House Calendar

Wednesday, March 13, 2013

64th DAY OF THE BIENNIAL SESSION

House Convenes at 1:00 P.M.

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ORDERS OF THE DAY

ACTION CALENDAR

Action Postponed Until March 13, 2013

Committee Bill for Second Reading

H. 395

An act relating to the establishment of the Vermont Clean Energy Loan Fund.

(Rep. Botzow of Pownal will speak for the Committee on **Commerce and Economic Development.)**

Third Reading

H. 14

An act relating to the law enforcement authority of liquor control investigators

Favorable with Amendment

H. 112

An act relating to the labeling of food produced with genetic engineering

Rep. Bartholomew of Hartland, for the Committee on **Agriculture and Forest Products,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The General Assembly finds and declares that:

(1) U.S. federal law does not provide for the regulation of the safety and labeling of food that is produced with genetic engineering, as evidenced by the following:

(A) U.S. federal labeling and food and drug laws do not require manufacturers of food produced with genetic engineering to label such food as genetically engineered.

(B) As indicated by the testimony of Dr. Robert Merker, a U.S. Food and Drug Administration (FDA) Supervisory Consumer Safety Officer, the FDA has statutory authority to require labeling of food products, but does not consider genetically engineered foods to be materially different from their traditional counterparts to justify such labeling.

(C) No formal FDA policy on the labeling of genetically engineered foods has been adopted. Currently, the FDA only provides nonbinding

guidance on the labeling of genetically engineered foods, including a 1992 draft guidance regarding the need for the FDA to regulate labeling of food produced from genetic engineering and a 2001 draft guidance for industry regarding voluntary labeling of food produced from genetic engineering.

(D) The FDA regulates genetically engineered foods in the same way it regulates foods developed by traditional plant breeding.

(E) Under its regulatory framework, the FDA does not independently test the safety of genetically engineered foods. Instead, manufacturers may submit safety research and studies, the majority of which the manufacturers finance or conduct. The FDA reviews the manufacturers' research and reports through a voluntary safety consultation, and issues a letter to the manufacturer acknowledging the manufacturer's conclusion regarding the safety of the genetically engineered food product being tested.

(F) The FDA does not use meta-studies or other forms of statistical analysis to verify that the studies it reviews are not biased by financial or professional conflicts of interest.

(G) There is a lack of consensus regarding the validity of the research and science surrounding the safety of genetically engineered foods, as indicated by the fact that there are peer-reviewed studies published in international scientific literature showing negative, neutral, and positive health results.

(H) There have been no long-term or epidemiologic studies in the United States that examine the safety of human consumption of genetically engineered foods.

(I) Independent scientists are limited from conducting safety and risk-assessment research of genetically engineered materials used in food products due to industry restrictions on the use for research of those genetically engineered materials used in food products.

(2) Genetically engineered foods are increasingly available for human consumption, as evidenced by the fact that:

(A) it is estimated that up to 80 percent of the processed foods sold in the United States are at least partially produced from genetic engineering; and

(B) according to the U.S. Department of Agriculture, in 2012, genetically engineered soybeans accounted for 93 percent of U.S. soybean acreage, and genetically engineered corn accounted for 88 percent of U.S. corn acreage.

(3) Genetically engineered foods pose potential risks to health, safety, agriculture, and the environment, as evidenced by the following:

(A) Independent studies in laboratory animals indicate that the ingestion of genetically engineered foods may lead to health problems such as gastrointestinal damage, liver and kidney damage, reproductive problems, immune system interference, and allergic responses.

(B) The genetic engineering of plants and animals may cause unintended consequences. The use of genetic engineering to manipulate genes by inserting them into organisms is an imprecise process. Mixing plant, animal, bacteria, and viral genes through genetic engineering in combinations that cannot occur in nature may produce results that lead to adverse health or environmental consequences.

(C) The use of genetically engineered crops is increasing in commodity agricultural production practices. Genetically engineered crops promote large-scale monoculture production, which contributes to genetic homogeneity, loss of biodiversity, and increased vulnerability of crops to pests, diseases, and variable climate conditions.

(D) Genetically engineered crops that include pesticides may adversely affect populations of bees, butterflies, and other nontarget insects.

(E) Cross-pollination of or cross-contamination by genetically engineered crops may contaminate organic crops and prevent organic farmers and organic food producers from qualifying for organic certification under federal law.

(F) Cross-pollination from genetically engineered crops may have an adverse effect on native flora and fauna. The transfer of unnatural deoxyribonucleic acid to wild relatives can lead to displacement of those native plants, and in turn, displacement of the native fauna dependent on those wild varieties.

(4) For multiple health, personal, cultural, religious, environmental, and economic reasons, the State of Vermont finds that food produced from genetic engineering should be labeled as such, as evidenced by the following:

(A) Public opinion polls conducted by the Center for Rural Studies at the University of Vermont indicate that a large majority of Vermonters want foods produced with genetic engineering to be labeled as such.

(B) Because genetic engineering, as regulated by this act, involves the direct injection of genes into cells, the fusion of cells, or the hybridization of genes that does not occur in nature, labeling foods produced with genetic engineering as "natural," "naturally made," "naturally grown," "all natural," or other similar descriptors is inherently misleading, poses a risk of confusing or deceiving consumers, and conflicts with the general perception that "natural"

foods are not genetically engineered.

(C) Persons with certain religious beliefs object to producing foods using genetic engineering because of objections to tampering with the genetic makeup of life forms and the rapid introduction and proliferation of genetically engineered organisms and, therefore, need food to be labeled as genetically engineered in order to conform to religious beliefs and comply with dietary restrictions.

(D) Requiring that foods produced through genetic engineering be labeled as such will create additional market opportunities for those producers who are not certified as organic and whose products are not produced from genetic engineering. Such additional market opportunities will also contribute to vibrant and diversified agricultural communities.

(E) Labeling gives consumers information they can use to make informed decisions about what products they would prefer to purchase.

(5) Because both the FDA and the U.S. Congress do not require the labeling of food produced with genetic engineering, the State should require food produced with genetic engineering to be labeled as such in order to serve the interests of the State, notwithstanding limited exceptions, to prevent inadvertent consumer deception, prevent potential risks to human health, promote food safety, protect cultural and religious practices, protect the environment, and promote economic development.

Sec. 2. 9 V.S.A. chapter 82A is added to read:

CHAPTER 82A: LABELING OF FOOD PRODUCED WITH GENETIC ENGINEERING

§ 3041. PURPOSE

It is the purpose of this chapter to:

(1) Public health and food safety. Promote food safety and protect public health by enabling consumers to avoid the potential risks associated with genetically engineered foods, and serve as a risk management tool enabling consumers, physicians, and scientists to identify unintended health effects resulting from the consumption of genetically engineered foods.

(2) Environmental impacts. Assist consumers who are concerned about the potential effects of genetic engineering on the environment to make informed purchasing decisions.

(3) Consumer confusion and deception. Reduce and prevent consumer confusion and deception and promote the disclosure of factual information on food labels to allow consumers to make informed decisions.

(4) Promoting economic development. Create additional market opportunities for those producers who are not certified organic and whose products are not produced using genetic engineering and to enable consumers to make informed purchasing decisions.

(5) Protecting religious and cultural practice. Provide consumers with data from which they may make informed decisions for personal, religious, moral, cultural, or ethical reasons.

§ 3042. DEFINITIONS

As used in this chapter:

(1) "Consumer" shall have the same meaning as in subsection 2451a(a) of this title.

(2) "Enzyme" means a protein that catalyzes chemical reactions of other substances without itself being destroyed or altered upon completion of the reactions.

(3) "Genetic engineering" is a process by which a food is produced from an organism or organisms in which the genetic material has been changed through the application of:

(A) in vitro nucleic acid techniques, including recombinant deoxyribonucleic acid (DNA) techniques and the direct injection of nucleic acid into cells or organelles; or

(B) fusion of cells (including protoplast fusion) or hybridization techniques that overcome natural physiological, reproductive, or recombination barriers, where the donor cells or protoplasts do not fall within the same taxonomic group, in a way that does not occur by natural multiplication or natural recombination.

(4) "In vitro nucleic acid techniques" means techniques, including recombinant DNA or ribonucleic acid techniques, that use vector systems and techniques involving the direct introduction into the organisms of hereditary materials prepared outside the organisms such as micro-injection, chemoporation, electroporation, micro-encapsulation, and liposome fusion.

(5) "Organism" means any biological entity capable of replication, reproduction, or transferring of genetic material.

(6) "Processed food" means any food other than a raw agricultural commodity and includes any food produced from a raw agricultural commodity that has been subjected to processing such as canning, smoking, pressing, cooking, freezing, dehydration, fermentation, or milling.

(7) "Processing aid" means:

(A) a substance that is added to a food during the processing of the food but that is removed in some manner from the food before the food is packaged in its finished form;

(B) a substance that is added to a food during processing, is converted into constituents normally present in the food, and does not significantly increase the amount of the constituents naturally found in the food; or

(C) a substance that is added to a food for its technical or functional effect in the processing but is present in the finished food at levels that do not have any technical or functional effect in that finished food.

(8) "Raw agricultural commodity" means any food in its raw or natural state, including any fruit that is washed, colored, or otherwise treated in its unpeeled natural form prior to marketing.

§ 3043. LABELING OF FOOD PRODUCED WITH GENETIC ENGINEERING

(a) Except as set forth in section 3044 of this title, food shall be labeled as produced entirely or in part from genetic engineering if it is a product:

(1) offered for retail sale in Vermont; and

(2) entirely or partially produced with genetic engineering.

(b) If a food is required to be labeled under subsection (a) of this section, it shall be labeled as follows:

(1) in the case of a raw agricultural commodity, on the package offered for retail sale, with the clear and conspicuous words, "produced with genetic engineering" or "genetically engineered" on the front of the package of the commodity or in the case of any such commodity that is not separately packaged or labeled, on a label appearing on the retail store shelf or bin in which the commodity is displayed for sale; or

(2) in the case of any processed food that contains a product or products of genetic engineering, in clear and conspicuous language on the front or back of the package of the food, with the words "partially produced with genetic engineering" or "may be partially produced with genetic engineering."

(c) Except as set forth under section 3044 of this title, a food produced entirely or in part from genetic engineering shall not be labeled on the product, in signage, or in advertising as "natural," "naturally made," "naturally grown," "all natural," or any words of similar import that would have a tendency to mislead a consumer.

(d) This law shall not be construed to require:

(1) the listing or identification of any ingredient or ingredients that were genetically engineered; or

(2) the placement of the term "genetically engineered" immediately preceding any common name or primary product descriptor of a food.

§ 3044. EXEMPTIONS

The following foods shall not be subject to the labeling requirements of section 3043 of this title:

(1) Food consisting entirely of or derived entirely from an animal which has not itself been produced with genetic engineering, regardless of whether the animal has been fed or injected with any food or drug produced with genetic engineering.

(2) A raw agricultural commodity or processed food derived from it that has been grown, raised, or produced without the knowing and intentional use of food or seed produced with genetic engineering. Food will be deemed to be as described in this subdivision only if the person otherwise responsible for complying with the requirements of subsection 3043(a) of this title with respect to a raw agricultural commodity or processed food obtains, from whomever sold the commodity or food to that person, a sworn statement that the commodity or food has not been knowingly or intentionally produced with genetic engineering and has been segregated from and has not been knowingly or intentionally commingled with food that may have been produced with genetic engineering at any time. In providing such a sworn statement, any person may rely on a sworn statement from his or her own supplier that contains the affirmation set forth in this subdivision.

(3) Any processed food which would be subject to subsection 3043(a) of this title solely because it includes one or more processing aids or enzymes produced with genetic engineering.

(4) Any beverage that is subject to the provisions of Title 7.

(5) Until July 1, 2019, any processed food that would be subject to subsection 3043(a) of this title solely because it includes one or more materials that have been produced with genetic engineering, provided that the genetically engineered materials in the aggregate do not account for more than nine-tenths of one percent of the total weight of the processed food.

(6) Food that an independent organization has verified has not been knowingly and intentionally produced from or commingled with food or seed produced with genetic engineering. The Office of the Attorney General, after consultation with the Department of Health, shall approve by procedure the

independent organizations from which verification shall be acceptable under this section.

(7) Food that has been lawfully certified to be labeled, marketed, and offered for sale as "organic" pursuant to the federal Organic Food Products Act of 1990 and the regulations promulgated pursuant thereto by the U.S. Department of Agriculture.

(8) Food that is not packaged for retail sale and that is:

(A) a processed food prepared and intended for immediate human consumption; or

(B) served, sold, or otherwise provided in any restaurant or other food establishment, as defined in 18 V.S.A. § 4301, that is primarily engaged in the sale of food prepared and intended for immediate human consumption.

(9) Medical food, as that term is defined in 21 U.S.C. § 360ee(b)(3).

§ 3045. RETAILER LIABILITY

(a) A retailer shall not be liable for the failure to label a processed food as required by section 3043 of this title, unless:

(1) the retailer is the producer or manufacturer of the processed food; or

(2) the retailer sells the processed food under a brand it owns, but the food was produced or manufactured by another producer or manufacturer.

(b) A retailer shall not be held liable for failure to label a raw agricultural commodity as required by section 3043 of this title, provided that the retailer, within 20 days of any proposed enforcement action or notice of violation, obtains a sworn statement in accordance with subdivision 3044(2) of this title.

§ 3046. SEVERABILITY

If any provision of this subchapter or its application to any person or circumstance is held invalid or in violation of the Constitution or laws of the United States or in violation of the Constitution or laws of Vermont, the invalidity or the violation shall not affect other provisions of this section which can be given effect without the invalid provision or application, and to this end, the provisions of this section are severable.

§ 3047. PENALTIES; ENFORCEMENT

(a) A violation of this chapter is deemed to be a violation of section 2453 of this title.

(b) The Attorney General shall have the same authority to make rules, conduct civil investigations, enter into assurances of discontinuance, and bring

civil actions, and consumers shall have the same rights and remedies as provided under subchapter 1 of chapter 63 of this title.

Sec. 3. EFFECTIVE DATE

This act shall take effect on the first occurring of the following two dates:

(1) 18 months after two other states enact legislation with requirements substantially comparable to the requirements of this act for the labeling of food produced from genetic engineering; or

(2) July 1, 2015.

(Committee Vote: 8-3-0)

H. 182

An act relating to search and rescue

Rep. Hubert of Milton, for the Committee on **Government Operations,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 20 V.S.A. chapter 112 is amended to read:

CHAPTER 112. MISSING PERSONS AND SEARCH AND RESCUE

Subchapter 1. Missing Persons

§ 1820. DEFINITIONS

As used in this chapter:

(1) "Missing person" means an individual whose whereabouts is unknown and who is either physically disabled, mentally disabled, developmentally disabled, or an unemancipated minor.

(2) "Unemancipated minor" means an individual under the age of majority who has not married and who resides with a parent or legal guardian.

§ 1821. MISSING PERSON COMPLAINT

(a) A person filing a missing person complaint with a law enforcement agency shall provide at a minimum the following information:

(1) the name, age, address, and identifying characteristics of the missing person;

(2) the length of time the person has been missing;

(3) the name of the complainant and the relationship of the complainant to the missing person; and

(4) any other relevant information provided by the complainant or

requested by the law enforcement agency.

(b) All law enforcement personnel on active duty shall be notified forthwith that the person is missing.

§ 1822. MISSING PERSON REPORT

Upon receiving a complaint, the law enforcement agency shall forthwith prepare a missing person report. The report shall include all information contained in the missing person complaint and any information or evidence gathered by a preliminary investigation, if one was made.

§ 1823. DISSEMINATION OF MISSING PERSON REPORT

(a) Upon completion of the report, a copy shall forthwith be forwarded to the ~~commissioner of public safety~~ Commissioner of Public Safety, all law enforcement agencies within the jurisdiction where the missing person lives or was last seen, and other law enforcement agencies that can reasonably be expected to be involved in any investigation.

(b) A copy of the report shall also be forwarded to:

(1) all law enforcement agencies to which the complainant reasonably requests the report be sent;

(2) any law enforcement agency requesting a copy of the missing person report; and

(3) all media in the region in which the missing person lives, or was last seen, unless such disclosure would impede an ongoing investigation or unless otherwise requested by the complainant.

§ 1824. SEARCHES FOR MISSING PERSONS

(a) A law enforcement agency shall commence a search for a missing person as soon as a report is received.

(b) Any rule specifying an automatic time limitation before commencing a missing person investigation shall be invalid.

(c) Notwithstanding any provision of law to the contrary, the search for a missing person whose whereabouts is unknown within the backcountry, remote areas, or waters of the State shall be conducted as provided in subchapter 2 of this chapter.

§ 1825. MISSING PERSON COMPLAINTS REGARDING UNEMANCIPATED MINORS

If a missing person complaint involves an unemancipated minor, including a runaway child as defined in 13 V.S.A. § 1311, the law enforcement agency

shall transmit the report, as soon as it is complete, to the ~~department of public safety~~ Department of Public Safety for inclusion in the National Crime Information Center ~~computer~~ database.

§ 1826. FALSE INFORMATION ON MISSING PERSON

A person who knowingly makes a false report of a missing person, or knowingly makes a false statement in the report shall be fined not more than $1,000.00.

§ 1827. COMMISSIONER OF PUBLIC SAFETY; COOPERATION

The ~~commissioner of public safety~~ Commissioner of Public Safety shall cooperate with and support all law enforcement agencies in this ~~state~~ State in matters relating to missing persons. When necessary to protect a missing person from harm, the ~~commissioner~~ Commissioner shall coordinate local and state efforts to search for and rescue the missing person.

§ 1828. VERMONT AMBER ALERT PROGRAM

The ~~department of public safety~~ Department of Public Safety shall establish the Vermont Amber ~~alert program~~ Alert Program to aid in the identification and location of abducted children. The ~~department~~ Department shall administer the program pursuant to the following:

(1) A law enforcement agency which verifies the abduction of a child shall notify the ~~department of public safety~~ Department of Public Safety.

(2) The ~~department~~ Department shall establish a procedure for verifying the need to issue an Amber ~~alert~~ Alert.

(3) The ~~department of public safety~~ Department of Public Safety shall issue an alert over the Vermont ~~emergency alert system~~ Emergency Alert System if:

(A) a law enforcement agency notifies the ~~department~~ Department of the abduction of a child;

(B) there is sufficient information about the child or the person suspected of abducting the child that an immediate broadcast might help locate the child; and

(C) the child is in danger of imminent death or serious bodily harm.

(4) An ~~alert~~ Alert issued under this section shall be sent to the Federal Communications Commission's designated state ~~emergency alert system~~ Emergency Alert System broadcaster in Vermont. Participating radio and television stations shall broadcast the ~~alert~~ Alert at intervals established by the ~~department~~ Department. The ~~alert~~ Alert shall include all information which

the ~~department~~ Department determines may assist in the safe recovery of the abducted child and instructions explaining how a person with information related to the abduction may contact a law enforcement agency.

(5) A law enforcement agency which locates a child who is the subject of an ~~alert~~ Alert issued under this section shall immediately notify the law enforcement agency which requested the Amber ~~alert~~ Alert.

(6) An ~~alert~~ Alert issued under this section shall be canceled:

(A) if the ~~department~~ Department notifies the Federal Communications Commission's designated state ~~emergency alert system~~ Emergency Alert System broadcaster in Vermont that the child has been located; or

(B) at the expiration of a notification period specified by the ~~department~~ Department.

(7) A radio or television station that accurately broadcasts information pursuant to this section shall not be liable for civil damages as a result of the broadcast of such information.

Subchapter 2. Search and Rescue

§ 1841. DEFINITIONS

As used in this chapter:

(1) "Public safety agency" means any municipal, county, or state agency or organization within the State that specializes in protecting the safety of the public.

(2) "Search and rescue" means the deployment, coordination, and utilization of available resources and personnel in locating, relieving the distress, and preserving the lives of and removing persons who are missing or lost in the backcountry, remote areas, or waters of the State.

§ 1842. COMMISSIONER OF PUBLIC SAFETY; JURISDICTION OVER SEARCH AND RESCUE OPERATIONS; COORDINATION

(a) The Commissioner of Public Safety shall have jurisdiction over all search and rescue operations.

(b)(1) The Commissioner shall cooperate with and support all public safety agencies and any nonpublic entities that specialize in protecting the safety of the public in this State in matters relating to search and rescue operations. When necessary to protect a person missing in the backcountry, remote areas, or waters of the State from harm, the Commissioner shall coordinate local, county, state, and any nonpublic efforts to search for and rescue that person.

(2) The Commissioner shall specifically coordinate with game wardens in the Department of Fish and Wildlife as needed to search for and rescue a person missing or lost in the backcountry, remote areas, or waters of the State.

§ 1843. INCIDENT COMMAND SYSTEM; TRAINING

(a) The Commissioner shall ensure that all search and rescue operations are conducted using the incident command system in order to provide the seamless integration of all responding search and rescue agencies and organizations. Incident command is a standardized, on-scene approach to incident management that allows all responders to adopt a collaborative, integrated organizational structure while respecting agency and jurisdictional authorities.

(b) All Search and Rescue Team members within the Department of Public Safety shall maintain equipment standards and high-level search and rescue training and training on the incident command system as established by the Search and Rescue Council set forth in section 1847 of this subchapter. The Search and Rescue Team shall regularly conduct search and rescue training with collaborating agencies and organizations with the goal of continually refining search and rescue operations.

§ 1844. SEARCH AND RESCUE COORDINATOR

(a) The Search and Rescue Coordinator shall be responsible for the general support of search and rescue operations conducted in the State. The Search and Rescue Coordinator shall be a permanent classified position within the Department of Public Safety and shall not be a law enforcement officer.

(b) The duties of the Coordinator shall include:

(1) assessing and populating with resources the database set forth in section 1846 of this subchapter as provided in that section;

(2) maintaining records of all search and rescue operations reported to the Department, including the date of the operation, the resources that assisted in the operation, and the result of the operation;

(3) maintaining records of all training completed by the Search and Rescue Team; and

(4) communicating with public safety agencies and any nonpublic entities that specialize in protecting the safety of the public regarding search and rescue training and equipment standards.

§ 1845. SEARCH AND RESCUE REPORT; RESPONSE

(a) Report of a person missing; response.

(1) A public safety agency taking a report of any person missing in the

backcountry, remote areas, or waters of the State shall immediately:

(A) respond and take immediate action to locate the person reported missing; and

(B) notify the Department of Public Safety to advise of the situation.

(2) A nonpublic entity that specializes in protecting the safety of the public and is included in the search and rescue database set forth in section 1846 of this subchapter which takes a report of any person missing in the backcountry, remote areas, or waters of the State:

(A) shall immediately notify the Department of Public Safety to advise of the situation; and

(B) may respond and take immediate action to locate the person reported missing.

(b) Department of Public Safety response.

(1) When provided with a report of a person missing in the backcountry, remote areas, or waters of the State, the Department shall ensure that notification is made to its Search and Rescue Team and the Team, in consultation with the entity providing the report, shall determine the appropriate level of response needed based on best practices in search and rescue operations.

(2) The Department shall ensure that an immediate response to any report of a person missing in the backcountry, remote areas, or waters of the State is made, including immediate action to locate the person reported missing.

§ 1846. SEARCH AND RESCUE DATABASE

The Department of Public Safety shall populate and use a search and rescue database as set forth in this section.

(1) The Search and Rescue Coordinator, on a geographic basis, shall identify all agencies and organizations having specific search and rescue response capability. The points of contact for each agency and organization having specific search and rescue capability shall be compiled and entered into the search and rescue database. The database shall be updated on a regular basis by the Search and Rescue Coordinator.

(2) When the Search and Rescue Team determines that additional resources are necessary to respond to a search and rescue operation, the Team shall use this database in order to deploy properly those additional resources.

§ 1847. SEARCH AND RESCUE COUNCIL

(a) Creation of council. There is created a Search and Rescue Council which shall be responsible for analyzing the performance of search and rescue operations conducted in the State.

(b)(1) Membership. The Council shall be composed of eight members who shall serve two-year terms commencing on July 1 of each odd-numbered year. Members of the Council shall be as follows:

(A) the Search and Rescue Coordinator;

(B) the Vermont State Police Search and Rescue Team Leader;

(C) one member of the House of Representatives, appointed by the Speaker of the House;

(D) one member of the Senate, appointed by the Senate Committee on Committees;

(E) one member of the Department of Fish and Wildlife, appointed by the Commissioner of the Department;

(F) one member of the public with experience in search and rescue operations, appointed by the Governor;

(G) one member of the National Ski Patrol or the Green Mountain Club with extensive experience in search and rescue operations, appointed by the Governor; and

(H) one member of a professional or volunteer search and rescue organization, appointed by the Governor.

(2) The appointed members shall be appointed to reflect the different geographic regions of the State.

(c) Powers and duties. The Council shall:

(1) meet quarterly and upon the call of the Chair;

(2) establish the search and rescue training and equipment standards that shall be required of members of the Search and Rescue Team;

(3) review completed search and rescue operations and make recommendations to search and rescue resources on how those operations may be improved; and

(4) at its discretion and subject to the provisions of 32 V.S.A. § 5, apply for and accept contributions, capital grants, gifts, services, and funds from any source.

(d) Structure; decision-making. The Council shall elect a Chair from its membership. The provisions of 1 V.S.A. § 172 (joint authority of three or

more) shall apply to the meetings and decision-making of the Council.

(e) Report. The Council shall report annually to the House and Senate Committees on Government Operations its findings and any recommendations for legislative action.

(f) Reimbursement. Members of the Council who are not employees of the State of Vermont shall be entitled to compensation as provided in 32 V.S.A. § 1010.

§ 1848. FALSE REPORT OR STATEMENT

A person who knowingly makes a false report of a person missing in the backcountry, remote areas, or waters of the State or knowingly makes a false statement in the report shall be fined not more than $1,000.00.

Sec. 2. 20 V.S.A. § 2365a is added to read:

§ 2365a. SEARCH AND RESCUE TRAINING

A person shall receive search and rescue training approved by the Vermont Criminal Justice Training Council and the Vermont Search and Rescue Council as part of basic training in order to become certified as a law enforcement officer.

Sec. 3. REALLOCATION OF POSITION WITHIN THE DEPARTMENT OF PUBLIC SAFETY; SEARCH AND RESCUE COORDINATOR

(a) Within its existing financial resources and existing positions, the Department of Public Safety shall reallocate one position and necessary funding to establish by July 1, 2013 the position of Search and Rescue Coordinator set forth in Sec. 1, 20 V.S.A. § 1844, of this act.

(b) Any duties required by this act to be performed by the Search and Rescue Coordinator shall be performed by the Commissioner of Public Safety or his or her designee prior to the establishment of the position of Search and Rescue Coordinator as required by subsection (a) of this section.

Sec. 4. EFFECTIVE DATES

This act shall take effect on passage, except Sec. 1, 20 V.S.A. § 1846 (search and rescue database), which shall take effect no later than 15 days after passage of this act. The search and rescue database shall be established, populated, and used as set forth in 20 V.S.A. § 1846 upon its effective date.

(Committee Vote: 9-0-2)

Rep. Manwaring of Wilmington, for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committee on **Government Operations** and when further amended as follows:

amended in Sec. 1, 20 V.S.A. § 1847 (search and rescue council), in subsection (f) (reimbursement), after the first sentence, by adding "Legislative members of the Council shall be entitled to the same per diem compensation and reimbursement for necessary expenses for attendance at a meeting when the General Assembly is not in session as provided to members of standing committees under 2 V.S.A. § 406."

(Committee Vote: 9-0-2)

NOTICE CALENDAR

H. 107

An act relating to health insurance, Medicaid, and the Vermont Health Benefit Exchange

Rep. Woodward of Johnson, for the Committee on **Health Care,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

* * * Health Insurance * * *

Sec. 1. 8 V.S.A. § 4079 is amended to read:

§ 4079. GROUP INSURANCE POLICIES; DEFINITIONS

Group health insurance is hereby declared to be that form of health insurance covering one or more persons, with or without their dependents, and issued upon the following basis:

(1)(A) Under a policy issued to an employer, who shall be deemed the policyholder, insuring at least one employee of such employer, for the benefit of persons other than the employer. The term "employees," as used herein, shall be deemed to include the officers, managers, and employees of the employer, the partners, if the employer is a partnership, the officers, managers, and employees of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms, the business of which is controlled by the insured employer through stock ownership, contract, or otherwise. The term "employer," as used herein, may be deemed to include any municipal or governmental corporation, unit, agency, or department thereof and the proper officers as such, of any unincorporated municipality or department thereof, as well as private individuals, partnerships, and corporations.

(B) In accordance with section 3368 of this title, an employer domiciled in another jurisdiction that has more than 25 certificate- holder employees whose principal worksite and domicile is in Vermont and that is defined as a large group in its own jurisdiction and under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1304, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, may purchase insurance in the large group health insurance market for its Vermont-domiciled certificate-holder employees.

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Sec. 2. 8 V.S.A. § 4089a is amended to read:

§ 4089a. MENTAL HEALTH CARE SERVICES REVIEW

* * *

(b) Definitions. As used in this section:

* * *

(4) "Review agent" means a person or entity performing service review activities within one year of the date of a fully compliant application for licensure who is either affiliated with, under contract with, or acting on behalf of a business entity in this ~~state; or a third party~~ State and who provides or administers mental health care benefits to ~~citizens of Vermont~~ members of health benefit plans subject to the Department's jurisdiction, including a health insurer, nonprofit health service plan, health insurance service organization, health maintenance organization or preferred provider organization, including organizations that rely upon primary care physicians to coordinate delivery of services~~, authorized to offer health insurance policies or contracts in Vermont~~.

* * *

(g) ~~Members of the independent panel of mental health care providers shall be compensated as provided in 32 V.S.A. § 1010(b) and (c).~~ [Deleted.]

* * *

Sec. 3. 8 V.S.A. § 4089i(d) is amended to read:

(d) For prescription drug 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, except that a plan may offer first-dollar prescription drug benefits to the extent permitted under federal law. 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.

Sec. 4. 8 V.S.A. § 4092(b) is amended to read:

(b) Coverage for a newly born child shall be provided without notice or additional premium for no less than ~~31~~ 60 days after the date of birth. If payment of a specific premium or subscription fee is required in order to have the coverage continue beyond such ~~31-day~~ 60-day period, the policy may require that notification of birth of newly born child and payment of the required premium or fees be furnished to the insurer or nonprofit service or indemnity corporation within a period of not less than ~~31~~ 60 days after the date of birth.

Sec. 5. 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:

* * *

(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:

(A) ~~Health~~ health maintenance organization;

(B) ~~Preferred~~ preferred provider organization;

(C) ~~Fee-for-service~~ fee-for-service or indemnity plan;

(D) Medicare Advantage HMO plan;

(E) Medicare Advantage private fee-for-service plan;

(F) Medicare Advantage special needs plan;

(G) Medicare Advantage PPO;

(H) Medicare supplement plan;

(I) ~~Workers~~ workers compensation plan; or

(J) ~~Catamount Health; or~~

~~(K)~~ ~~Any~~ any other commercial health coverage plan or product.

(b) No later than 30 days following receipt of a claim, a health plan, contracting entity, or payer shall do one of the following:

(1) Pay or reimburse the claim.

(2) Notify the claimant in writing that the claim is contested or denied. The notice shall include specific reasons supporting the contest or denial and a description of any additional information required for the health plan, contracting entity, or payer to determine liability for the claim.

(3) Pend a claim for services rendered to an enrollee during the second and third months of the consecutive three-month grace period required for recipients of advance payments of premium tax credits pursuant to 26 U.S.C. § 36B. In the event the enrollee pays all outstanding premiums prior to the exhaustion of the grace period, the health plan, contracting entity, or payer shall have 30 days following receipt of the outstanding premiums to proceed as provided in subdivision (1) or (2) of this subsection, as applicable.

* * *

* * * Catamount Health and VHAP * * *

Sec. 6. 8 V.S.A. § 4080d is amended to read:

§ 4080d. COORDINATION OF INSURANCE COVERAGE WITH MEDICAID

Any insurer as defined in section 4100b of this title is prohibited from considering the availability or eligibility for medical assistance in this or any other state under 42 U.S.C. § 1396a (Section 1902 of the Social Security Act), herein referred to as Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders. ~~This section shall not apply to Catamount Health, as established by section 4080f of this title.~~

Sec. 7. 8 V.S.A. § 4080g(b) is amended to read:

(b) Small group plans.

* * *

(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~~ the Health Insurance Premium Payment program established pursuant to Section 1906 of the Social Security Act, 42 U.S.C. § 1396e, 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.

* * *

Sec. 8. 8 V.S.A. § 4088i is amended to read:

§ 4088i. COVERAGE FOR DIAGNOSIS AND TREATMENT OF EARLY CHILDHOOD DEVELOPMENTAL DISORDERS

(a)(1) A health insurance plan shall provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 21.

(2) Coverage provided pursuant to this section by Medicaid~~, the Vermont health access plan,~~ or any other public health care assistance program shall comply with all federal requirements imposed by the Centers for Medicare and Medicaid Services.

* * *

(f) As used in this section:

* * *

(7) "Health insurance plan" means Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this ~~state~~ State by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include benefit plans providing coverage for specific diseases or other limited benefit coverage.

* * *

Sec. 9. 8 V.S.A. § 4089j is amended to read:

§ 4089j. RETAIL PHARMACIES; FILLING OF PRESCRIPTIONS

* * *

(c) This section shall apply to Medicaid~~, the Vermont health access plan, the VScript pharmaceutical assistance program,~~ and any other public health care assistance program.

Sec. 10. 8 V.S.A. § 4089w is amended to read:

§ 4089w. OFFICE OF HEALTH CARE OMBUDSMAN

* * *

(h) As used in this section, "health insurance plan" means a policy, service contract or other health benefit plan offered or issued by a health insurer, as defined by 18 V.S.A. § 9402, and includes ~~the Vermont health access plan and~~ beneficiaries covered by the Medicaid program unless such beneficiaries are otherwise provided ombudsman services.

Sec. 11. 8 V.S.A. § 4099d is amended to read:

§ 4099d. MIDWIFERY COVERAGE; HOME BIRTHS

* * *

(d) As used in this section, "health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program offered or administered by the ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term shall not include policies or plans providing coverage for specific disease or other limited benefit coverage.

Sec. 12. 8 V.S.A. § 4100b is amended to read:

§ 4100b. COVERAGE OF CHILDREN

(a) As used in this subchapter:

(1) "Health plan" shall include~~, but not be limited to,~~ a group health plan as defined under Section 607(1) of the Employee Retirement Income Security Act of 1974~~,~~ and a nongroup plan as defined in section 4080b of this title~~, and a Catamount Health plan as defined in section 4080f of this title~~.

* * *

Sec. 13. 8 V.S.A. § 4100e is amended to read:

§ 4100e. REQUIRED COVERAGE FOR OFF-LABEL USE

* * *

(b) As used in this section, the following terms have the following meanings:

(1) "Health insurance plan" means a health benefit plan offered, administered, or issued by a health insurer doing business in Vermont.

(2) "Health insurer" is defined by ~~section~~ 18 V.S.A. § 9402 ~~of Title 18~~. As used in this subchapter, the term includes the ~~state~~ State of Vermont and any agent or instrumentality of the ~~state~~ State that offers, administers, or provides financial support to state government, including Medicaid~~, the Vermont health access plan, the VScript pharmaceutical assistance program,~~ or any other public health care assistance program.

* * *

Sec. 14. 8 V.S.A. § 4100j is amended to read:

§ 4100j. COVERAGE FOR TOBACCO CESSATION PROGRAMS

* * *

(b) As used in this subchapter:

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program offered or administered by the ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

* * *

Sec. 15. 8 V.S.A. § 4100k is amended to read:

§ 4100k. COVERAGE FOR TELEMEDICINE SERVICES

* * *

(g) As used in this subchapter:

(1) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, as defined in 18 V.S.A. § 9402, as well as Medicaid~~, the Vermont health access plan,~~ and any other public health care assistance program offered or administered by the ~~state~~ State or by any subdivision or instrumentality of the ~~state~~ State. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

* * *

Sec. 16. 13 V.S.A. § 5574(b) is amended to read:

(b) A claimant awarded judgment in an action under this subchapter shall be

entitled to damages in an amount to be determined by the trier of fact for each year the claimant was incarcerated, provided that the amount of damages shall not be less than $30,000.00 nor greater than $60,000.00 for each year the claimant was incarcerated, adjusted proportionally for partial years served. The damage award may also include:

(1) Economic damages, including lost wages and costs incurred by the claimant for his or her criminal defense and for efforts to prove his or her innocence.

(2) ~~Notwithstanding the income eligibility requirements of the Vermont Health Access Plan in section 1973 of Title 33, and notwithstanding the requirement that the individual be uninsured, up~~ Up to 10 years of eligibility for ~~the Vermont Health Access Plan using state-only funds~~ state-funded health coverage equivalent to Medicaid services.

* * *

Sec. 17. 18 V.S.A. § 1130 is amended to read:

§ 1130. IMMUNIZATION PILOT PROGRAM

(a) As used in this section:

* * *

(5) "State health care programs" shall include Medicaid, ~~the Vermont health access plan,~~ Dr. Dynasaur, and any other health care program providing immunizations with funds through the Global Commitment for Health waiver approved by the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act.

* * *

Sec. 18. 18 V.S.A. § 3801 is amended to read:

§ 3801. DEFINITIONS

As used in this subchapter:

(1)(A) "Health insurer" shall have the same meaning as in section 9402 of this title and shall include:

(i) a health insurance company, a nonprofit hospital and medical service corporation, and health maintenance organizations;

(ii) an employer, a labor union, or another group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont; and

(iii) except as otherwise provided in section 3805 of this title, the ~~state~~ State of

Vermont and any agent or instrumentality of the ~~state~~ State that offers, administers, or provides financial support to state government.

(B) The term "health insurer" shall not include Medicaid~~, the Vermont health access plan, Vermont Rx,~~ or any other Vermont public health care assistance program.

* * *

Sec. 19. 18 V.S.A. § 4474c(b) is amended to read:

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

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

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

(3) an employer; or

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

Sec. 20. 18 V.S.A. § 9373 is amended to read:

§ 9373. DEFINITIONS

As used in this chapter:

* * *

(8) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of a health benefit plan offered by a public or a private entity. The term does not include Medicaid~~, the Vermont health access plan,~~ or any other state health care assistance program financed in whole or in part through a federal program.

* * *

Sec. 21. 18 V.S.A. § 9471 is amended to read:

§ 9471. DEFINITIONS

As used in this subchapter:

* * *

(2) "Health insurer" is defined by section 9402 of this title and shall include:

(A) a health insurance company, a nonprofit hospital and medical service

corporation, and health maintenance organizations;

(B) an employer, labor union, or other group of persons organized in Vermont that provides a health plan to beneficiaries who are employed or reside in Vermont;

(C) the ~~state~~ State of Vermont and any agent or instrumentality of the ~~state~~ State that offers, administers, or provides financial support to state government; and

(D) Medicaid, ~~the Vermont health access plan, Vermont Rx,~~ and any other public health care assistance program.

* * *

Sec. 22. 33 V.S.A. § 1807(b) is amended to read:

(b) Navigators shall have the following duties:

* * *

(3) ~~Facilitate~~ facilitate enrollment in qualified health benefit plans, Medicaid, Dr. Dynasaur, VPharm, ~~VermontRx,~~ and other public health benefit programs;

* * *

(5) ~~Provide~~ provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Vermont health benefit exchange; ~~and~~

(6) ~~Distribute~~ distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, ~~VermontRx,~~ other public health benefit programs, or the Vermont health benefit exchange in order to ensure that all eligible individuals are enrolled~~.~~; and

(7) ~~Provide~~ 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. 23. 33 V.S.A. § 1901(b) is amended to read:

(b) ~~The secretary may charge a monthly premium, in amounts set by the general assembly, to each individual 18 years or older who is eligible for enrollment in the health access program, as authorized by section 1973 of this title and as implemented by rules. All premiums collected by the agency of human services or designee for enrollment in the health access program shall be deposited in the state health care resources fund established in section 1901d of this title. Any co-payments, coinsurance, or other cost sharing to be~~

~~charged shall also be authorized and set by the general assembly.~~ [Deleted.]

Sec. 24. 33 V.S.A. § 1903a is amended to read:

§ 1903a. CARE MANAGEMENT PROGRAM

(a) The ~~commissioner~~ Commissioner of Vermont ~~health access~~ Health Access shall coordinate with the ~~director~~ Director of the Blueprint for Health to provide chronic care management through the Blueprint and, as appropriate, create an additional level of care coordination for individuals with one or more chronic conditions who are enrolled in Medicaid~~, the Vermont health access plan (VHAP),~~ or Dr. Dynasaur. The program shall not include individuals who are in an institute for mental disease as defined in 42 C.F.R. § 435.1009.

* * *

Sec. 25. 33 V.S.A. § 1997 is amended to read:

§ 1997. DEFINITIONS

As used in this subchapter:

* * *

(7) "State public assistance program"~~,~~ includes~~, but is not limited to,~~ the Medicaid program, ~~the Vermont health access plan,~~ VPharm, ~~VermontRx,~~ the ~~state children's health insurance program~~ State Children's Health Insurance Program, the ~~state~~ State of Vermont AIDS ~~medication assistance program~~ Medication Assistance Program, the General Assistance program, the ~~pharmacy discount plan program~~ Pharmacy Discount Plan Program, and the out-of-state counterparts to such programs.

Sec. 26. 33 V.S.A. § 1998(c)(1) is amended to read:

(c)(1) The ~~commissioner~~ Commissioner may implement the ~~pharmacy best practices and cost control program~~ Pharmacy Best Practices and Cost Control Program for any other health benefit plan within or outside this ~~state~~ State that agrees to participate in the program. For entities in Vermont, the ~~commissioner~~ Commissioner shall directly or by contract implement the program through a joint pharmaceuticals purchasing consortium. The joint pharmaceuticals purchasing consortium shall be offered on a voluntary basis no later than January 1, 2008, with mandatory participation by state or publicly funded, administered, or subsidized purchasers to the extent practicable and consistent with the purposes of this chapter, by January 1, 2010. If necessary, the ~~department of Vermont health access~~ Department of Vermont Health Access shall seek authorization from the Centers for Medicare and Medicaid to include purchases funded by Medicaid. "State or publicly funded purchasers" shall include the ~~department of corrections~~ Department of Corrections, the

~~department of mental health~~ Department of Mental Health, Medicaid, ~~the Vermont Health Access Program (VHAP),~~ Dr. Dynasaur, ~~VermontRx,~~ VPharm, Healthy Vermonters, workers' compensation, and any other state or publicly funded purchaser of prescription drugs.

Sec. 27. 33 V.S.A. § 2004(a) is amended to read:

(a) Annually, each pharmaceutical manufacturer or labeler of prescription drugs that are paid for by the ~~department of Vermont health access~~ Department of Vermont Health Access for individuals participating in Medicaid, ~~the Vermont Health Access Program,~~ Dr. Dynasaur, or VPharm~~, or VermontRx~~ shall pay a fee to the ~~agency of human services~~ Agency of Human Services. The fee shall be 0.5 percent of the previous calendar year's prescription drug spending by the ~~department~~ Department and shall be assessed based on manufacturer labeler codes as used in the Medicaid rebate program.

* * * Vermont Health Benefit Exchange * * *

Sec. 28. 33 V.S.A. § 1804 is amended to read:

§ 1804. QUALIFIED EMPLOYERS

(a)(1) Until January 1, 2016, a qualified employer shall be an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 50 employees on working days during the preceding calendar year, ~~employed at least one and no more than 50 employees,~~ and the term "qualified employer" includes self-employed persons to the extent permitted under the Affordable Care Act. 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.

* * *

(b)(1) From January 1, 2016 until January 1, 2017, a qualified employer shall be an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 100 employees on working days during the preceding calendar year~~, employed at least one and no more than 100 employees,~~ and the term "qualified employer" includes self-employed persons to the extent permitted under the Affordable Care Act. ~~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~~ The number of employees shall be calculated using the method set forth in 26 U.S.C. § 4980H(c)(2)(E).

* * *

Sec. 29. 33 V.S.A. § 1805 is amended to read:

§ 1805. DUTIES AND RESPONSIBILITIES

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

* * *

(2) Determining eligibility for and enrolling individuals in Medicaid, Dr. Dynasaur, and VPharm~~, and VermontRx~~ pursuant to chapter 19 of this title, as well as any other public health benefit program.

* * *

(12) ~~Consistent with federal law, crediting the amount of any free choice voucher provided pursuant to Section 10108 of the Affordable Care Act to the monthly premium of the plan in which a qualified employee is enrolled and collecting the amount credited from the offering employer.~~ [Deleted.]

* * *

Sec. 30. 33 V.S.A. § 1811(a) is amended to read:

(a) As used in this section:

* * *

(3)(A) Until January 1, 2016, "small employer" means an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 50 employees on working days during the preceding calendar year, ~~employs at least one and no more than 50 employees~~. The term includes self-employed persons to the extent permitted under the Affordable Care Act. 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~~ 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~~ Health Benefit Exchange available to its employees.

(B) Beginning on January 1, 2016, "small employer" means an ~~employer~~ entity which~~, on at least 50 percent of its~~ employed an average of not more than 100 employees on working days during the preceding calendar year, ~~employs at least one and no more than 100 employees~~. The term includes self-employed persons to the extent permitted under the Affordable Care Act. ~~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 number of employees shall be calculated using the method set forth in 26 U.S.C. § 4980H(c)(2)(E). An employer may continue to participate in the ~~exchange~~ 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~~ Health Benefit Exchange available to its employees.

* * * Medicaid and CHIP * * *

Sec. 31. 33 V.S.A. § 2003(c) is amended to read:

(c) As used in this section:

(1) "Beneficiary" means any individual enrolled in the Healthy Vermonters program.

(2) "Healthy Vermonters beneficiary" means any individual Vermont resident without adequate coverage:

(A) who is at least 65 years of age, or is disabled and is eligible for Medicare or Social Security disability benefits, with household income equal to or less than 400 percent of the federal poverty level, as calculated ~~under the rules of the Vermont health access plan, as amended~~ using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B); or

(B) whose household income is equal to or less than 350 percent of the federal poverty level, as calculated ~~under the rules of the Vermont Health access plan, as amended~~ using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B).

* * *

Sec. 32. 33 V.S.A. § 2072(a) is amended to read:

(a) An individual shall be eligible for assistance under this subchapter if the individual:

(1) is a resident of Vermont at the time of application for benefits;

(2) is at least 65 years of age or is an individual with disabilities as defined in subdivision 2071(1) of this title; and

(3) has a household income, when calculated ~~in accordance with the rules adopted for the Vermont health access plan under No. 14 of the Acts of 1995, as amended~~ using modified adjusted gross income as defined in 26 U.S.C. § 36B(d)(2)(B), no greater than 225 percent of the federal poverty level.

* * * Health Information Exchange * * *

Sec. 33. 18 V.S.A. § 707(a) is amended to read:

(a) No later than July 1, 2011, hospitals shall participate in the Blueprint for Health by creating or maintaining connectivity to the ~~state's~~ State's health information exchange network as provided ~~for~~ in this section and in section 9456 of this title. ~~The director of health care reform or designee and the director of the Blueprint shall establish criteria by rule for this requirement consistent with the state health information technology plan required under~~

~~section 9351 of this title. The criteria shall not require a hospital to create a level of connectivity that the state's exchange is not able to support.~~

Sec. 34. 18 V.S.A. § 9456 is amended to read:

§ 9456. BUDGET REVIEW

(a) The ~~board~~ 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 ~~board~~ Board. ~~The 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 ~~board~~ Board shall:

* * *

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

(11) require each hospital to create or maintain connectivity to the State's health information exchange network in accordance with the criteria established by the Vermont Information Technology Leaders, Inc., pursuant to subsection 9352(i) of this title, provided that the Board shall not require a hospital to create a level of connectivity that the State's exchange is unable to support.

* * *

Sec. 34a. 18 V.S.A. § 9352(i) is amended to read:

(i) Certification of meaningful use and connectivity.

(1) To the extent necessary to support Vermont's health care reform goals or as required by federal law, VITL shall be authorized to certify the meaningful use of health information technology and electronic health records by health care providers licensed in Vermont.

(2) VITL shall establish criteria for creating or maintaining connectivity to the State's health information exchange network. VITL shall provide the criteria annually by March 1 to the Green Mountain Care Board established pursuant to chapter 220 of this title.

* * * Special Funds * * *

Sec. 35. 18 V.S.A. § 9382 is added to read:

§ 9382. REGULATORY AND SUPERVISION FUND

(a) There is hereby created a fund to be known as the Green Mountain Care

Board Regulatory and Supervision Fund for the purpose of providing the financial means for the Green Mountain Care Board to administer this chapter and chapter 221 of this title. The Fund shall be managed pursuant to 32 V.S.A. chapter 7, subchapter 5.

(1) All fees and assessments received by the Board in the course of administering its duties shall be credited to the Green Mountain Care Board Regulatory and Supervision Fund.

(2) All fines and administrative penalties received by the Board in the course of administering its duties shall be deposited directly into the General Fund.

(b) All payments from the Green Mountain Care Board Regulatory and Supervision Fund for the maintenance of staff and associated expenses, including contractual services as necessary, shall be disbursed from the State Treasury only upon warrants issued by the Commissioner of Finance and Management after receipt of proper documentation regarding services rendered and expenses incurred.

(c) The Commissioner of Finance and Management may anticipate receipts to the Green Mountain Care Board Regulatory and Supervision Fund and issue warrants based thereon.

Sec. 36. 18 V.S.A. § 9404 is amended to read:

§ 9404. ADMINISTRATION ~~OF THE DIVISION~~

(a) The ~~commissioner~~ Commissioner shall supervise and direct the execution of all laws vested in the ~~division~~ Department by ~~virtue of~~ this chapter, and shall formulate and carry out all policies relating to this chapter.

(b) ~~The commissioner may delegate the powers and assign the duties required by this chapter as the commissioner may deem appropriate and necessary for the proper execution of the provisions of this chapter, including the review and analysis of certificate of need applications and hospital budgets; however, the commissioner shall not delegate the commissioner's quasi-judicial and rulemaking powers or authority, unless the commissioner has a personal or financial interest in the subject matter of the proceeding.~~

~~(c) The commissioner may employ professional and support staff necessary to carry out the functions of the commissioner, and may employ consultants and contract with individuals and entities for the provision of services.~~

~~(d)~~ The ~~commissioner~~ Commissioner may:

(1) ~~Apply~~ apply for and accept gifts, grants, or contributions from any person for purposes consistent with this chapter~~.~~;

(2) ~~Adopt~~ adopt rules necessary to implement the provisions of this chapter~~.~~;

and

(3) ~~Enter~~ enter into contracts and perform such acts as are necessary to accomplish the purposes of this chapter.

~~(e)~~(c) There is hereby created a fund to be known as the ~~division of health care administration regulatory and supervision fund~~ Health Care Administration Regulatory and Supervision Fund for the purpose of providing the financial means for the ~~commissioner of financial regulation~~ Commissioner of Financial Regulation to administer this chapter and 33 V.S.A. § 6706. All fees and assessments received by the ~~department~~ Department pursuant to such administration shall be credited to this ~~fund~~ Fund. All fines and administrative penalties, however, shall be deposited directly into the ~~general fund~~ General Fund.

(1) All payments from the ~~division of health care administration regulatory and supervision fund~~ Health Care Administration Regulatory and Supervision Fund for the maintenance of staff and associated expenses, including contractual services as necessary, shall be disbursed from the ~~state treasury~~ State Treasury only upon warrants issued by the ~~commissioner of finance and management~~ Commissioner of Finance and Management, after receipt of proper documentation regarding services rendered and expenses incurred.

(2) The ~~commissioner of finance and management~~ Commissioner of Finance and Management may anticipate receipts to the ~~division of health care administration regulatory and supervision fund~~ Health Care Administration Regulatory and Supervision Fund and issue warrants based thereon.

* * * Health Resource Allocation Plan * * *

Sec. 37. 18 V.S.A. § 9405 is amended to read:

§ 9405. STATE HEALTH PLAN; HEALTH RESOURCE ALLOCATION PLAN

(a) No later than January 1, 2005, the ~~secretary of human services~~ Secretary of Human Services or designee, in consultation with the ~~commissioner~~ Chair of the Green Mountain Care Board and health care professionals and after receipt of public comment, shall adopt a ~~state health plan~~ State Health Plan that sets forth the health goals and values for the ~~state~~ State. The ~~secretary~~ Secretary may amend the ~~plan~~ Plan as the ~~secretary~~ Secretary deems necessary and appropriate. The ~~plan~~ Plan shall include health promotion, health protection, nutrition, and disease prevention priorities for the ~~state~~ State, identify available human resources as well as human resources needed for achieving the ~~state's~~ State's health goals and the planning required to meet those needs, and identify geographic parts of the ~~state~~ State needing investments of additional resources

in order to improve the health of the population. The ~~plan~~ Plan shall contain sufficient detail to guide development of the ~~state health resource allocation plan~~ State Health Resource Allocation Plan. Copies of the ~~plan~~ Plan shall be submitted to members of the ~~senate and house committees on health and welfare~~ Senate and House Committees on Health and Welfare no later than January 15, 2005.

(b) On or before July 1, 2005, the ~~commissioner~~ Green Mountain Care Board, in consultation with the ~~secretary of human services~~ Secretary of Human Services, shall submit to the ~~governor~~ Governor a four-year ~~health resource allocation plan~~ Health Resource Allocation Plan. The ~~plan~~ 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~~ Plan shall include:

(A) A statement of principles reflecting the policies enumerated in sections 9401 and 9431 of this chapter to be used in allocating resources and in establishing priorities for health services.

(B) Identification of the current supply and distribution of hospital, nursing home, and other inpatient services; home health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services, including primary care resources, federally qualified health centers, and free clinics; major medical equipment; and health screening and early intervention services.

(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~~ Green Mountain Care Board shall consider at least the following factors:

(i) the values and goals reflected in the ~~state health plan~~ State Health Plan;

(ii) the needs of the population on a statewide basis;

(iii) the needs of particular geographic areas of the ~~state~~ State, as identified in the ~~state health plan~~ State Health Plan;

(iv) the needs of uninsured and underinsured populations;

(v) the use of Vermont facilities by out-of-state residents;

(vi) the use of out-of-state facilities by Vermont residents;

(vii) the needs of populations with special health care needs;

(viii) the desirability of providing high quality services in an economical and efficient manner, including the appropriate use of midlevel practitioners;

(ix) 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;~~

(x) the overall quality and use of health care services as reported by the Vermont ~~program for quality in health care~~ Program for Quality in Health Care and the Vermont ~~ethics network~~ Ethics Network;

(xi) the overall quality and cost of services as reported in the annual hospital community reports;

(xii) individual hospital four-year capital budget projections; and

(xiii) the four-year projection of health care expenditures prepared by the ~~division~~ Board.

(2) In the preparation of the ~~plan~~ Plan, the ~~commissioner~~ ~~shall assemble an advisory committee of no fewer than nine nor more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, payers, third-party payers, and consumer representatives~~ Green Mountain Care Board shall convene the Green Mountain Care Board General Advisory Committee established pursuant to subdivision 9374(e)(1) of this title. The ~~advisory committee~~ Green Mountain Care Board General Advisory Committee shall review drafts and provide recommendations to the ~~commissioner~~ Board during the development of the ~~plan~~ Plan. ~~Upon adoption of the plan, the advisory committee shall be dissolved.~~

(3) The ~~commissioner~~ Board, with the ~~advisory committee~~ Green Mountain Care Board General Advisory Committee, shall conduct at least five public hearings, in different regions of the state, on the ~~plan~~ Plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. To the extent possible, the ~~commissioner~~ Board shall arrange for hearings to be broadcast on interactive television. Not less than 30 days prior to any such hearing, the ~~commissioner~~ Board shall publish in the manner prescribed in 1 V.S.A. § 174 the time and place of the hearing and the place and period during which to direct written comments to the ~~commissioner~~ Board. In addition, the ~~commissioner~~ Board may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others.

(4) The ~~commissioner~~ Board shall develop a mechanism for receiving ongoing public comment regarding the ~~plan~~ Plan and for revising it every four years or as needed.

(5) The ~~commissioner~~ Board in consultation with appropriate health care organizations and state entities shall inventory and assess existing state health care data and expertise, and shall seek grants to assist with the preparation of any revisions to the ~~health resource allocation plan~~ Health Resource Allocation Plan.

(6) The ~~plan~~ Plan or any revised ~~plan~~ Plan proposed by the ~~commissioner~~ Board shall be the ~~health resource allocation plan~~ Health Resource Allocation Plan for the ~~state~~ State after it is approved by the ~~governor~~ Governor or upon passage of three months from the date the ~~governor~~ Governor receives the ~~plan~~ proposed Plan, whichever occurs first, unless the ~~governor~~ Governor disapproves the ~~plan~~ proposed Plan, in whole or in part. If the ~~governor~~ Governor disapproves, he or she shall specify the sections of the ~~plan~~ proposed Plan which are objectionable and the changes necessary to meet the objections. The sections of the ~~plan~~ proposed Plan not disapproved shall become part of the ~~health resource allocation plan~~ Health Resource Allocation Plan.

* * * Hospital Community Reports * * *

Sec. 38. 18 V.S.A. § 9405b is amended to read:

§ 9405b. HOSPITAL COMMUNITY REPORTS

(a) The ~~commissioner~~ Commissioner of Health, in consultation with representatives from hospitals, other groups of health care professionals, and members of the public representing patient interests, shall adopt rules establishing a standard format for community reports, as well as the contents, which shall include:

* * *

(b) On or before January 1, 2005, and annually thereafter beginning on June 1, 2006, the board of directors or other governing body of each hospital licensed under chapter 43 of this title shall publish on its website, making paper copies available upon request, its community report in a uniform format approved by the ~~commissioner,~~ Commissioner of Health and in accordance with the standards and procedures adopted by rule under this section~~, and shall hold one or more public hearings to permit community members to comment on the report. Notice of meetings shall be by publication, consistent with 1 V.S.A. § 174~~. Hospitals located outside this ~~state~~ State which serve a significant number of Vermont residents, as determined by the ~~commissioner~~ Commissioner of Health, shall be invited to participate in the community

report process established by this subsection.

(c) The community reports shall be provided to the ~~commissioner~~ Commissioner of Health. The ~~commissioner~~ Commissioner of Health shall publish the reports on a public website and shall develop and include a format for comparisons of hospitals within the same categories of quality and financial indicators.

Sec. 39. TEMPORARY SUSPENSION

Notwithstanding the requirements of 18 V.S.A. § 9405b, the Commissioner of Financial Regulation may suspend publication of the hospital community reports in calendar year 2013 in order to effectuate the transfer of responsibility from the Department of Financial Regulation to the Department of Health.

* * * VHCURES * * *

Sec. 40. 18 V.S.A. § 9410 is amended to read:

§ 9410. HEALTH CARE DATABASE

(a)(1) The ~~commissioner~~ Board shall establish and maintain a unified health care database to enable the ~~commissioner and the Green Mountain Care board~~ Commissioner and the Board to carry out their duties under this chapter, chapter 220 of this title, and Title 8, including:

(A) ~~Determining~~ determining the capacity and distribution of existing resources~~.~~;

(B) ~~Identifying~~ identifying health care needs and informing health care policy~~.~~;

(C) ~~Evaluating~~ evaluating the effectiveness of intervention programs on improving patient outcomes~~.~~;

(D) ~~Comparing~~ comparing costs between various treatment settings and approaches~~.~~;

(E) ~~Providing~~ providing information to consumers and purchasers of health care~~.~~; and

(F) ~~Improving~~ improving the quality and affordability of patient health care and health care coverage.

(2)(A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the ~~commissioner~~ Board determines is necessary to empower individuals, including uninsured individuals, to make economically

sound and medically appropriate decisions.

(B) ~~The commissioner shall convene a working group composed of the commissioner of mental health, the commissioner of Vermont health access, health care consumers, the office of the health care ombudsman, employers and other payers, health care providers and facilities, the Vermont program for quality in health care, health insurers, and any other individual or group appointed by the commissioner to advise the commissioner on the development and implementation of the consumer health care price and quality information system.~~

~~(C)~~ The ~~commissioner~~ Commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this state to file with the ~~commissioner~~ Commissioner a consumer health care price and quality information plan in accordance with rules adopted by the ~~commissioner~~ Commissioner.

~~(D)~~(C) The ~~commissioner~~ Board shall adopt such rules as are necessary to carry out the purposes of this subdivision. The ~~commissioner's~~ Board's rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care price and quality information that the ~~commissioner~~ Board determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The ~~regulations~~ rules shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

(b) The database shall contain unique patient and provider identifiers and a uniform coding system, and shall reflect all health care utilization, costs, and resources in this ~~state~~ State, and health care utilization and costs for services provided to Vermont residents in another ~~state~~ State.

(c) Health insurers, health care providers, health care facilities, and governmental agencies shall file reports, data, schedules, statistics, or other information determined by the ~~commissioner~~ Board to be necessary to carry out the purposes of this section. Such information may include:

(1) health insurance claims and enrollment information used by health insurers;

(2) information relating to hospitals filed under subchapter 7 of this chapter

(hospital budget reviews); and

(3) any other information relating to health care costs, prices, quality, utilization, or resources required by the Board to be filed ~~by the commissioner~~.

(d) The ~~commissioner~~ Board may by rule establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.

(e) Records or information protected by the provisions of the physician-patient privilege under 12 V.S.A. § 1612(a), or otherwise required by law to be held confidential, shall be filed in a manner that does not disclose the identity of the protected person.

(f) The ~~commissioner~~ Board shall adopt a confidentiality code to ensure that information obtained under this section is handled in an ethical manner.

(g) Any person who knowingly fails to comply with the requirements of this section or rules adopted pursuant to this section shall be subject to an administrative penalty of not more than $1,000.00 per violation. The ~~commissioner~~ Board may impose an administrative penalty of not more than $10,000.00 each for those violations the ~~commissioner~~ Board finds were willful. In addition, any person who knowingly fails to comply with the confidentiality requirements of this section or confidentiality rules adopted pursuant to this section and uses, sells, or transfers the data or information for commercial advantage, pecuniary gain, personal gain, or malicious harm shall be subject to an administrative penalty of not more than $50,000.00 per violation. The powers vested in the ~~commissioner~~ Board by this subsection shall be in addition to any other powers to enforce any penalties, fines, or forfeitures authorized by law.

(h)(1) All health insurers shall electronically provide to the ~~commissioner~~ Board in accordance with standards and procedures adopted by the ~~commissioner~~ Board by rule:

(A) their health insurance claims data, provided that the ~~commissioner~~ Board may exempt from all or a portion of the filing requirements of this subsection data reflecting utilization and costs for services provided in this ~~state~~ State to residents of other states;

(B) cross-matched claims data on requested members, subscribers, or policyholders; and

(C) member, subscriber, or policyholder information necessary to determine third party liability for benefits provided.

(2) The collection, storage, and release of health care data and statistical information that is subject to the federal requirements of the Health Insurance

Portability and Accountability Act ("HIPAA") shall be governed exclusively by the ~~rules~~ regulations adopted thereunder in 45 ~~CFR~~ C.F.R. Parts 160 and 164.

(A) All health insurers that collect the Health Employer Data and Information Set (HEDIS) shall annually submit the HEDIS information to the ~~commissioner~~ Board in a form and in a manner prescribed by the ~~commissioner~~ Board.

(B) All health insurers shall accept electronic claims submitted in Centers for Medicare and Medicaid Services format for UB-92 or HCFA-1500 records, or as amended by the Centers for Medicare and Medicaid Services.

(3)(A) The ~~commissioner~~ Board shall collaborate with the ~~agency of human services~~ Agency of Human Services and participants in ~~agency of human services~~ the Agency's initiatives in the development of a comprehensive health care information system. The collaboration is intended to address the formulation of a description of the data sets that will be included in the comprehensive health care information system, the criteria and procedures for the development of ~~limited use~~ limited-use data sets, the criteria and procedures to ensure that HIPAA compliant ~~limited use~~ limited-use data sets are accessible, and a proposed time frame for the creation of a comprehensive health care information system.

(B) To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in Vermont. In presenting data for public access, comparative considerations shall be made regarding geography, demographics, general economic factors, and institutional size.

(C) Consistent with the dictates of HIPAA, and subject to such terms and conditions as the ~~commissioner~~ Board may prescribe by ~~regulation~~ rule, the Vermont ~~program for quality in health care~~ Program for Quality in Health Care shall have access to the unified health care database for use in improving the quality of health care services in Vermont. In using the database, the Vermont ~~rogram for quality in health care~~ Program for Quality in Health Care shall agree to abide by the rules and procedures established by the ~~commissioner~~ Board for access to the data. The ~~commissioner's~~ Board's rules may limit access to the database to limited-use sets of data as necessary to carry out the purposes of this section.

(D) Notwithstanding HIPAA or any other provision of law, the comprehensive health care information system shall not publicly disclose any data that contains direct personal identifiers. For the purposes of this section, "direct

personal identifiers" include information relating to an individual that contains primary or obvious identifiers, such as the individual's name, street address, e-mail address, telephone number, and Social Security number.

(i) On or before January 15, 2008 and every three years thereafter, the ~~commissioner~~ Commissioner shall submit a recommendation to the ~~general assembly~~ General Assembly for conducting a survey of the health insurance status of Vermont residents.

(j)(1) As used in this section, and without limiting the meaning of subdivision 9402(8) of this title, the term "health insurer" includes:

(A) any entity defined in subdivision 9402(8) of this title;

(B) any third party administrator, any pharmacy benefit manager, any entity conducting administrative services for business, and any other similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident, and health care provided by Vermont health care providers and facilities required to be filed by a health insurer under this section;

(C) any health benefit plan offered or administered by or on behalf of the ~~state~~ State of Vermont or an agency or instrumentality of the ~~state~~ State; and

(D) any health benefit plan offered or administered by or on behalf of the federal government with the agreement of the federal government.

(2) The ~~commissioner~~ Board may adopt rules to carry out the provisions of this subsection, including ~~standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner and~~ criteria for the required filing of such claims data, eligibility data, provider files, and other information as the ~~commissioner~~ Board determines to be necessary to carry out the purposes of this section and this chapter.

* * * Cost-Shift Reporting * * *

Sec. 41. 18 V.S.A. § 9375(d) is amended to read:

(d) Annually on or before January 15, the ~~board~~ Board shall submit a report of its activities for the preceding ~~state fiscal~~ calendar year to the ~~house committee on health care and the senate committee on health and welfare~~ House Committee on Health Care and the Senate Committee on Health and Welfare.

(1) The report shall include:

(A) any changes to the payment rates for health care professionals pursuant to section 9376 of this title~~,~~;

(B) any new developments with respect to health information technology~~,~~;

(C) the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications~~,~~;

(D) the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations~~,~~;

(E) the process and outcome measures used in the evaluation~~,~~;

(F) any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged;

(G) any recommendations for modifications to Vermont statutes~~,~~; and

(H) any actual or anticipated impacts on the work of the ~~board~~ Board as a result of modifications to federal laws, regulations, or programs.

(2) The report shall identify how the work of the ~~board~~ Board comports with the principles expressed in section 9371 of this title.

Sec. 42. 2000 Acts and Resolves No. 152, Sec. 117b is amended to read:

Sec. 117b. MEDICAID COST SHIFT REPORTING

(a) It is the intent of this section to measure the elimination of the Medicaid cost shift. For hospitals, this measurement shall be based on a comparison of the difference between Medicaid and Medicare reimbursement rates. For other health care providers, an appropriate measurement shall be developed that includes an examination of the Medicare rates for providers. In order to achieve the intent of this section, it is necessary to establish a reporting and tracking mechanism to obtain the facts and information necessary to quantify the Medicaid cost shift, to evaluate solutions for reducing the effect of the Medicaid cost shift in the commercial insurance market, to ensure that any reduction in the cost shift is passed on to the commercial insurance market, to assess the impact of such reductions on the financial health of the health care delivery system, and to do so within a sustainable utilization growth rate in the Medicaid program.

(b) ~~By~~ Notwithstanding 2 V.S.A. § 20(d), annually on or before December 15, ~~2000, and annually thereafter, the commissioner of banking, insurance, securities, and health care administration, the secretary of human services~~ the chair of the Green Mountain Care Board, the Commissioner of Vermont Health Access, and each acute care hospital shall file with the ~~joint fiscal committee~~ Joint Fiscal Committee, in the manner required by the ~~committee~~ Committee, such information as is necessary to carry out the purposes of this section. Such information shall pertain to the provider delivery system to the

extent it is available.

(c) ~~By December 15, 2000, and annually thereafter, the~~ The report of hospitals to the ~~joint fiscal committee~~ Joint Fiscal Committee under subsection (b) of this section shall include information on how they will manage utilization in order to assist the ~~agency of human services~~ Department of Vermont Health Access in developing sustainable utilization growth in the Medicaid program.

~~(d) By December 15, 2000, the commissioner of banking, insurance, securities, and health care administration shall report to the joint fiscal committee with recommendations on mechanisms to assure that appropriations intended to address the Medicaid cost shift will result in benefits to commercial insurance premium payers in the form of lower premiums than they otherwise would be charged.~~

~~(e) The first $250,000.00 resulting from declines in caseload and utilization related to hospital costs, as determined by the commissioner of social welfare, from the funds allocated within the Medicaid program appropriation for hospital costs in fiscal year 2001 shall be reserved for cost shift reduction for hospitals.~~

* * * Workforce Planning Data * * *

Sec. 43. 26 V.S.A. § 1353 is amended to read:

§ 1353. POWERS AND DUTIES OF THE BOARD

The ~~board~~ Board shall have the following powers and duties to:

* * *

(10) As part of the license application or renewal process, collect data necessary to allow for workforce strategic planning required under 18 V.S.A. chapter 222.

Sec. 44. WORKFORCE PLANNING; DATA COLLECTION

(a) The Board of Medical Practice shall collaborate with the Director of Health Care Reform in the Agency of Administration, the Vermont Medical Society, and other interested stakeholders to develop data elements for the Board to collect pursuant to 26 V.S.A. § 1353(10) to allow for the workforce strategic planning required under 18 V.S.A. chapter 222. The data elements shall be consistent with any nationally developed or required data in order to simplify collection and minimize the burden on applicants.

(b) The Office of Professional Regulation, the Board of Nursing, and other relevant professional boards shall collaborate with the Director of Health Care Reform in the Agency of Administration in the collection of data necessary to allow for workforce strategic planning required under 18 V.S.A. chapter 222.

The boards shall develop the data elements in consultation with the Director and with interested stakeholders. The data elements shall be consistent with any nationally developed or required data elements in order to simplify collection and minimize the burden on applicants. Data shall be collected as part of the licensure process to minimize administrative burden on applicants and the State.

* * * Administration * * *

Sec. 45. 8 V.S.A. § 11(a) is amended to read:

(a) General. The ~~department of financial regulation~~ Department of Financial Regulation created by 3 V.S.A. ~~section 212,~~ § 212 shall have jurisdiction over and shall supervise:

(1) Financial institutions, credit unions, licensed lenders, mortgage brokers, insurance companies, insurance agents, broker-dealers, investment advisors, and other similar persons subject to the provisions of this title and 9 V.S.A. chapters 59, 61, and 150.

(2) The administration of health care~~, including oversight of the quality and cost containment of health care provided in this state, by conducting and supervising the process of health facility certificates of need, hospital budget reviews, health care data system development and maintenance, and funding and cost containment of health care~~ as provided in 18 V.S.A. chapter 221.

* * * Miscellaneous Provisions * * *

Sec. 46. 33 V.S.A. § 1901(h) is added to read:

(h) To the extent required to avoid federal antitrust violations, the Department of Vermont Health Access shall facilitate and supervise the participation of health care professionals and health care facilities in the planning and implementation of payment reform in the Medicaid and SCHIP programs. The Department shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the Attorney General for appropriate action the activities of any individual or entity that the Department determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

Sec. 47. 33 V.S.A. § 1901b is amended to read:

§ 1901b. PHARMACY PROGRAM ENROLLMENT

(a) The ~~department of Vermont health access~~ Department of Vermont Health Access and the ~~department for children and families~~ Department for Children

and Families shall monitor actual caseloads, revenue, and expenditures~~,~~; anticipated caseloads, revenue, and expenditures~~,~~; and actual and anticipated savings from implementation of the preferred drug list, supplemental rebates, and other cost containment activities in each state pharmaceutical assistance program, including VPharm ~~and VermontRx~~. ~~The departments~~ When applicable, the Departments shall allocate supplemental rebate savings to each program proportionate to expenditures in each program. ~~During the second week of each month, the department of Vermont health access shall report such actual and anticipated caseload, revenue, expenditure, and savings information to the joint fiscal committee and to the health care oversight committee.~~

(b)~~(1) If at any time expenditures for VPharm and VermontRx are anticipated to exceed the aggregate amount of state funds expressly appropriated for such state pharmaceutical assistance programs during any fiscal year, the department of Vermont health access shall recommend to the joint fiscal committee and notify the health care oversight committee of a plan to cease new enrollments in VermontRx for individuals with incomes over 225 percent of the federal poverty level.~~

~~(2) If at any time expenditures for VPharm and VermontRx are anticipated to exceed the aggregate amount of state funds expressly appropriated for such state pharmaceutical assistance programs during any fiscal year, even with the cessation of new enrollments as provided for in subdivision (1) of this subsection, the department of Vermont health access shall recommend to the joint fiscal committee and notify the health health care oversight committee of a plan to cease new enrollments in the VermontRx for individuals with incomes more than 175 percent and less than 225 percent of the federal poverty level.~~

~~(3) The determinations of the department of Vermont health access under subdivisions (1) and (2) of this subsection shall be based on the information and projections reported monthly under subsection (a) of this section, and on the official revenue estimates under 32 V.S.A. § 305a. An enrollment cessation plan shall be deemed approved unless the joint fiscal committee disapproves the plan after 21 days notice of the recommendation and financial analysis of the department of Vermont health access.~~

~~(4) Upon the approval of or failure to disapprove an enrollment cessation plan by the joint fiscal committee, the department of Vermont health access shall cease new enrollment in VermontRx for the individuals with incomes at the appropriate level in accordance with the plan.~~

~~(c)(1) If at any time after enrollment ceases under subsection (b) of this section expenditures for VermontRx, including expenditures attributable to renewed enrollment, are anticipated, by reason of increased federal financial~~

~~participation or any other reason, to be equal to or less than the aggregate amount of state funds expressly appropriated for such state pharmaceutical assistance programs during any fiscal year, the department of Vermont health access shall recommend to the joint fiscal committee and notify the health care oversight committee of a plan to renew enrollment in VermontRx, with priority given to individuals with incomes more than 175 percent and less than 225 percent, if adequate funds are anticipated to be available for each program for the remainder of the fiscal year.~~

~~(2) The determination of the department of Vermont health access under subdivision (1) of this subsection shall be based on the information and projections reported monthly under subsection (a) of this section, and on the official revenue estimates under 32 V.S.A. § 305a. An enrollment renewal plan shall be deemed approved unless the joint fiscal committee disapproves the plan after 21 days notice of the recommendation and financial analysis of the department of Vermont health access.~~

~~(3) Upon the approval of, or failure to disapprove an enrollment renewal plan by the joint fiscal committee, the department of Vermont health access shall renew enrollment in VermontRx in accordance with the plan.~~

~~(d)~~ As used in this section~~:~~,

~~(1) "State~~ "state pharmaceutical assistance program" means any health assistance programs administered by the ~~agency of human services~~ Agency of Human Services providing prescription drug coverage, including the Medicaid program, ~~the Vermont health access plan,~~ VPharm, ~~VermontRx,~~ the ~~state children's health insurance program~~ State Children's Health Insurance Program, the ~~state~~ State of Vermont AIDS ~~medication assistance program~~ Medication Assistance Program, the General Assistance program, the ~~pharmacy discount plan program~~ Pharmacy Discount Plan Program, and any other health assistance programs administered by the ~~agency~~ Agency providing prescription drug coverage.

~~(2) "VHAP" or "Vermont health access plan" means the programs of health care assistance authorized by federal waivers under Section 1115 of the Social Security Act, by No. 14 of the Acts of 1995, and by further acts of the General Assembly.~~

~~(3) "VHAP Pharmacy" or "VHAP Rx" means the VHAP program of state pharmaceutical assistance for elderly and disabled Vermonters with income up to and including 150 percent of the federal poverty level (hereinafter "FPL").~~

~~(4) "VScript" means the Section 1115 waiver program of state pharmaceutical assistance for elderly and disabled Vermonters with income over 150 and less than or equal to 175 percent of FPL, and administered under subchapter 4 of~~

~~chapter 19 of this title.~~

~~(5) "VScript-Expanded" means the state-funded program of pharmaceutical assistance for elderly and disabled Vermonters with income over 175 and less than or equal to 225 percent of FPL, and administered under subchapter 4 of chapter 19 of this title.~~

Sec. 48. 2012 Acts and Resolves No. 171, Sec. 2c, is amended to read:

Sec. 2c. EXCHANGE OPTIONS

In approving benefit packages for the Vermont health benefit exchange pursuant to 18 V.S.A. ~~§ 9375(b)(7)~~ § 9375(b)(9), the Green Mountain Care ~~board~~ 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~~ 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. 49. 2012 Acts and Resolves No. 171, Sec. 41(e), is amended to read:

(e) ~~33~~ 18 V.S.A. chapter 13, subchapter 2 (payment reform pilots) is repealed on passage.

* * * Transfer of Positions * * *

Sec. 50. TRANSFER OF POSITIONS

(a) On or before July 1, 2013, the Department of Financial Regulation shall transfer positions numbered 290071, 290106, and 290074 and associated funding to the Green Mountain Care Board for the administration of the health care database.

(b) On or before July 1, 2013, the Department of Financial Regulation shall transfer position number 297013 and associated funding to the Agency of Administration.

(c) On or after July 1, 2013, the Department of Financial Regulation shall transfer one position and associated funding to the Department of Health for the purpose of administering the hospital community reports in 18 V.S.A. § 9405b. The Department of Financial Regulation shall continue to collect funds for the publication of the reports pursuant to 18 V.S.A. § 9415 and shall transfer the necessary funds annually to the Department of Health.

* * * Emergency Rulemaking * * *

Sec. 51. EMERGENCY RULEMAKING

The Agency of Human Services may adopt emergency rules pursuant to 3 V.S.A. § 844 prior to the operation of the Vermont Health Benefit Exchange in order to conform Vermont's rules regarding operation of the Exchange to emerging federal guidance and regulations implementing the provisions of the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152). The need for timely compliance with federal laws and guidance prior to operation of the Vermont Health Benefit Exchange shall be deemed to meet the standard for the adoption of emergency rules required pursuant to 3 V.S.A. § 844(a).

* * * Repeals * * *

Sec. 52. REPEALS

(a) 8 V.S.A. § 4080f (Catamount Health) is repealed on January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers on Medicare and Medicaid Services.

(b) 18 V.S.A. § 708 (health information technology certification process) is repealed on passage.

(c) 33 V.S.A. § chapter 19, subchapter 3a (Catamount Health Assistance) is repealed January 1, 2014, except that current enrollees may continue to receive transitional coverage from the Department of Vermont Health Access as authorized by the Centers for Medicare and Medicaid Services.

(d) 33 V.S.A. § 2074 (VermontRx) is repealed on January 1, 2014.

(e) 18 V.S.A. § 9403 (Division of Health Care Administration) is repealed on July 1, 2013.

* * * Effective Dates * * *

Sec. 53. EFFECTIVE DATES

(a) Secs. 2 (mental health care services review), 3 (prescription drug deductibles), 33–34a (health information exchange), 39 (temporary suspension of hospital reports), 40 (VHCURES), 43 and 44 (workforce planning), 46 (DVHA antitrust provision), 48 (Exchange options), 49 (correction to payment reform pilot repeal), 50 (transfer of positions), 51 (emergency rules), and 52 (repeals) of this act and this section shall take effect on passage.

(b) Sec. 1 (interstate employers) and Secs. 28–30 (employer definitions) shall take effect on October 1, 2013 for the purchase of insurance plans effective for coverage beginning January 1, 2014.

(c) Secs. 4 (newborn coverage), 5 (grace period for premium payment), 6–27

(Catamount and VHAP), 31 (Healthy Vermonters), 32 (VPharm), and 47 (pharmacy program enrollment) shall take effect on January 1, 2014.

(d) All remaining sections of this act shall take effect on July 1, 2013.

and that after passage the title of the bill be amended to read: "An act relating to health insurance, Medicaid, the Vermont Health Benefit Exchange, and the Green Mountain Care Board".

(Committee Vote: 8-3-0)

H. 198

An act relating to the Legacy Insurance Management Act

Rep. Kitzmiller of Montpelier, for the Committee on **Commerce and Economic Development,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. TITLE

This act shall be known as the "Legacy Insurance Management Act."

Sec. 2. FINDINGS AND PURPOSE

(a) The Vermont General Assembly finds:

(1) The creation of jobs and investment in the state of Vermont through business expansion and recruitment is of the highest importance.

(2) Vermont has created a thriving alternative risk financing industry, which has provided Vermonters with well-paying jobs and has created significant premium tax revenue for the state.

(b) The purpose of this act is to regulate the receipt and management by solvent Vermont companies of closed blocks of nonadmitted commercial insurance policies and reinsurance agreements.

Sec. 3. 8 V.S.A. chapter 147 is added to read:

CHAPTER 147. LEGACY INSURANCE TRANSFERS

§ 7111. DEFINITIONS

As used in this chapter:

(1) "Assuming company" means a Vermont-domiciled company established specifically to acquire a closed block under a legacy insurance transfer plan approved by the Commissioner.

(2) "Closed block" means a block, line, or group of commercial

nonadmitted insurance policies or reinsurance agreements or both:

(A) which a transferring insurer has ceased to offer, write, or sell to new applicants;

(B) for which all policy periods have been fully expired for not less than 60 months;

(C) for which active premiums are no longer being paid; and

(D) which is not workers' compensation, health, life, or any other personal line of insurance.

(3) "Comment period" means the 60-day period starting on the date notice is issued by an assuming company under subsection 7112(h) of this chapter. For good cause, the comment period may be extended by the Commissioner up to an additional 30 days.

(4) "Commissioner" means the Commissioner of Financial Regulation.

(5) "Controlling party" means a person having "control" of an assuming company or transferring insurer. "Control" shall have the same meaning as in section 3681 of this title.

(6) "Department" means the Department of Financial Regulation.

(7) "Domicile regulator" means the primary insurance regulatory authority of the domicile jurisdiction of a transferring insurer.

(8) "Inward reinsurance agreement" means a contract of reinsurance between a transferring insurer and another insurance company with respect to which a transferring insurer is a party as the reinsurer.

(9) "Inward reinsurance counterparty" means an insurance company, other than the transferring insurer, that is a party to an inward reinsurance agreement.

(10) "Legacy insurance transfer" means the transfer of a closed block in accordance with the requirements of this chapter.

(11) "Legacy insurance transfer plan" or "plan" means a plan that sets forth all provisions and includes all documentation regarding a legacy insurance transfer required under subsection 7112(b) of this chapter.

(12) "Nonadmitted insurance" means any property and casualty insurance permitted to be placed directly or through a surplus lines broker with a nonadmitted insurer eligible to accept such insurance.

(13) "Nonadmitted insurer" means, with respect to a state, an insurer not licensed to engage in the business of insurance in such state. The term does

not include a risk retention group or a captive insurance company.

(14) "Outward reinsurance agreement" means a contract of reinsurance between a transferring insurer and another insurance company with respect to which a transferring insurer is a party as the reinsured.

(15) "Outward reinsurance counterparty" means an insurance company, other than the transferring insurer, that is a party to an outward reinsurance agreement.

(16) "Party" means:

(A) the assuming company;

(B) the transferring insurer;

(C) with respect to any policy to be transferred under a plan, each policyholder;

(D) with respect to any inward reinsurance agreement to be transferred under a plan, each inward reinsurance counterparty; and

(E) any other person the Commissioner approves as a party with respect to such proceeding.

(17) "Plan summary" means a written statement of the key terms and provisions of a plan as required under subdivision 7112(b)(18) of this chapter.

(18) "Policy" means a contract of property and casualty insurance that is not a contract of reinsurance or a personal lines insurance policy.

(19) "Policyholder" means the person identified as the policyholder or first named in a policy.

(20) "Reinsurance agreement" means an inward reinsurance agreement or an outward reinsurance agreement.

(21) "Reinsurance agreement counterparty" means an inward reinsurance agreement counterparty or an outward reinsurance counterparty.

(22) "Transferring insurer" means a nonadmitted insurer that is transferring a closed block to an assuming company under a legacy insurance transfer plan.

§ 7112. APPLICATION; FEE; PLAN

(a) An assuming company shall file a plan with the Commissioner and, at the time of filing, shall pay to the Commissioner the fee described in subdivision 7116(a)(1) of this chapter.

(b) A plan shall include the following:

(1) a list of all policies and inward reinsurance agreements in the closed block to be transferred under the plan;

(2) a list of all outward reinsurance agreements attaching to the closed block;

(3) a list of all policyholders and inward reinsurance counterparties to policies and inward reinsurance agreements in the closed block to be transferred under the plan;

(4) the identities of the transferring insurer and the assuming company and their respective controlling parties, if any;

(5) certificates issued by the domicile regulator of the transferring insurer and, if applicable, by any controlling party that is a regulated insurance company attesting to the good standing of the transferring insurer and the controlling party under the insurance regulatory laws of the jurisdiction of their respective domiciles; or, if any such certificate is not obtainable under the laws or practices of a domicile regulator, a certificate of an officer of the transferring insurer or the controlling party, as applicable, attesting to the foregoing;

(6) a letter of no objection, or the equivalent, from the domicile regulator of the transferring insurer confirming that the regulator has no objection to the transfer of the closed block under the plan; or, if any such certificate is not obtainable under the laws or practices of a domicile regulator, a certificate of an officer of the transferring insurer or the controlling party, as applicable, attesting to the foregoing;

(7) a statement describing the terms and conditions, if any, of any policy or inward reinsurance agreement in the closed block prohibiting assignment and assumption of the rights, liabilities, and obligations of the transferring insurer without the prior written consent of the respective policyholder or inward reinsurance counterparty;

(8) the most recent audited financial statements and annual reports of the transferring insurer filed with its domicile regulator and such other financial information as the Commissioner may reasonably require with respect to a controlling party, if any;

(9) an actuarial study or opinion in a form satisfactory to the Commissioner that quantifies the liabilities to be transferred to the assuming company under the policies or inward reinsurance agreements in the closed block;

(10) a statement of outward reinsurance agreement assets attaching to the closed block;

(11) three years of pro-forma financial statements demonstrating the solvency of the assuming company;

(12) officer's certificates of the transferring insurer and the assuming company attesting that each has obtained all required internal approvals and authorizations regarding the plan and completed all necessary and appropriate actions relating thereto;

(13) the form of notice to be provided under the plan to any policyholder or inward reinsurance counterparty in the closed block and how such notice shall be provided;

(14) the form of notice to be provided under the plan to any outward reinsurance counterparty attaching to the closed block and how such notice shall be provided;

(15) a statement describing any pending dispute between the transferring insurer and any policyholder or inward reinsurance counterparty or any disputed claim by a third party with respect to any policy or inward reinsurance agreement in the closed block;

(16) a statement describing the assuming company's proposed investment policies, officers, directors, key employees, and other arrangements regarding matters such as:

(A) any contemplated third-party claims management and administration arrangements;

(B) operations, management, and solvency relating to the closed block; and

(C) a detailed plan for annual or other periodic financial reporting to the Commissioner, including an annual financial audit with actuarial opinion;

(17) a statement from the assuming company consenting to the jurisdiction of the Commissioner with regard to ongoing oversight of operations, management, and solvency relating to the closed block, including the authority of the Commissioner to conduct examinations under section 7117 of this chapter and to set reasonable standards for oversight of the assuming company, including:

(A) material transactions with affiliates;

(B) adequacy of surplus; and

(C) dividends and other distributions, including limitations on extraordinary dividends.

(18) a statement from the assuming company submitting to the

jurisdiction and authority of the Commissioner of Insurance, or the equivalent regulatory authority, in states in which policyholders or reinsurance counterparties reside, for the purposes of implementing each such state's Unfair Claims Settlement Practices Act, or its equivalent, if any, in such state's market conduct statutory framework. Notwithstanding any provision to the contrary in such act, the submission under this subdivision shall not confer a private cause of action upon any policyholder or reinsurance counterparty against the assuming company, even if the applicable Unfair Claims Settlement Practices Act, or equivalent, purports to provide a private cause of action;

(19) a plan summary which includes all information regarding the plan as reasonably required by the Commissioner;

(20) the statement described in subsection (c) of this section regarding the information and documents submitted as part of or with respect to a plan which are confidential; and

(21) any other information the Commissioner may reasonably require with respect to the plan in the exercise of his or her discretion.

(c) The plan shall include a statement of the information and documentation included in the plan that the assuming company or the transferring insurer may request be given confidential treatment, which in all cases shall include all information identifying policyholders and reinsurance counterparties and which may include any information that qualifies as a trade secret or other confidential research, development, or commercial information of the transferring insurer or the assuming company. The Commissioner, subject to the exercise of his or her reasonable discretion, shall determine whether the information designated in such statement qualifies for confidential treatment and therefore shall be exempt from public inspection and copying under the Public Records Act. Any information qualifying for confidential treatment shall not be subject to subpoena and shall not be made public by the Commissioner or by any other person; provided, however, the Commissioner may in his or her discretion grant access to such information to public officers having jurisdiction over the regulation of insurance in any other state or country, to public officers of a foreign or alien financial regulatory authority, or to state or federal law enforcement officers pursuant to a validly issued subpoena or search warrant; provided that such officers receiving the information agree in writing to hold it in a manner consistent with this section.

(d) Within 10 business days of the date the application is filed and the fee payable under subsection (a) of this section is paid in full, the Commissioner shall notify the assuming company whether the plan is complete. In his or her discretion, the Commissioner may extend the 10-business-day application review period for an additional 10 business days. With the written consent of

the assuming company, the application review period may be extended beyond 20 business days.

(e) Upon submission of a plan, the assuming company shall have a continuing obligation to notify the Commissioner promptly and in a full and accurate manner of any material change to information in the plan.

(f) If the Commissioner notifies the assuming company that the plan is not complete, the Commissioner shall specify any modifications, supplements, or amendments to the plan that are required, and any additional information or documentation with respect to the plan that must be provided to the Commissioner before the Commissioner issues the notice referenced in subsection (d) of this section.

(g) If the Commissioner notifies the assuming company that the plan is complete, the Commissioner shall set a date, time, and place for a hearing on the plan as required under subsection (l) of this section.

(h) Within 30 days of the date the Commissioner notifies the assuming company under subsection (g) of this section that the plan is complete, the assuming company shall cause notice to be provided, in the form and manner specified in the plan, to all policyholders and reinsurance counterparties listed in the plan. The notice shall:

(1) comply with the plan and the provisions of 3 V.S.A. § 809(b);

(2) include the plan summary;

(3) describe the effect of the plan and the transfer on each policyholder and reinsurance counterparty and on his or her respective policy or reinsurance agreement, as applicable;

(4) state the right of each policyholder or inward reinsurance counterparty to:

(A) accept or object to the plan, together with a description of the means by which a policyholder or inward reinsurance counterparty may expressly accept or object to the plan and the effect of such acceptance or objection;

(B) file written comments on the plan with the Commissioner; and

(C) appear and present evidence on the plan at the hearing;

(5) describe the terms and conditions under which a policyholder or inward reinsurance counterparty shall be deemed to have accepted the plan;

(6) specify the date, time, and place of the hearing on the plan;

(7) include all other information reasonably required by the

Commissioner; and

(8) be published in two newspapers of general nationwide circulation on two separate occasions, as determined by the Commissioner.

(i) During the comment period:

(1) any party may file written comments on the plan with the Commissioner;

(2) any policyholder or inward reinsurance counterparty may, by delivery of such notice in accordance with the terms and conditions of the plan and prior to the expiration of the comment period, provide an express written notice that he or she accepts or objects to the plan; and

(3) the assuming company shall file with the Commissioner such additional documentation and information regarding the plan as the Commissioner may reasonably require.

(j) In the event that, prior to the expiration of the comment period, any policyholder or inward reinsurance counterparty provides express written notice that he or she objects to the plan and specifies the policy or agreement with respect to which such objection is made, the assuming company shall, not later than 15 days after the end of the comment period, submit to the Commissioner either:

(1) an amended list of policies and reinsurance agreements in the plan, excluding such policyholder or inward reinsurance counterparty and its respective policy or inward reinsurance agreement from the plan; or

(2) an express written notice from such policyholder or inward reinsurance counterparty accepting the plan and consenting to the transfer having the full force and effect of a statutory novation of its respective policy or reinsurance agreement, as applicable, and withdrawing and rescinding its prior notice of objection.

(k) Any policyholder or inward reinsurance counterparty that, prior to the expiration of the comment period, has not provided express written notice objecting to the plan shall be deemed to have accepted the plan and the transfer shall have the full force and effect of a statutory novation of his or her respective policy or inward reinsurance agreement, as applicable.

(l) Notwithstanding any provision of this chapter to the contrary, if a policy or inward reinsurance agreement contains a provision prohibiting the transfer of the policy or inward reinsurance agreement without the consent of the policyholder or inward reinsurance counterparty, then such policy or inward reinsurance agreement shall not be transferred under this chapter unless the applicable policyholder or inward reinsurance counterparty provides written

consent to the proposed transfer.

(m) The hearing on the plan shall be held not later than 60 days after the end of the comment period. In his or her discretion, the Commissioner may postpone the hearing for an additional 10 days. With the written consent of the assuming company, the hearing may be postponed beyond 70 days. Each person participating in the hearing shall bear his or her own costs and attorney's fees.

§ 7113. PLAN REVIEW

(a) The Commissioner may retain an actuary to conduct an actuarial study quantifying the liabilities under insurance policies and reinsurance agreements to be transferred to the assuming company under the plan and is authorized to retain any other legal, financial, and examination services from outside the Department necessary to assist in plan review.

(b) In reviewing the plan, the Commissioner shall take into account all written comments filed with respect to the plan, all evidence taken at the hearing, and any other factors the Commissioner reasonably deems relevant with respect to the plan. In all cases, the Commissioner shall make findings with respect to each of the following:

(1) the solvency of the assuming company before and after the implementation of the proposed plan;

(2) the adequacy of the assuming company's proposals described in the statement required under subdivision 7112(b)(16) of this chapter;

(3) the adequacy of the assuming company's consent to jurisdiction required under subdivision 7112(b)(17) of this chapter;

(4) the ability of the assuming company to comply with all requirements of the policies and inward reinsurance agreements, including the capacity of the assuming company regarding the administration of claims in process on or after the effective date of the transfer;

(5) whether any outward reinsurance agreement relating to any policy or policies in the closed block will be adversely effected by the transfer;

(6) whether the plan materially adversely affects the interests of any party or outward reinsurance counterparty or the interests of any policyholder or inward reinsurance counterparty who has accepted or been deemed to have accepted the plan;

(7) whether policyholders or inward reinsurance counterparties objecting to the plan and not withdrawing such objections, together with their respective insurance policies and inward reinsurance agreements, have been

excluded from the plan as required under subsections 7112(j) and (l) of this chapter; and

(8) the fairness of the plan to all parties.

§ 7114. ORDER

(a) Within 30 days of the date the hearing is held on the plan, the Commissioner shall issue an order setting forth the amount of fees payable by the assuming company under subdivision 7116(a)(2) of this chapter, payable not later than 14 days after the date of such order. Upon receipt of such payment, the Commissioner shall within five days issue an order approving or disapproving the plan in whole or in part. Whenever it is not practicable to issue an order within 30 days, the Commissioner may extend such time up to an additional 30 days. If the order approves the plan, the order shall:

(1) include the terms and conditions of the Commissioner's oversight with regard to ongoing oversight of the operations, management, and solvency relating to the closed block and any specific standards that the assuming company will be required to comply with, including standards relating to:

(A) material transactions with affiliates;

(B) adequacy of surplus; and

(C) dividends and other distributions, including limitations on dividends;

(2) set forth the fee payable by the assuming company under subsection 7116(b) of this chapter, which fee shall be payable not later than 14 days after the date of such order;

(3) not be effective until such time as the fees described in this subsection have been paid in full.

(b) The Commissioner shall not approve a plan unless the Commissioner finds that the assuming company has:

(1) sufficient assets to meet its liabilities;

(2) sufficient procedures in place for the handling of claims;

(3) consented to sufficient regulatory oversight by the Department; and

(4) excluded from the plan any policy or agreement with respect to which a policyholder or inward reinsurance agreement counterparty has objected to the proposed transfer under the plan, as required under subsections 7112(j) and (l) of this chapter.

(c) An order issued under subsection (a) of this section approving the plan

shall have the full force and effect of a statutory novation with respect to all policyholders and reinsurance counterparties and their respective policies and reinsurance agreements under the plan and shall provide that the transferring insurer shall have no further rights, obligations, or liabilities with respect to such policies and reinsurance agreements, and that the assuming company shall have all such rights, obligations, and liabilities as if it, instead of the transferring insurer, were the original party to such policies and reinsurance agreements.

(d) The Commissioner may issue any other orders he or she reasonably deems necessary to fully implement an order issued under subsection (a) of this section.

(e) No order issued under subsection (a) or (d) of this section shall be construed to modify or amend the terms of a policy or reinsurance agreement, other than with respect to matters specifically subject to modification or amendment under this chapter.

(f) If a party objects to a plan, the Commissioner may not approve the plan with respect to such party unless the Commissioner determines that the plan:

(1) does not materially adversely affect the objecting party; and

(2) otherwise complies with the requirements of this chapter.

(g) At any time before the Commissioner issues the order described in subsection (a) of this section, the assuming company may file an amendment to the plan, subject to the Commissioner's approval.

(h) At any time before the Commissioner issues the order described in subsection (a) of this section, the assuming company may withdraw the plan without prejudice. Upon such withdrawal, however, the Commissioner shall issue an order setting forth the amount of fees payable by the assuming company under subdivision 7116(a)(2) of this chapter, payable not later than 14 days after the date of such order.

§ 7115. JURISDICTION; APPEALS

(a) The Commissioner shall have exclusive jurisdiction with respect to the review and approval or denial of any plan.

(b) Any party aggrieved by a final order of the Commissioner may appeal that order to the Vermont Supreme Court under 3 V.S.A. § 815.

§ 7116. FEES AND COSTS

(a) To cover the costs of processing and reviewing a plan under this chapter, the assuming company shall pay to the Commissioner the following nonrefundable fees at the times set forth in subsections 7112(a) and 7114(a) of

this chapter:

(1) an administrative fee in the amount of $30,000.00; and

(2) the reasonable costs of persons retained by the Commissioner under subsection 7113(a) of this chapter.

(b) When a plan is approved, the assuming company shall pay the Commissioner a transfer fee equal to the sum of:

(1) one percent of the first $100,000,000.00 of the gross liabilities transferred, including direct and assumed unpaid claims, losses, and loss adjustment expenses with no reductions for amounts ceded; and

(2) 0.5 percent of the gross liabilities transferred that exceed $100,000,000.00, including direct and assumed unpaid claims, losses, and loss adjustment expenses with no reductions for amounts ceded.

(c) All fees and payments received by the Department under subsection (a) of this section and 10 percent of the transfer fee under subsection (b) of this section shall be credited to the insurance regulatory and supervision fund under section 80 of this title. The remaining 90 percent of the transfer fee shall be deposited directly into the general fund.

§ 7117. EXAMINATIONS

(a) The Commissioner has the authority to order any assuming company to produce any records, books, and papers in the possession of the assuming company or its affiliates necessary to ascertain the financial condition or legality of conduct of the assuming company.

(b) The Commissioner shall exercise his or her authority under subsection (a) of this section only if he or she has reason to believe the interests of the assuming company's policyholders may be adversely affected under the plan.

(c) The Commissioner may retain, at the assuming company's expense, attorneys, actuaries, accountants, and other experts not otherwise a part of the Commissioner's staff reasonably necessary to assist with an examination under this section. Any persons so retained shall be under the direction and control of the Commissioner and shall act in a purely advisory capacity.

(d) Each assuming company that produces records, books, and papers for examination under this section shall pay the expense of such examination.

§ 7118. APPLICABLE LAWS

(a) Chapter 157 (transfer and novation of insurance contracts) of this title shall not apply to any legacy insurance transfer under this chapter.

(b) In the event of any conflict between a provision of this chapter and any

other provision of this title, such provision of this chapter shall control.

(c) A proposed legacy insurance transfer shall be a "contested case" under 3 V.S.A. chapter 25, except that a "party" shall be limited as defined in subdivision 7111(15) of this chapter.

§ 7119. ASSUMING COMPANY; BOARD; PRINCIPAL PLACE OF BUSINESS; REGISTERED AGENT

No assuming company shall be a party to a legacy insurance transfer under this chapter unless:

(1) its board of directors or committee of managers holds at least one meeting each year in this State;

(2) it maintains its principal place of business in this State; and

(3) it appoints a registered agent to accept service of process and to otherwise act on its behalf in this State; provided that whenever such registered agent cannot with reasonable diligence be found at the registered office of the assuming company, the Secretary of State shall be an agent of such assuming company upon whom any process, notice, or demand may be served.

§ 7120. POSTING OF PLANS ON WEBSITE

The Commissioner shall require that all plans filed with the Department are posted on the Department's website, along with any other notice or other information the Commissioner deems appropriate, excluding any information designated as confidential under subsection 7112(c) of this chapter.

§ 7121. REGULATION OF ASSUMING COMPANIES AND SERVICE PROVIDERS

(a) An assuming company shall be subject to all rules adopted by the Commissioner under this subchapter and also shall be subject to:

(1) chapter 145 (supervision, rehabilitation, and liquidation of insurers) of this title; and

(2) the market conduct and unfair trade practices provisions of chapter 129 (insurance trade practices) of this title, as deemed applicable by the Commissioner.

(b) An assuming company shall not be subject to the requirements of chapter 101, subchapter 9 (Property and Casualty Insurance Guaranty Association) of this title.

(c) The Commissioner may adopt rules regarding the provision of services to an assuming company by persons other than any director, officer, or

employee of the assuming company with respect to the administration of policies and reinsurance agreements assumed by the assuming company under a legacy insurance transfer, including licensing or other requirements.

(d) The Commissioner may adopt any other rules necessary or appropriate to carry out the provisions of this chapter.

Sec. 4. EFFECTIVE DATE

This act shall take effect on passage.

(Committee Vote: 9-2-0)

Senate Proposal of Amendment

H. 41

An act relating to civil forfeiture of retirement payments to public officials convicted of certain crimes

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

First: In Sec. 1, 32 V.S.A. § 623, by inserting a new subsection (h) to read:

(h) If the Court determines that a member's retirement benefits should be forfeited to any degree, the maximum value of the benefits ordered forfeited shall not be greater than ten times the amount of monetary loss suffered by the State, a county, a municipality, or by any other person as a result of the crime related to public office.

And by relettering the existing subsection (h) and the remaining subsection to be alphabetically correct.

Second: In Sec. 1, 32 V.S.A. § 625, in subsection (b), in the second sentence, by inserting after "any court of competent jurisdiction" and before the comma, the following: that relates to the crime related to public office of which the member was convicted

(For text see House Journal 2/14/2013)

Information Notice
CROSSOVER DEADLINES

The following bill reporting deadlines are established for the 2013 session:

(1) From the standing committee of last reference, excluding the Committees on Appropriations and Ways and Means, all House bills must be reported out of committee on or before March 15, 2013.

(2) House bills referred pursuant to House Rule 35a, must be reported out of the Committees on Appropriations and Ways and Means on or before March 22, 2013.