding Sec. 41(i) of this act, repealing 8 V.S.A. §§ 4080a and 4080b, the department of banking, insurance, securities, and health care administration and the Green Mountain Care board may continue to approve rates and forms for nongroup and small group health insurance plans under the statutes and rules in effect prior to the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. In the alternative, the department of banking, insurance, securities, and health care administration may allow individuals and small employers to extend coverage under an existing health insurance plan. The department of banking, insurance, securities, and health care administration and the Green Mountain Care board shall maintain their authority pursuant to this subsection until the exchange is able to enroll all qualified individuals and small employers who apply for coverage through the exchange.

(d) Notwithstanding Sec. 41(h) of this act, repealing the Vermont health access plan and employer-sponsored insurance assistance, the department of Vermont health access may continue to provide employer-sponsored insurance assistance and coverage through the Vermont health access plan to eligible individuals beyond the date of repeal if the Vermont health benefit exchange is not operational by January 1, 2014 and the department of Vermont health access or a health insurer is unable to facilitate enrollment in health benefit plans through another mechanism, including paper enrollment. The

department of Vermont health access shall maintain its authority to administer these programs until the exchange is able to enroll all qualified applicants who apply for coverage through the exchange.

(e) Notwithstanding the provisions of 8 V.S.A. §§ 4080a(d)(1) and 4080b(d)(1), a health insurer shall not be required to guarantee acceptance of any individual, employee, or dependent on or after January 1, 2014 for a small group plan offered pursuant to 8 V.S.A. § 4080a or a nongroup plan offered pursuant to 8 V.S.A. § 4080b except as required by the department of banking, insurance, securities, and health care administration or the Green Mountain Care board, or both, pursuant to subsection (c) of this section.

(f) To the extent permitted under the Affordable Care Act, in implementing the Vermont health benefit exchange, it is the intent of the general assembly not to impair the health care coverage provided to Vermonters through collective bargaining agreements entered into prior to January 1, 2013 and in effect on January 1, 2014 until the date that any such collective bargaining agreement relating to such health care coverage terminates.

Sec. 42. EFFECTIVE DATES

(a) Secs. 5 (Green Mountain Care board authority), 5a (bill-back report), 6–11 (unified health care budget), 11a (claims edit standards), 11d (rulemaking on primary mental health care parity), 12–14 (Green Mountain Care board duties, health care administration), 23 (hospital budgets), 24 (provider bargaining groups), 24g (pretrial screening feasibility analysis), 25 and 26 (insurance rate reviews), 26a (ombudsman's report), 27 (payment reform pilot projects, 28 (Blueprint for Health), 28a (Blueprint intent), 29 (HMO reporting requirements), 33–35a (waivers), 35c (transition planning and exchange updates), 36 (health access eligibility unit), 36a (preconditions for Green Mountain Care), 36b (JFO review), 37–39 (technical/clarifying changes), 40b (transfer of position), 40c (maximizing federal funds), 41 (repeals), and 41a (transitional provisions) of this act and this section shall take effect on passage.

(b) Secs. 40 (hospital budget rules) and 40a (rulemaking) of this act shall take effect on passage, provided that in order to comply with the deadlines contained in this act, the Green Mountain Care board may begin the rulemaking process prior to passage.

(c) Secs. 1 and 2 (50 employees or fewer), 2a (qualified health benefit plans), 2b (navigators), 2c (exchange options), 2d (brokers and agents), and 2e (exchange disclosure) shall take effect on July 1, 2012.

(d) Sec. 30 (VPQHC) shall take effect on July 1, 2013.

(e) Sec. 31 (prohibition on discretionary clauses) shall take effect on January 1, 2013 and shall apply to all policies, contracts, certificates, and

agreements renewed, offered, or issued in this state with effective dates on or after such date.

(f)(1) Secs. 32(a), (e), and (f) (prescription drug coverage); 32a and 32b (prescribed products); 35b (Medicaid and exchange advisory committee); 39a (sports injuries); and 40d (health access oversight committee) shall take effect on July 1, 2012.

(2) Sec. 32(b), (c), and (d) (prescription drug cost-sharing) shall take effect on October 1, 2012 and shall apply to all health insurance plans and health benefit plans on and after October 1, 2012 on such date as a health insurer issues, offers, or renews the plan, but in no event later than October 1, 2013.

(g) Secs. 3 (merged insurance market) and 4 (grandfathered plans) shall take effect on January 1, 2013, provided that:

(1) the department of banking, insurance, securities, and health care administration and the Green Mountain Care board may adopt rules as needed before that date to ensure that enrollment in the health insurance plans will be available no later than October 1, 2013; and

(2) January 1, 2014 shall be the earliest date that coverage may begin under a plan offered in the merged market.

(h) Secs. 14a–22 (certificates of need) shall take effect on January 1, 2013, and the Green Mountain Care board shall have sole jurisdiction over all applications for new certificates of need and over the administration of all existing certificates of need on and after that date, provided that for applications already in process on that date, the rules and procedures in place at the time the application was filed shall continue to apply until a final decision is made on the application.

(i) Secs. 11b (mental health and substance abuse quality assurance), 11e (mental health ombudsman), and 11f (prior authorization) shall take effect on July 1, 2012.

(j) Sec. 11c (parity for primary mental health care services) shall apply to health insurance plans on or after July 1, 2013, on such date as a health insurer issues, offers, or renews the health insurance plan, but in no event later than July 1, 2014.

(k) Secs. 24a–24f (medical malpractice reform) shall take effect on February 1, 2013, except that Sec. 24b(f) (Sorry Works! rulemaking) shall take effect on passage.

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

Senator Cummings, for the Committee on Finance, to which the bill was referred, reported recommending that the Senate propose to the House that the bill be amended as recommended by the Committee on Health and Welfare with the following amendments thereto:

First: By replacing "of banking, insurance, securities, and health care administration" wherever it appears with "of financial regulation"

Second: In Sec. 2, 33 V.S.A. § 1804, in subdivisions (a)(1) and (b)(1), following the word "calendar", each time it appears, by striking out the word "quarter" and inserting in lieu thereof the word year

Third: By striking out Sec. 2d, 33 V.S.A. § 1805, in its entirety and inserting in lieu thereof the following:

Sec. 2d. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

The Vermont health benefit exchange shall have the following duties and responsibilities consistent with the Affordable Care Act:

* * *

(17) Establishing procedures that allow licensed insurance agents and brokers to be appropriately compensated for:

(A) facilitating the enrollment of qualified individuals and qualified employers in any qualified health plan offered through the exchange for which the individual or employer is eligible; and

(B) assisting qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health benefit plans purchased through the exchange.

Fourth: In Sec. 3, 33 V.S.A. § 1811, in subdivisions (a)(3)(A) and (B), following the word "calendar", each time it appears, by striking out the word "quarter" and inserting in lieu thereof the word year

Fifth: By striking out Secs. 11c and 11d in their entirety and inserting in lieu thereof the following:

Sec. 11c. PARITY FOR PRIMARY MENTAL HEALTH CARE SERVICES; RECOMMENDATIONS

No later than January 15, 2013, the commissioner of financial regulation or designee shall recommend to the house committee on health care and the senate committees on health and welfare and on finance guidelines for distinguishing between primary and specialty mental health services, taking into consideration factors such as mental health care providers' scope of

practice and patterns of patient visitation. In addition, the commissioner or designee shall provide the committees with an estimate of the impact on health insurance premiums if such guidelines are enacted into law.

Sixth: By inserting a new Sec. 11e to read as follows:

Sec. 11e. 18 V.S.A. § 9418 is amended to read:

§ 9418. PAYMENT FOR HEALTH CARE SERVICES

(a) Except as otherwise specified, as used in this subchapter:

* * *

(15) "Prior authorization" means the process used by a health plan to determine the medical necessity, medical appropriateness, or both, of otherwise covered drugs, medical procedures, medical tests, and health care services. The term "prior authorization" includes preadmission review, pretreatment review, and utilization review.

(16) "Procedure codes" means a set of descriptive codes indicating the procedure performed by a health care provider and includes the American Medical Association's Current Procedural Terminology codes (CPT), the Healthcare Common Procedure Coding System Level II Codes (HCPCS), the American Society of Anesthesiologists' (ASA) current procedural terminology, and the American Dental Association's current dental terminology.

~~(16)~~(17) "Product" means, to the extent permitted by state and federal law, one of the following types of categories of coverage for which a participating provider may be obligated to provide health care services pursuant to a health care contract:

* * *

And by redesignating the current Sec. 11e to be Sec. 11d

Seventh: By striking out Sec. 11f in its entirety and inserting in lieu thereof the following:

Sec. 11f. 18 V.S.A. § 9418b is amended to read:

§ 9418b. PRIOR AUTHORIZATION

* * *

(g)(1) Notwithstanding any provision of law to the contrary, on and after March 1, 2014, when requiring prior authorization for prescription drugs, medical procedures, and medical tests, a health plan shall accept:

(A) The HIPAA 278 standard transaction for sending or receiving authorizations electronically; or

(B) a uniform prior authorization form developed pursuant to subdivisions (2) and (3) of this subsection.

(2)(A) No later than September 1, 2013, the department of financial regulation shall develop a uniform prior authorization form for prior authorization requests for medical procedures and medical tests.

(B) No later than September 1, 2013, the department of financial regulation shall develop uniform forms for prior authorization requests for prescription drugs after determining the appropriate number of forms.

(3) Each uniform prior authorization form developed pursuant to subdivision (2) of this subsection shall meet the following criteria, where applicable:

(A) The form shall include the core set of common data requirements for prior authorization included in the HIPAA 278 standard transaction.

(B) The form shall be made available electronically by the department and by the health plan.

(C) The completed form may be submitted electronically from the prescribing health care provider to the health plan.

(D) The department shall develop the form with input from interested parties from at least one public meeting.

(E) The department shall consider input on the proposed form from the national ASC X-12 workgroup, if available.

(F) In developing the uniform prior authorization forms, the department shall take into consideration the following:

(i) existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services, by the department of Vermont health access, and by insurance and Medicaid departments and agencies in other states; and

(ii) national standards related to electronic prior authorization.

(4) A health plan shall respond to a completed prior authorization request from a prescribing health care provider within two business days for urgent requests and within seven business days for non-urgent requests. The health plan shall notify a health care provider of or make available to a health care provider a receipt of the request for prior authorization and any needed missing information within 24 hours of receipt. If a health plan does not, within the time limits set forth in this section, respond to a completed prior

authorization request, acknowledge receipt of the request for prior authorization, or request missing information, the prior authorization request shall be deemed to have been granted.

Eighth: In Sec. 12, 18 V.S.A. § 9375(b), in subdivision (6), following "Approve", by inserting the following: , modify,

Ninth: By striking out Sec. 25, 8 V.S.A. § 4062, in its entirety and inserting in lieu thereof the following:

Sec. 25. 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 filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, health maintenance organization, or a managed care organization and 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) 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~~ financial regulation; ~~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~~ and

(B) a decision by the Green Mountain Care board has been applied by the commissioner as provided ~~herein, unless the commissioner shall sooner give his or her written approval thereto~~ in subdivision (2) of this subsection.

(2)(A) Prior to approving a rate ~~increase~~ pursuant to this subsection, the commissioner shall seek approval for such rate ~~increase~~ from the Green Mountain Care board established in 18 V.S.A. chapter 220~~, which~~. The commissioner shall make a recommendation to the Green Mountain Care board about whether to approve, modify, or disapprove the rate within 30 days of receipt of a completed application from an insurer. In the event that the commissioner does not make a recommendation to the board within the 30-day period, the commissioner shall be deemed to have recommended approval of the rate, and the Green Mountain Care board shall review the rate request pursuant to subdivision (B) of this subdivision (2).

(B) The Green Mountain Care board shall review rate requests forwarded by the commissioner pursuant to subdivision (A) of this subdivision (2) and shall approve, modify, or disapprove ~~the~~ a rate ~~increase~~ request within

~~10 business~~ 30 days of receipt of the commissioner's recommendation or, in the absence of a recommendation from the commissioner, the expiration of the 30-day period following the department's receipt of the completed application. In the event that the board does not approve or disapprove a rate within 30 days, the board shall be deemed to have approved the rate request.

(C) The commissioner shall apply the decision of the Green Mountain Care board as to rates referred to the board within five business days of the board's decision.

~~(2)~~(3) 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 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.

~~(3) After the expiration of the review period provided herein or at any time after having given written approval, the~~

(b) The commissioner may, after a hearing of which at least 20 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. For premium rates, such withdrawal may occur at any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section. ~~Such disapproval~~ Disapproval pursuant to this subsection 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)~~(c) 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)~~

(d) of this section. In addition, the insurer shall post the summaries on its website.

~~(c)~~(d)(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 rate filings pursuant to subsection (a) of this section and summaries pursuant to subsection ~~(b)~~(c) 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~~ submitting the policy or rate for the Green Mountain Care board's approval 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~~ rates.

~~(d)~~(e)(1) The following provisions of this section shall not apply to policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, or other limited benefit coverage~~, but shall apply to long-term care policies~~:

(A) the requirement in ~~subdivision~~ subdivisions (a)(1) and (2) for the Green Mountain Care board's approval ~~for any~~ on rate ~~increase~~ requests;

(B) the review standards in subdivision ~~(a)(2)~~ (a)(3) 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) and (d) 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.

(3) Medicare supplemental insurance policies shall be exempt only from the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests and shall be subject to the remaining provisions of this section.

Tenth: By adding a new section to be numbered Sec. 25a to read as follows:

Sec. 25a. 8 V.S.A. § 5104 is amended to read:

§ 5104. FILING AND APPROVAL OF RATES AND FORMS; SUPPLEMENTAL ORDERS

(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~~ the commissioner deems necessary to evaluate the filing. 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, or to seek the Green Mountain Care board's approval of, 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.

(b) In connection with a rate decision, the commissioner may also, with the prior approval of the Green Mountain Care board established in 18 V.S.A. chapter 220, make reasonable supplemental orders and may attach reasonable conditions and limitations to such orders as the commissioner finds, on the basis of competent and substantial evidence, necessary to insure that benefits and services are provided at reasonable cost under efficient and economical management of the organization. The commissioner shall not set the rate of payment or reimbursement made by the organization to any physician, hospital or health care provider.

Eleventh: By striking out Sec. 26a in its entirety and inserting in lieu thereof the following:

Sec. 26a. CONSUMER PROTECTION REPORT

No later than January 15, 2013, the department of financial regulation, in collaboration with the state health care ombudsman and the agency of human services, shall report to the house committee on health care and the senate committees on health and welfare and on finance regarding:

(1) recommendations on how best to represent the public interest before the Green Mountain Care board and other regulatory agencies and estimates of resource needs;

(2) recommendations on how best to coordinate, consolidate, or both the consumer protection efforts of the ombudsman's office, the department, and the agency; and

(3) the ombudsman's current and projected funding and resource needs to meet existing statutory responsibilities and suggestions for funding mechanisms to meet those needs.

Twelfth: In Sec. 28, 18 V.S.A. § 702, in subdivision (b)(1)(A), following "with clinical experience in Vermont;", by inserting the following: a representative of the Vermont council of developmental and mental health services;

Thirteenth: In Sec. 31, 8 V.S.A. § 4062f, in subsections (c), (d), and (e), preceding "any such provision", each time it appears, by inserting the following: on and after July 1, 2012,

Fourteenth: In Sec. 32b, 18 V.S.A. § 4632, in subdivisions (a)(1)(B) and (a)(5)(A), by striking out the word "and" preceding the word "items", each time it appears, and following the word "equipment", by inserting the following: , medical food, and infant formula in both places

Fifteenth: In Sec. 35c, Exchange Implementation and Transition Planning; Updates, in subsection (a), in the first sentence, following the word "senate", by striking the word "committee" and inserting in lieu thereof the word "committees" and following the word "welfare", by inserting the words "and on finance"; and in the second sentence, following the words "the chairs of", by striking out the word "both" and inserting in lieu thereof the word the

Sixteenth: By striking out Sec. 40d, 2 V.S.A. § 852, in its entirety and inserting in lieu thereof the following:

Sec. 40d. 2 V.S.A. chapter 24 is amended to read:

CHAPTER 24. HEALTH ~~ACCESS~~ CARE OVERSIGHT COMMITTEE

§ 851. CREATION OF COMMITTEE

(a) A legislative health ~~access~~ care oversight committee is created. The committee shall be appointed biennially and consist of ten members: five members of the house appointed by the speaker, not all from the same political party, and five members of the senate appointed by the senate committee on committees, not all from the same political party. The house appointees shall include ~~two members~~ one member from the house committee on human services, ~~two members~~ one member from the house committee on health care, ~~and~~ one member from the house committee on appropriations, and two at-large members. The senate appointees shall include ~~three members~~ one member from the senate committee on health and welfare, one member from the senate committee on finance, ~~and~~ one member from the senate committee on appropriations, and two at-large members.

(b) The committee may adopt rules of procedure to carry out its duties.

§ 852. FUNCTIONS AND DUTIES

(a) The health ~~access~~ care oversight committee shall ~~carry on~~ monitor, oversee, and provide a continuing review of ~~the operation of the Medicaid program and all Medicaid waiver programs that may affect the administration and beneficiaries of these programs~~ health care and human services programs in Vermont when the general assembly is not in session, including programs and initiatives related to mental health, substance abuse treatment, and health care reform.

(b) In conducting its ~~review~~ oversight and in order to fulfill its duties, the committee ~~shall~~ may consult the following:

(1) Consumers and advocacy groups ~~regarding their satisfaction and complaints~~.

(2) Health care providers ~~regarding their satisfaction and complaints~~.

(3) The department of Vermont health access.

(4) The department of ~~banking, insurance, securities, and health care administration~~ financial regulation.

(5) The department of health.

(6) The department for children and families.

(7) The department of disabilities, aging, and independent living.

(8) The department of mental health.

(9) The agency of human services.

(10) The agency of administration.

(11) The Green Mountain Care board.

(12) The director of health care reform.

~~(6)~~(13) The attorney general.

~~(7)~~(14) The health care ombudsman.

(15) The long-term care ombudsman.

~~(8)~~(16) The Vermont program for quality in health care.

~~(9)~~(17) Any other person or entity as determined by the committee.

(c) The committee shall work with, assist, and advise other committees of the general assembly, members of the executive branch, and the public on matters relating to ~~the state Medicaid program and other state~~ health care and human services programs. Annually, no later than January 15, the committee shall report its recommendations to the governor and the general assembly.

§ 853. MEETINGS AND STAFF SUPPORT

(a) The committee may meet during a session of the general assembly at the call of the chair or by a majority of the members of the committee. The committee may meet during adjournment subject to the approval of the speaker of the house and the president pro tempore of the senate.

(b) For attendance at meetings which are held when the general assembly is not in session, the members of the committee shall be entitled to the same per diem compensation and reimbursement for necessary expenses as those provided to members of standing committees under section 406 of this title.

(c) The staff of the legislative council and the joint fiscal office shall provide professional and administrative support to the committee. The department of ~~banking, insurance, securities, and health care administration~~ financial regulation, the agency of human services, and other agencies of the state shall provide information, assistance, and support upon request of the committee.

Seventeenth: In Sec. 41, Repeals, by striking out subsection (j) in its entirety and inserting in lieu thereof the following:

(j) 8 V.S.A. §§ 4062d (market security trust), 4077 (industrial policies), and 4078 (franchise plan policies) are repealed on July 1, 2012.

And by adding a subsection (k) to read as follows:

(k) Sec. 141c of No. 122 of the Acts of the 2003 Adj. Sess. (2004), as amended (mental health oversight committee), is repealed.

Eighteenth: In Sec. 41a, Transitional Provisions; Implementation, by redesignating the current subsection (a) to be subdivision (a)(1); in the new subdivision (a)(1), following the word "purchased", by inserting the words that took effect and by adding a subdivision (a)(2) to read as follows:

(2) Notwithstanding subdivision (1) of this subsection, the commissioner of financial regulation may, in his or her discretion, allow for the extension of a small group or association plan beyond the plan's renewal date in order to ensure a smooth and orderly transition from health plans offered in the small group and association markets in 2013 to health plans offered in the small group market through the Vermont health benefit exchange in 2014.

Nineteenth: By adding a new section to be numbered Sec. 41b to read as follows:

Sec. 41b. MEDICARE SUPPLEMENTAL INSURANCE; WEB PORTAL

Nothing in this act shall be construed to prohibit the department of Vermont health access from allowing Medicare supplemental insurance to be offered on the web portal for the Vermont health benefit exchange, nor to require that the cost of providing such offerings on the web portal be paid in whole or in part with federal funds. Prior to allowing Medicare supplemental insurance to be offered on the Vermont health benefit exchange web portal, the department shall seek the input of consumers, insurers, and other stakeholders.

Twentieth: In Sec. 42, Effective dates, in subsection (a), by striking out "11d (rulemaking on primary mental health parity)" and inserting in lieu thereof the following: 11c (parity for primary mental health care services) by striking out "25 and 26" and inserting in lieu thereof the following 25–26 following "26a", by striking out "(ombudsman's report)" and inserting in lieu thereof the following: (consumer protection report) by striking out the word "and" preceding "41a", and following "(transitional provisions)", by inserting the following: , and 41b (Medicare supplemental policies) in subsection (e), by striking out "January 1, 2013" and inserting in lieu thereof the following: July 1, 2012 in subdivision (f)(1), preceding the word "oversight", by striking out the word "access" and inserting in lieu thereof the word care in subsection (i), by striking out "11e" preceding "(mental health ombudsman)" and inserting in lieu thereof the following: 11d and following "(mental health ombudsman),", by inserting the following: 11e (payment; definitions), and by striking out subsection (j) in its entirety and redesignating current subsection (k) to be subsection (j)

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

Senator Kitchel, for the Committee on Appropriations, to which the bill was referred, reported that the bill ought to pass when so amended.

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

Thereupon, pending the question, Shall the recommendation of amendment of Health and Welfare be amended as recommended by the Committee on Finance? Senator Sears raised a point of order that Secs. 24a-24g of the recommendation of amendment of the Committee on Health and Welfare was *not germane* in that they dealt with medical malpractice and were beyond the scope of the purpose of the bill.

Thereupon, the Chair overruled the point of order stating that Sec. 24 of the underlying bill deals with medical malpractice and that medical malpractice reform is a related component of health care cost containment, one of the purposes of the bill, the sections were germane.

Thereupon, the proposal of amendment of the Committee on Health and Welfare, was amended as proposed by the Committee on Finance.

Thereupon, the proposal of amendment of the Committee on Health and Welfare, as amended was agreed to.

Thereupon, pending the question, Shall the bill be read a third time?, Senator Brock moved that Senate proposal of amendment be amended as follows:

First: By inserting a Sec. 36c to read as follows:

Sec. 36c. FINDINGS

The general assembly finds:

(1) Health care costs and the financing of those costs have a significant impact on the life of every Vermonter.

(2) Decisions regarding health care financing have a significant impact on Vermont's economy.

(3) No. 48 of the Acts of 2011 directs the secretary of administration to recommend plans for sustainable financing for Green Mountain Care and for Vermont's health benefit exchange. Under the language of that act, both plans are due to the legislative committees of jurisdiction by January 15, 2013.

(4) The public has a right to hear and understand the proposed financing plans in advance of the November 2012 election, in which the future direction of Vermont's health care planning is likely to be a major issue for debate.

Second: By inserting a Sec. 36d to read as follows:

Sec. 36d. Sec. 9 of No. 48 of the Acts of 2011 is amended to read:

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~~ September 15, 2012.

* * *

Third: In Sec. 42, Effective Dates, in subsection (a), following "36b (JFO review)", by inserting ", 36c and 36d (financing plan)"

Which was disagreed to.

Thereupon, pending the question, Shall the bill be read a third time?, Senator Sears, on behalf of the Committee on Judiciary that the Senate proposal of amendment be amended as follows:

First: By striking out Sec. 24b in its entirety and inserting in lieu thereof a new Sec. 24b to read as follows:

Sec. 24b. [DELETED]

Second: In Sec. 24c, 12 V.S.A. § 7012(c), by striking out the words "in accordance with" and inserting in lieu thereof the words prepared pursuant to

Third: In Sec. 24e by striking out ",24b (Sorry Works! pilot program),"

Fourth: In Sec. 24e(3) by striking out ", 24b,"

Fifth: By striking Sec. 24g in its entirety.

Thereupon, Senator Sears requested and was granted leave to withdraw the proposal of amendment.

Thereupon, pending the question, Shall the bill be read a third time?, Senator Sears moved that the Senate proposal of amendment be amended as follows:

In Sec. 39a, 16 V.S.A. § 1413(d)(1), by striking out the words "reason to believe" and inserting in lieu thereof the words actual knowledge

Thereupon, Senator Sears requested and was granted leave to withdraw the proposal of amendment.

Thereupon, third reading of the bill was ordered.

Adjournment

On motion of Senator Campbell, the Senate adjourned until three o'clock in the afternoon on Tuesday, April 24, 2012.