# House Calendar

Thursday, April 25, 2013

107th 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 April 25, 2013**

**Favorable with Amendment**

**H. 270**

An act relating to providing access to publicly funded prekindergarten education

**Rep. Buxton of Tunbridge,** for the Committee on **Education,** recommends the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 16 V.S.A. § 829 is amended to read:

§ 829. PREKINDERGARTEN EDUCATION~~; RULES~~

(a) Definitions. As used in this section:

(1) "Prekindergarten child" means a child who, as of the date established by the district of residence for kindergarten eligibility, is three or four years of age or is five years of age but is not yet enrolled in kindergarten.

(2) "Prekindergarten education" means services designed to provide to prekindergarten children developmentally appropriate early development and learning experiences based on Vermont's early learning standards.

(3) "Prequalified private provider" means a private provider of prekindergarten education that is qualified pursuant to subsection (c) of this section.

(b) Access to publicly funded prekindergarten education.

(1) No fewer than ten hours per week of publicly funded prekindergarten education shall be available for 35 weeks annually to each prekindergarten child whom a parent or guardian wishes to enroll in an available, prequalified program operated by a public school or a private provider.

(2) If a parent or guardian chooses to enroll a prekindergarten child in an available, prequalified program, then, pursuant to the parent or guardian's choice, the school district of residence shall:

(A) pay tuition pursuant to subsection (d) of this section upon the request of the parent or guardian to:

(i) a prequalified private provider; or

(ii) a public school located outside the district that operates a prekindergarten program that has been prequalified pursuant to subsection (c) of this section; or

(B) enroll the child in the prekindergarten education program that it operates.

(3) If requested by the parent or guardian of a prekindergarten child, the school district of residence shall pay tuition to a prequalified program operated by a private provider or a public school in another district even if the district of residence operates a prekindergarten education program.

(4) If the supply of prequalified private and public providers is insufficient to meet the demand for publicly funded prekindergarten education in any region of the State, nothing in this section shall be construed to require a district to begin or expand a program to satisfy that demand; but rather, in collaboration with the Agencies of Education and of Human Services, the local Building Bright Futures Council shall meet with school districts and private providers in the region to develop a regional plan to expand capacity.

(c) Prequalification. Pursuant to rules jointly developed and overseen by the Secretaries of Education and of Human Services and adopted by the State Board pursuant to 3 V.S.A. chapter 25, the Agencies jointly may determine that a private or public provider of prekindergarten education is qualified for purposes of this section and include the provider in a publicly accessible database of prequalified providers. At a minimum, the rules shall define the process by which a provider applies for and maintains prequalification status, shall identify the minimum quality standards for prequalification, and shall include the following requirements:

(1) A program of prekindergarten education, whether provided by a school district or a private provider, shall have received:

(A) National Association for the Education of Young Children (NAEYC) accreditation; or

(B) at least four stars in the Department for Children and Families STARS system with at least two points in each of the five arenas; or

(C) three stars in the STARS system if the provider has developed a plan, approved by the Commissioner for Children and Families and the Secretary of Education, to achieve four or more stars in no more than two years with at least two points in each of the five arenas, and the provider has met intermediate milestones.

(2) A licensed provider shall employ or contract for the services of at

least one teacher who is licensed and endorsed in early childhood education or in early childhood special education under chapter 51 of this title.

(3) A registered home provider that is not licensed and endorsed in early childhood education or early childhood special education shall receive regular, active supervision and training from a teacher who is licensed and endorsed in early childhood education or in early childhood special education under chapter 51 of this title.

(d) Tuition, budgets, and average daily membership.

(1) On behalf of a resident prekindergarten child, a district shall pay tuition for prekindergarten education for ten hours per week for 35 weeks annually to a prequalified private provider or to a public school outside the district that is prequalified pursuant to subsection (c) of this section; provided, however, that the district shall pay tuition for weeks that are within the district's academic year. Tuition paid under this section shall be at a statewide rate, which may be adjusted regionally, that is established annually through a process jointly developed and implemented by the Agencies of Education and of Human Services. A district shall pay tuition upon:

(A) receiving notice from the child's parent or guardian that the child is or will be admitted to the prekindergarten education program operated by the prequalified private provider or the other district; and

(B) concurrent enrollment of the prekindergarten child in the district of residence for purposes of budgeting and determining average daily membership.

(2) In addition to any direct costs of operating a prekindergarten education program, a district of residence shall include anticipated tuition payments and any administrative, quality assurance, quality improvement, transition planning, or other prekindergarten-related costs in its annual budget presented to the voters.

(3) The district of residence may include within its average daily membership any prekindergarten child for whom it has provided prekindergarten education or on whose behalf it has paid tuition pursuant to this section.

(4) A prequalified private provider may receive additional payment directly from the parent or guardian only for prekindergarten education in excess of the hours paid for by the district pursuant to this section or for child care services, or both. The provider is not bound by the statewide rate established in this subsection when determining the rates it will charge the parent or guardian.

(e) Rules. The ~~commissioner of education and the commissioner for children and families~~ Secretary of Education and the Commissioner for Children and Families shall jointly develop and agree to rules and present them to the ~~state board of education~~ State Board for adoption under 3 V.S.A. chapter 25 as follows:

(1) ~~To ensure that, before a school district begins or expands a prekindergarten education program that intends to enroll students who are included in its average daily membership, the district engage the community in a collaborative process that includes an assessment of the need for the program in the community and an inventory of the existing service providers; provided, however, if a district needs to expand a prekindergarten education program in order to satisfy federal law relating to the ratio of special needs children to children without special needs and if the law cannot be satisfied by any one or more qualified service providers with which the district may already contract, then the district may expand an existing school-based program without engaging in a community needs assessment.~~ To permit private providers that are not prequalified pursuant to subsection (c) of this section to create new or continue existing partnerships with school districts through which the school district provides supports that enable the provider to fulfill the requirements of subsection (c), and through which the district may or may not make in-kind payments as a component of the statewide tuition established under this section.

(2) ~~To ensure that, if a school district begins or expands a prekindergarten education program that intends to include any of the students in its average daily membership, the district shall use existing qualified service providers to the extent that existing qualified service providers have the capacity to meet the district's needs effectively and efficiently.~~ To authorize a district to begin or expand a school-based prekindergarten education program only upon prior approval obtained through a process jointly overseen by the Secretaries of Education and of Human Services, which shall be based upon analysis of the number of prekindergarten children residing in the district and the availability of enrollment opportunities with prequalified private providers in the region. Where the data are not clear or there are other complex considerations, the Secretaries may choose to conduct a community needs assessment.

(3) To require that the school district provides opportunities for effective parental participation in the prekindergarten education program.

(4) To establish a process by which:

(A) a parent or guardian ~~residing in the district or a provider, or both, may request a school district to enter into a contract with a provider located in~~

~~or outside the district~~ notifies the district that the prekindergarten child is or will be admitted to a prekindergarten education program not operated by the district and concurrently enrolls the child in the district pursuant to subdivision (d)(1) of this section;

(B) a district:

(i) pays tuition pursuant to a schedule that does not inhibit the ability of a parent or guardian to enroll a prekindergarten child in a prekindergarten education program or the ability of a prequalified private provider to maintain financial stability; and

(ii) enters into an agreement with any provider to which it will pay tuition regarding quality assurance, transition, and any other matters; and

(C) a provider that has received tuition payments under this section on behalf of a prekindergarten child notifies a district that the child is no longer enrolled.

(5) ~~To identify the services and other items for which state funds may be expended when prekindergarten children are counted for purposes of average daily membership, such as tuition reduction, quality improvements, or professional development for school staff or private providers.~~ To establish a process to calculate an annual statewide tuition rate that is based upon the actual cost of delivering ten hours per week of prekindergarten education that meets all established quality standards and to allow for regional adjustments to the rate.

(6) ~~To ensure transparency and accountability by requiring private providers under contract with a school districts to report costs for prekindergarten programs to the school district and by requiring school districts to report these costs to the commissioner of education.~~ [Repealed.]

(7) To require ~~school districts~~ a district to include identifiable costs for prekindergarten programs and essential early education services in ~~their~~ its annual budgets and reports to the community.

(8) To require ~~school districts~~ a district to report to the ~~departments their~~ Agency of Education annual expenditures made in support of prekindergarten ~~care and~~ education, with distinct figures provided for expenditures made from the ~~general fund~~ General Fund, from the ~~education fund~~ Education Fund, and from all other sources, which shall be specified.

(9) To provide an ~~appeal~~ administrative process for:

(A) a parent, guardian, or provider to challenge an action of ~~the~~ a school district or the State when the ~~appellant~~ complainant believes that the district or State is in violation of state statute or rules regarding

prekindergarten education; and

(B) a school district to challenge an action of a provider or the State when the district believes that the provider or the State is in violation of state statute or rules regarding prekindergarten education.

(10) ~~To establish the minimum quality standards necessary for a district to include prekindergarten children within its average daily membership. At a minimum, the standards shall include the following requirements:~~

~~(A) The prekindergarten education program, whether offered by or through the district, shall have received:~~

~~(i) National Association for the Education of Young Children (NAEYC) accreditation; or~~

~~(ii) At least four stars in the department for children and families STARS system with at least two points in each of the five arenas; or~~

~~(iii) Three stars in the STARS system if the provider has developed a plan, approved by the commissioner for children and families and the commissioner of education, to achieve four or more stars within three years with at least two points in each of the five arenas, and the provider has met intermediate milestones; and~~

~~(B) A licensed center shall employ or contract for the services of at least one teacher who is licensed and endorsed in early childhood education or in early childhood special education under chapter 51 of this title; and~~

~~(C) A registered home shall receive regular, active supervision and training from a teacher who is licensed and endorsed in early childhood education or in early childhood special education under chapter 51 of this title.~~ To establish a system by which the Agency of Education and Department for Children and Families shall jointly monitor prekindergarten education programs to promote optimal outcomes for children and to collect data that will inform future decisions. At a minimum, the system shall monitor and assess:

(A) programmatic details, including the number of children served, the number of private and public programs operated, and the public financial investment made to ensure access to quality prekindergarten education;

(B) the quality of public and private prekindergarten education programs and efforts to ensure continuous quality improvements through mentoring, training, technical assistance, and otherwise; and

(C) the outcomes for children, including school readiness and proficiency in numeracy and literacy.

(11) To establish a process for documenting the progress of children enrolled in prekindergarten education programs and to require public and private providers to use the process to:

(A) help individualize instruction and improve program practice; and

(B) collect and report child progress data to the ~~commissioner of education~~ Secretary of Education on an annual basis.

(12) If the Secretaries find it advisable, to establish guidelines designed to help coordinate prekindergarten education programs under this section with essential early education as defined in section 2942 of this title and with Head Start programs.

(f) Other provisions of law. Section 836 of this title shall not apply to this section.

(g) Limitations. Nothing in this section shall be construed to permit or require payment of public funds to a private provider of prekindergarten education in violation of Chapter I, Article 3 of the Vermont Constitution.

Sec. 2. 16 V.S.A. § 4010(c) is amended to read:

(c) The ~~commissioner~~ Secretary shall determine the weighted long-term membership for each school district using the long-term membership from subsection (b) of this section and the following weights for each class:

Prekindergarten ~~0.46~~ 0.5

Elementary or kindergarten 1.0

Secondary 1.13

Sec. 3. PREKINDERGARTEN EDUCATION; CALCULATION OF EQUALIZED PUPILS; EXCLUSION FROM EDUCATION SPENDING

(a) If a school district did not provide or pay for prekindergarten education pursuant to 16 V.S.A. § 829 in fiscal year 2015, then:

(1) for purposes of determining the equalized pupil count for the fiscal year 2016 budget, the long-term membership of prekindergarten children shall be the number of prekindergarten children for whom the district anticipates it will provide prekindergarten education or pay tuition, or both, in fiscal year 2016; and

(2) for purposes of determining the equalized pupil count for the fiscal year 2017 budget, the long-term membership of prekindergarten children shall be the total number of prekindergarten children for whom the district provided prekindergarten education or paid tuition, or both, in fiscal year 2016, adjusted

to reflect the difference between the estimated and actual count for that fiscal year.

(b) For purposes of calculating excess spending pursuant to 32 V.S.A. § 5401(12) in fiscal years, 2016, 2017, and 2018 "education spending" shall not include the portion of a district's proposed budget directly attributable to providing a prekindergarten education program or paying tuition on behalf of a resident prekindergarten child pursuant to 16 V.S.A. § 829 as amended by this act.

Sec. 4. QUALITY STANDARDS

(a) The Agencies of Education and of Human Services shall review existing quality standards for prekindergarten education programs and may initiate rulemaking under 3 V.S.A. chapter 25 to require higher standards of quality; provided, however, that no new standards shall take effect earlier than July 1, 2015. Changes to the quality standards shall be designed to ensure that programs are based on intentional, evidence-based practices that create a developmentally appropriate environment and support the delivery of an engaging program that supports the social, emotional, intellectual, language, literacy, and physical development of prekindergarten children.

(b) In January of the 2015, 2016, and 2017 legislative sessions, the Agencies shall report to the House and Senate Committees on Education, the House Committee on Human Services, and the Senate Committee on Health and Welfare regarding the quality of prekindergarten education in the State.

Sec. 5. CONSTITUTIONALITY

On or before July 1, 2014, the Secretary of Education shall identify the private prekindergarten education programs to which school districts are paying tuition on behalf of resident prekindergarten children, determine the extent to which any program provides religious prekindergarten education, and establish the steps the Agency will take to ensure that public funds are not expended in violation of Chapter I, Article 3 of the Vermont Constitution and the Vermont Supreme Court's decision in *Chittenden Town School District v. Vermont Department of Education*, 169 Vt. 310 (1999).

Sec. 6. EFFECTIVE DATE

This act shall take effect on July 1, 2013 and shall apply to enrollments on July 1, 2015 and after.

**( Committee Vote: 9-0-2)**

**Rep. Greshin of Warren,** for the Committee on **Ways and Means,** recommends the bill ought to pass when amended as recommended by the Committee on **Education** and when further amended as follows:

First: In Sec. 1, 16 V.S.A. § 829, subsection (d), subdivision (3), by striking the word "The" and inserting in lieu thereof the following: "Pursuant to subdivision 4001(1)(C) of this title, the"

Second: By striking out Sec. 2 (weighted membership) in its entirety

Third: In Sec. 3, by striking out subsection (b) (excess spending) in its entirety and by striking out the subsection designation for subsection (a)

Fourth: In Sec. 1, 16 V.S.A. § 829(g), and Sec. 5, before the period, by inserting the following: "or in violation of the Establishment Clause of the U.S. Constitution"

**( Committee Vote: 7-4-0)**

**Rep. Johnson of South Hero,** for the Committee on **Appropriations,** recommends the bill ought to pass when amended as recommended by the Committee on **Education and Ways and Means** and when further amended as follows:

First: In Sec. 1, 16 V.S.A. § 829, subsection (e), in subdivision (10), after the first period, by inserting a new sentence to read: "The Agency and Department shall be required to report annually to the General Assembly in January."

Second: In Sec. 4, subsection (b), after the words: "on Education" by inserting the words: "and on Appropriations"

**( Committee Vote: 8-3-0)**

**Amendment to be offered by Rep. Buxton of Tunbridge to the recommendation of amendment of the Committee on Education to H. 270**

First: In Sec. 1, 16 V.S.A. § 829, by adding a new subsection to be subsection (h) to read:

(h) Geographic limitations.

(1) Notwithstanding the requirement that a district pay tuition to any prequalified public or private provider in the State, a school board may choose to limit the geographic boundaries within which the district shall pay tuition by paying tuition solely to those prequalified providers in which parents and guardians choose to enroll resident prekindergarten children that are located within the district's "prekindergarten region" as determined in subdivision (2) of this subsection.

(2) For purposes of this subsection, upon application from the school board, a district's prekindergarten region shall be determined jointly by the Agencies of Education and of Human Services in consultation with the school board, private providers of prekindergarten education, parents and guardians of prekindergarten children, and other interested parties pursuant to a process adopted by rule under subsection (e) of this section. A prekindergarten region:

(A) shall not be smaller than the geographic boundaries of the school district;

(B) shall be based in part upon the estimated number of prekindergarten children residing in the district and in surrounding districts, the availability of prequalified private and public providers of prekindergarten education, commuting patterns, and other region-specific criteria; and

(C) shall be designed to support existing partnerships between the school district and private providers of prekindergarten education.

(3) If a school board chooses to pay tuition to providers solely within its prekindergarten region, and if a resident prekindergarten child is unable to access publicly funded prekindergarten education within that region, then the child's parent or guardian may request and in its discretion the district may pay tuition at the statewide rate for a prekindergarten education program operated by a prequalified provider located outside the prekindergarten region.

(4) Except for the narrow exception permitting a school board to limit geographic boundaries under subdivision (1) of this subsection, all other provisions of this section and related rules shall continue to apply.

Second: By adding a new section to be Sec. 4a to read:

Sec. 4a. REPORT ON ENROLLMENT AND ACCESS

The Agencies of Education and of Human Services and the Building Bright Futures Council shall monitor and evaluate access to and enrollment in prekindergarten education programs under Sec. 1 of this act. On or before January 1, 2018, they shall report to the House and Senate Committees on Education and on Appropriations, the House Committee on Ways on Means, and the Senate Committee on Finance regarding their evaluation, conclusions, and any recommendations for amendments to statute or related rule.

Third: In Sec. 1, 16 V.S.A. § 829, subsection (e), in subdivision (1), by striking out the reference: "subsection (c)" and inserting in lieu thereof the reference: "subdivision (c)(2) or (3)"

**Amendment to be offered by Rep. Browning of Arlington to the recommendation of amendment of the Committee on Education to H. 270**

First: After Sec. 2, by adding a new section to be Sec. 2a to read:

Sec. 2a. 16 V.S.A. § 4025(a) is amended to read:

(a) An education fund is established to be comprised of the following:

* * *

(2) For each fiscal year, the amount of the general funds appropriated or transferred to the education fund shall be:

(A) $276,240,000.00 increased by the most recent New England economic project cumulative price index, as of November 15, for state and local government purchases of goods and services from fiscal year 2012 through the fiscal year for which the payment is being determined, plus an additional one-tenth of one percent; plus

(B) if there were an increase in the amount of education spending statewide for prekindergarten education between the two most recent fiscal years for which data is available, an amount equal to that increase.

* * *

Second: By striking out Sec. 6 in its entirety and inserting a new Sec. 6 to read:

Sec. 6. EFFECTIVE DATES

(a) This act shall take effect on July 1, 2013.

(b) Secs. 1 and 2 of this act shall apply to enrollments on July 1, 2015 and after.

(c) Sec. 2a of this act shall apply to appropriations and transfers for fiscal year 2016 and after.

## NEW BUSINESS

### Third Reading

### H. 403

An act relating to community supports for persons with serious functional impairments

### H. 450

An act relating to expanding the powers of regional planning commissions

**H. 538**

An act relating to making miscellaneous amendments to education funding laws

**Amendment to be offered by Reps. McCormack of Burlington, Cross of Winooski, Moran of Wardsboro, Pearson of Burlington, and Poirier of Barre City to H. 538**

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

Sec. 8. [Deleted.]

and in Sec. 13, in subsection (f), by striking the words "Secs. 8 (renter rebate) and" and inserting in lieu thereof the word "Sec."

**Amendment to be offered by Reps. McCormack of Burlington, Cross of Winooski, Moran of Wardsboro, and Pearson of Burlington to H. 538**

By adding a Sec. 8a to read:

Sec. 8a. RENTER REBATE STUDY

The Joint Fiscal Office shall report to the General Assembly on different ways to recognize renters as indirect property taxpayers in the context of Vermont's current education funding system. The report shall recognize that renters and property owners both contribute to the education funding system in this State, but that variations in statewide rents and the income limits on the renter rebate claim lead to unequal treatment. The report shall propose methodologies aimed at eliminating these inequities. The report shall be due on or before January 15, 2014 and shall include specific findings and recommendations. The Joint Fiscal Office shall have the assistance of the Department of Taxes and the Office of Legislative Council.

and in Sec. 13, in subsection (g), before the words "Sec. 10" by inserting the words "Sec. 8a (renter rebate study) and"

**S. 1**

An act relating to consideration of financial cost of criminal sentencing options

**S. 151**

An act relating to miscellaneous changes to the laws governing commercial motor vehicle licensing and operation

**Favorable with Amendment**

**S. 14**

An act relating to payment of fair-share fees

**Rep. Moran of Wardsboro,** for the Committee on **General, Housing and Military Affairs,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

* * * State Employees * * *

Sec. 1. 3 V.S.A. § 902 is amended to read:

§ 902. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

* * *

(19) "Collective bargaining service fee" means a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, which is paid to the employee organization which is the exclusive bargaining agent for the bargaining unit of the employee. The collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization, and shall be deducted in the same manner as dues are deducted from the salary or wages of members of the employee organization, and shall be used to defray the costs ~~incurred by the employee organization in fulfilling its duty to represent the employees in their employment relations with the state~~ of chargeable activities.

Sec. 2. 3 V.S.A. § 903 is amended to read:

§ 903. EMPLOYEES' RIGHTS AND DUTIES; PROHIBITED ACTS

(a) Employees shall have the right to self-organization; to form, join, or assist employee organizations; to bargain collectively through representatives of their own choice, and to engage in concerted activities for the purpose of collective bargaining or other mutual aid or protection, and shall also have the right to refrain from any or all such activities, except as provided in ~~subsection (b)~~ subsections (b) and (c) of this section, and to appeal grievances as provided in this chapter.

(b) ~~No~~ A state employee may not strike or recognize a picket line of an employee or labor organization while in the performance of his or her official duties.

(c) An employee who exercises the right not to join the employee organization representing the employee's collective bargaining unit shall pay

the collective bargaining service fee to the representative of the bargaining unit in the same manner as employees who pay membership fees to the representative. The employee organization shall indemnify and hold the employer harmless from any and all claims stemming from the implementation or administration of the collective bargaining service fee. Nothing in this section shall require an employer to discharge an employee who does not pay the collective bargaining service fee.

(d) All employers, their officers, agents, and employees or representatives shall exert every reasonable effort to make and maintain agreements concerning matters allowable under section 904 of this title and to settle all disputes, whether arising out of the application of those agreements~~,~~ or growing out of any dispute between the employer and the employees thereof.

Sec. 3. 3 V.S.A. § 904 is amended to read:

§ 904. SUBJECTS FOR BARGAINING

(a) All matters relating to the relationship between the employer and employees shall be the subject of collective bargaining except those matters which are prescribed or controlled by statute. Such matters appropriate for collective bargaining to the extent they are not prescribed or controlled by statute include ~~but are not limited to~~:

* * *

(9) ~~Rules~~ rules and regulations for personnel administration, except the following: rules and regulations relating to persons exempt from the classified service under section 311 of this title and rules and regulations relating to applicants for employment in state service and employees in an initial probationary status, including any extension or extensions thereof provided such rules and regulations are not discriminatory by reason of an applicant's race, color, creed, sex, or national origin; and

(10) ~~A collective bargaining service fee~~ the manner in which to enforce an employee's obligation to pay the collective bargaining service fee.

* * *

Sec. 4. 3 V.S.A. § 941 is amended to read:

§ 941. UNIT DETERMINATION, CERTIFICATION, AND REPRESENTATION

* * *

(k) Nothing in this chapter requires an individual to seek the assistance of his or her collective bargaining unit or its representative(s) in any grievance

proceeding. He or she may represent himself or herself or be represented by counsel of his or her own choice or may avail himself or herself of the unit representative in grievance proceedings. ~~Employees who are eligible for membership in a collective bargaining unit who exercise their right not to join such unit may upon agreement with the unit representative avail themselves of the services of the unit representative(s) in grievance proceedings upon payment to the unit of a fee established by the unit representative, provided that in the event a collective bargaining service fee is negotiated, the unit representative shall represent nonmember employees in grievance proceedings without charge.~~

Sec. 5. 3 V.S.A. § 962 is amended to read:

§ 962. EMPLOYEES

It shall be an unfair labor practice for an employee organization or its agents:

* * *

(10) To charge a collective bargaining fee ~~negotiated pursuant to section 904 of this title~~ unless such employee organization has established and maintained a procedure to provide nonmembers with:

(A) an audited financial statement that identifies the major categories of expenses, and divides them into chargeable and nonchargeable expenses;

(B) an opportunity to object to the amount of the agency fee sought, any amount reasonably in dispute to be placed in escrow;

(C) prompt arbitration by the board to resolve any objection over the amount of the collective bargaining fee.

* * * Judiciary Employees * * *

Sec. 6. 3 V.S.A. § 1011 is amended to read:

§ 1011. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

* * *

(4) "Collective bargaining service fee," means a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, and that fee is paid to the employee organization that is the exclusive bargaining agent for the bargaining unit of the employee. A collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization; shall be deducted in the same manner as dues are deducted from the salary or wages of members

of the employee organization; and shall be used to defray the costs ~~incurred by the employee organization in fulfilling its duty to represent the employees in their employment relations with the employer~~ of chargeable activities.

* * *

Sec. 7. 3 V.S.A. § 1012 is amended to read:

§ 1012. EMPLOYEES' RIGHTS AND DUTIES; PROHIBITED ACTS

(a) Employees shall have the right to self-organization; to form, join, or assist employee organizations; to bargain collectively through their chosen representatives; to engage in concerted activities of collective bargaining or other mutual aid or protection; to refrain from any or all those activities, except as provided in ~~subsection (b)~~ subsections (b) and (c) of this section; and to appeal grievances as provided in this chapter.

(b) ~~No~~ An employee may not strike or recognize a picket line of an employee organization while performing the employee's official duties.

(c) An employee who exercises the right not to join the employee organization representing the employee's certified unit pursuant to section 1021 of this title shall pay a collective bargaining service fee to the representative of the bargaining unit in the same manner as employees who pay membership fees to the representative. The employee organization shall indemnify and hold the employer harmless from any and all claims stemming from the implementation or administration of the collective bargaining service fee. Nothing in this section shall require an employer to discharge an employee who does not pay the collective bargaining service fee.

~~(c)~~(d) The employer and employees and the employee's representative shall exert every reasonable effort to make and maintain agreements concerning matters allowable under section 1013 of this title and to settle all disputes, whether arising out of the application of those agreements or growing out of any dispute between the employer and the employees.

Sec. 8. 3 V.S.A. § 1013 is amended to read:

§ 1013. SUBJECTS FOR BARGAINING

All matters relating to the relationship between the employer and employees are subject to collective bargaining, to the extent those matters are not prescribed or controlled by law, including:

* * *

(10) ~~A collective bargaining service fee~~ the manner in which to enforce an employee's obligation to pay the collective bargaining service fee.

Sec. 9. 3 V.S.A. § 1027 is amended to read:

§ 1027. EMPLOYEES

It shall be an unfair labor practice for an employee organization or its agents:

* * *

(10) To charge a ~~negotiated~~ collective bargaining fee unless the employee organization has established and maintained a procedure to provide nonmembers with all the following:

(A) An audited financial statement that identifies the major categories of expenses and divides them into chargeable and nonchargeable expenses.

(B) An opportunity to object to the amount of the fee requested and to place in escrow any amount reasonably in dispute.

(C) Prompt arbitration by the board to resolve any objection over the amount of the collective bargaining fee.

* * * Teachers * * *

Sec. 10. 16 V.S.A. § 1981 is amended to read:

§ 1981. DEFINITIONS

As used in this chapter unless the context requires otherwise:

* * *

(7) "Agency fee" ~~means a fee for representation in collective bargaining, not exceeding teachers' or administrators' organization dues, payable to the organization which is the exclusive bargaining agent for teachers or administrators in a bargaining unit, from individuals who are not members of the organization~~ means a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, which is paid to the employee organization that is the exclusive bargaining agent for the bargaining unit of the employee. The collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization and shall be deducted in the same manner as dues are deducted from the salary or wages of members of the employee organization and shall be used to defray the costs of chargeable activities.

* * *

Sec. 11. 16 V.S.A. § 1982 is amended to read:

§ 1982. RIGHTS

(a) Teachers shall have the right to or not to join, assist, or participate in any teachers' organization of their choosing. However, teachers ~~may be required to pay an agency fee~~ who choose not to join the teachers' organization, recognized as the exclusive representative pursuant to ~~an agreement negotiated under~~ section 1992 of this chapter, shall pay the agency fee in the same manner as teachers who choose to join the teachers' organization pay membership fees. The teachers' organization shall indemnify and hold the school board harmless from any and all claims stemming from the implementation or administration of the agency fee.

(b) Principals, assistant principals, and administrators other than superintendent and assistant superintendent shall have the right to or not to join, assist, or participate in any administrators' organization or as a separate unit of any teachers' organization of their choosing. However, subject to the provisions of subsection (d) of this section, administrators other than the superintendent and assistant superintendent ~~may be required to pay an agency fee~~ who choose not to join the administrators' organization, recognized as the exclusive representative pursuant to ~~an agreement negotiated under~~ section 1992 of this chapter, shall pay the agency fee in the same manner as administrators who choose to join the administrators' organization pay membership fees. The administrators' organization agrees to indemnify and hold the school harmless from any and all claims stemming from the implementation or administration of the agency fee.

(c) ~~Neither the~~ The school board ~~nor~~ or any employee of the school board serving in any capacity~~, nor~~ or any other person or organization shall not interfere with, restrain, coerce, or discriminate in any way against or for any teacher or administrator engaged in activities protected by this legislation.

(d) A teachers' or administrators' organization shall not charge the agency fee unless it has established and maintained a procedure to provide nonmembers with:

(1) an audited financial statement that identifies the major categories of expenses and divides them into chargeable and nonchargeable expenses;

(2) an opportunity to object to the amount of the agency fee sought, and to place in escrow any amount reasonably in dispute;

(3) prompt arbitration by an arbitrator selected jointly by the objecting fee payer and the teachers' or administrators' organization or pursuant to the rules of the American Arbitration Association to resolve any objection over the amount of the agency fee. The costs of arbitration shall be paid by the teachers' or administrators' organization.

(e) Nothing in this section shall require an employer to discharge an employee who does not pay the agency fee.

Sec. 12. 16 V.S.A. § 2004 is amended to read:

§ 2004. AGENDA

The school board, through its negotiations council, shall, upon request, negotiate with representatives of the teachers' or administrators' organization negotiations council on matters of salary, related economic conditions of employment, ~~an~~ the manner in which it will enforce an employee's obligation to pay the agency service fee, procedures for processing complaints and grievances relating to employment, and any mutually agreed upon matters not in conflict with the statutes and laws of the ~~state~~ State of Vermont.

* * * Certain Private Sector Employees * * *

Sec. 13. 21 V.S.A. § 1502 is amended to read:

§ 1502. DEFINITIONS

~~In~~ As used in this chapter ~~the following words shall have the following meaning~~:

* * *

(14) "Agency fee" means a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, which is paid to the employee organization that is the exclusive bargaining agent for the bargaining unit of the employee. A collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization and shall be deducted in the same manner as dues are deducted from the salary or wages of members of the employee organization and shall be used to defray the costs of chargeable activities.

Sec. 14. 21 V.S.A. § 1503 is amended to read:

§ 1503. RIGHTS OF EMPLOYEES; MUTUAL DUTY TO BARGAIN

(a) Employees shall have the right to self-organization; to form, join, or assist labor organizations; to bargain collectively through representatives of their own choice, and to engage in concerted activities for the purpose of collective bargaining or other mutual aid or protection, and shall also have the right to refrain from any or all such activities, except to the extent that such right may be affected by an agreement requiring membership in a labor organization as a condition of employment as authorized in ~~section~~ subsection 1621(a) of this title. An employee who exercises the right not to join the labor organization representing the employee's certified unit pursuant to section 1581 of this title shall, subject to subsection (b) of this section, pay the agency

fee to the representative of the bargaining unit in the same manner as employees who pay membership fees to the representative. The labor organization agrees to indemnify and hold the employer harmless from any and all claims stemming from the implementation or administration of the agency fee.

(b) A labor organization shall not charge the agency fee unless it has established and maintained a procedure to provide nonmembers with:

(1) an audited financial statement that identifies the major categories of expenses and divides them into chargeable and nonchargeable expenses;

(2) an opportunity to object to the amount of the agency fee sought, and to place in escrow any amount reasonably in dispute;

(3) prompt arbitration by an arbitrator selected jointly by the objecting fee payer and the teachers' or administrators' organization or pursuant to the rules of the American Arbitration Association to resolve any objection over the amount of the agency fee. The costs of arbitration shall be paid by the labor organization.

Sec. 15. 21 V.S.A. § 1621 is amended to read:

§ 1621. UNFAIR LABOR PRACTICES

(a) It shall be an unfair labor practice for an employer:

* * *

(6) Nothing in this chapter or any other statute of this state shall preclude an employer from making an agreement with a labor organization (not established, maintained or assisted by any action defined in this subsection (a) as an unfair labor practice) to require as a condition of employment membership in such labor organization on or after the 30th day following the beginning of such employment or the effective date of such agreement, whichever is the later, (i) if such labor organization is the representative of the employees as provided in section 1583 of this chapter, in the appropriate collective bargaining unit covered by such agreement when made; and (ii) unless following an election held as provided in section 1584 of this chapter within one year preceding the effective date of such agreement, the ~~board~~ Board shall have certified that at least a majority of the employees eligible to vote in such election have voted to rescind the authority of such labor organization to make such an agreement. Nothing in this section shall require an employer to discharge an employee in the absence of such an agreement. ~~No~~ An employer shall not justify any discrimination against an employee for nonmembership in a labor organization:

(A) ~~If~~ if the employer has reasonable grounds for believing that

membership was not available to the employee on the same terms and conditions generally applicable to other members; or

(B) ~~If~~ if the employer has reasonable grounds for believing that membership was denied or terminated for reasons other than the failure of the employee to tender the periodic dues and the initiation fees uniformly required as a condition of acquiring or retaining membership.

* * *

(b) It shall be an unfair labor practice for a labor organization or its agents:

* * *

(5) To require employees covered by ~~a~~ the agency fee requirement or other union security agreement authorized under subsection (a) of this section to pay, as a condition precedent to becoming a member of such organization, a fee in an amount which the ~~board~~ Board finds excessive or discriminatory under all the circumstances. In making such a finding, the ~~board~~ Board shall consider, among other relevant factors, the practices and customs of labor organizations in the particular industry, and the wages currently paid to the employees affected.

* * *

* * * Municipal Employees * * *

Sec. 16. 21 V.S.A. § 1722 is amended to read;

§ 1722. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

(1) "Agency service fee" means a fee ~~for representation in collective bargaining not exceeding employee organization dues, payable to an employee organization which is the exclusive bargaining agent for employees in a bargaining unit from individuals who are not members of the employee organization~~ a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, which is paid to the employee organization that is the exclusive bargaining agent for the bargaining unit of the employee. A collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization and shall be deducted in the same manner as dues are deducted from the salary or wages of members of the employee organization and shall be used to defray the costs of chargeable activities.

* * *

Sec. 17. 21 V.S.A. § 1726 is amended to read:

§ 1726. UNFAIR LABOR PRACTICES

(a) It shall be an unfair labor practice for an employer:

* * *

(8) ~~Nothing in this chapter or any other statute of this state shall preclude a municipal employer from making an agreement with the exclusive bargaining agent to require an agency service~~ A municipal employer and the exclusive bargaining agent may agree to require the agency service fee to be paid as a condition of employment, or ~~to~~ require as a condition of employment membership in such employee organization on or after the 30th day following the beginning of such employment or the effective date of such agreement, whichever is the later. Nothing in this section shall require an employer to discharge an employee in the absence of such an agreement. ~~No~~ A municipal employer shall not discharge or discriminate against any employee for nonpayment of ~~an~~ the agency service fee or for nonmembership in an employee organization:

(A) ~~If~~ if the employer has reasonable grounds for believing that membership was not available to the employee on the same terms and conditions generally applicable to other members; or

(B) ~~If~~ if the employer has reasonable grounds for believing that membership was denied or terminated for reasons other than the failure of the employee to tender the periodic dues and the initiation fees uniformly required as a condition of acquiring or retaining membership.

(b) It shall be an unfair labor practice for an employee organization or its agents:

* * *

(6) ~~To~~ to require employees covered by ~~an~~ the agency service fee ~~agreement~~ requirement or other union security agreement authorized under subsection (a) of this section to pay an initiation fee which the ~~board~~ Board finds excessive or discriminatory under all the circumstances, including the practices and customs of employee organizations representing municipal employees~~,~~ and the wages paid to the employees affected.

* * *

(12) to charge the agency service fee unless the employee organization has established and maintained a procedure to provide nonmembers with all the following:

(A) an audited financial statement that identifies the major categories of expenses and divides them into chargeable and nonchargeable expenses;

(B) an opportunity to object to the amount of the fee requested and to place in escrow any amount reasonably in dispute; and

(C) prompt arbitration by an arbitrator selected jointly by the objecting fee payer and the employee organization or pursuant to the rules of the American Arbitration Association to resolve any objection over the amount of the agency service fee. The costs of arbitration shall be paid by the employee organization.

Sec. 18. 21 V.S.A. § 1734 is amended to read:

§ 1734. MISCELLANEOUS

(a) Municipal employees and exclusive bargaining agents are authorized to negotiate provisions in a collective bargaining agreement calling for:

(1) ~~Payroll~~ payroll deduction of employee organization dues and initiation fees~~, or an agency service fee~~;

(2) ~~Binding~~ binding arbitration of grievances involving the interpretation or application of a written collective bargaining agreement. The cost of arbitration shall be shared equally by the parties.

* * *

(d) In the absence of an agreement requiring an employee to be a member of the employee organization, an employee choosing not to be a member of the employee organization shall pay the agency service fee in the same manner as employees who choose to join the employee organization pay dues. The employee organization shall indemnify and hold the employer harmless from any and all claims stemming from the implementation or administration of the agency service fee.

* * * Moderation of Union Dues * * *

Sec. 19. MODERATION OF UNION DUES

An employee organization shall use any increased revenue resulting from the implementation of this act solely for the purpose of moderating its existing membership dues.

* * * Effective Dates * * *

Sec. 20. EFFECTIVE DATES

This act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 on the date following the expiration date stated in the collective bargaining agreement, if any, then in effect, but in no event shall an employee be required to pay an agency fee under this act for any period prior

to July 1, 2013 unless an existing collective bargaining agreement requires payment of the fee. In the event that no collective bargaining agreement is in effect on June 30, 2013, this act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 on July 1, 2013.

and that after passage the title of the bill be amended to read: "An act relating to payment of agency fees and collective bargaining service fees"

**(Committee vote: 5-2-1 )**

**(For text see Senate Journal 2/1/2013 and 2/6/2013 )**

**Amendment to be offered by Rep. Townsend of Randolph to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

By striking out Sec. 20 in its entirety and inserting in lieu thereof a new Sec. 20 to read:

Sec. 20. EFFECTIVE DATES; TRANSITIONAL PROVISIONS

(a) This act shall take effect on June 30, 2013 and apply to employees hired after the effective date of this act and who are subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22.

(b) Notwithstanding any provision of law to the contrary, this act shall not apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 who have not paid a negotiated agency fee prior to the effective date of this act.

**Amendment to be offered by Rep. Bouchard of Colchester to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

In Sec. 20 by striking out the section in its entirety and inserting in lieu thereof the following:

Sec. 20. EFFECTIVE DATE; TRANSITIONAL PROVISIONS

(a) This act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 on the date following the expiration date stated in the collective bargaining agreement, if any agreement is then in effect.

(b) Notwithstanding subsection (a) of this section, this act shall not apply to employees subject to 3 V.S.A chapter 27 who have not paid an agency fee prior to June 30, 2013.

(c) In no event shall an employee be required to pay an agency fee under

this act for any period prior to July 1, 2013 unless an existing collective bargaining agreement requires payment of the fee.

(d) In the event that no collective bargaining agreement is in effect on June 30, 2013, this act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 on July 1, 2013.

**Amendment to be offered by Rep. Bouchard of Colchester to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

In Sec. 20 by striking out the section in its entirety and inserting in lieu thereof the following:

Sec. 20. EFFECTIVE DATE; TRANSITIONAL PROVISIONS

(a) This act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 on the date following the expiration date stated in the collective bargaining agreement, if any agreement is then in effect.

(b) Notwithstanding subsection (a) of this section, this act shall not apply to noncertified employees of a school district subject to 21 V.S.A chapter 22 whether or not they have paid an agency fee prior to June 30, 2013.

(c) In no event shall an employee be required to pay an agency fee under this act for any period prior to July 1, 2013 unless an existing collective bargaining agreement requires payment of the fee.

(d) In the event that no collective bargaining agreement is in effect on June 30, 2013, this act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 on July 1, 2013.

**Amendment to be offered by Rep. Bouchard of Colchester to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

First: By adding Sec. 5a to read:

Sec. 5a. 3 V.S.A. § 1008 is added to read:

§ 1008. CERTIFICATION

On or before December 1, 2018 and every five years thereafter, the Board shall conduct an election to certify the exclusive representative of the collective bargaining unit. The Board shall certify any exclusive representative that receives at least 51 percent of the votes of all employees in the bargaining

unit. If no representative receives at least 51 percent of the votes of all the employees in the bargaining unit, at the expiration of the collective bargaining agreement, the Board shall decertify the current representative and the employees shall not be represented.

Second: By adding Sec. 9a to read:

Sec. 9a. 3 V.S.A. § 1044 is added to read:

§ 1044. CERTIFICATION

On or before December 1, 2018 and every five years thereafter, the Board shall conduct an election to certify the exclusive representative of the collective bargaining unit. The Board shall certify any exclusive representative that receives at least 51 percent of the votes of all employees in the bargaining unit. If no representative receives at least 51 percent of the votes of all the employees in the bargaining unit, at the expiration of the collective bargaining agreement, the Board shall decertify the current representative and the employees shall not be represented.

Third: By adding Sec. 13a to read:

Sec. 13a. 16 V.S.A. § 2028 is added to read:

§ 2028. CERTIFICATION

On or before December 1, 2018 and every five years thereafter, the Board shall conduct an election to certify the exclusive representative of the collective bargaining unit. The Board shall certify any exclusive representative that receives at least 51 percent of the votes of all employees in the bargaining unit. If no representative receives at least 51 percent of the votes of all the employees in the bargaining unit, at the expiration of the collective bargaining agreement, the Board shall decertify the current representative and the employees shall not be represented.

Fourth: By adding Sec. 15a to read:

Sec. 15a. 21 V.S.A. § 1624 is added to read:

§ 1624. CERTIFICATION

On or before December 1, 2018 and every five years thereafter, the Board shall conduct an election to certify the exclusive representative of the collective bargaining unit. The Board shall certify any exclusive representative that receives at least 51 percent of the votes of all employees in the bargaining unit. If no representative receives at least 51 percent of the votes of all the employees in the bargaining unit, at the expiration of the collective bargaining agreement, the Board shall decertify the current representative and the employees shall not be represented.

Fifth: By adding Sec. 18a to read:

Sec. 18a. 21 V.S.A. § 1736 is added to read:

§ 1624. CERTIFICATION

On or before December 1, 2018 and every five years thereafter, the Board shall conduct an election to certify the exclusive representative of the collective bargaining unit. The Board shall certify any exclusive representative that receives at least 51 percent of the votes of all employees in the bargaining unit. If no representative receives at least 51 percent of the votes of all the employees in the bargaining unit, at the expiration of the collective bargaining agreement, the Board shall decertify the current representative and the employees shall not be represented.

Sixth: In Sec. 20, EFFECTIVE DATES, by adding a sentence at the end of the section to read: "Secs. 5a, 9a, 13a, 15a, and 18a of this act shall take effect on July 1, 2018."

**Amendment to be offered by Rep. Browning of Arlington to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

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

Sec. 1. 3 V.S.A. § 902 is amended to read:

§ 902. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

* * *

(6) "Employee organization," means an organization of any kind in which employees participate and which exists for the purpose of representing its members, if certified by the board as ~~an exclusive~~ a representative for the purposes of collective bargaining.

* * *

(19) ~~"Collective bargaining service fee" means a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, which is paid to the employee organization which is the exclusive bargaining agent for the bargaining unit of the employee. The collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization, and shall be deducted in the same manner as dues are deducted from the salary or wages of members of the employee organization, and shall be used to defray the costs~~

~~incurred by the employee organization in fulfilling its duty to represent the employees in their employment relations with the state.~~ [Repealed.]

Sec. 2. 3 V.S.A. § 904 is amended to read:

§ 904. SUBJECTS FOR BARGAINING

(a) All matters relating to the relationship between the employer and employees shall be the subject of collective bargaining except those matters which are prescribed or controlled by statute. Such matters appropriate for collective bargaining to the extent they are not prescribed or controlled by statute include ~~but are not limited to~~:

* * *

(9) Rules and regulations for personnel administration, except the following: rules and regulations relating to persons exempt from the classified service under section 311 of this title and rules and regulations relating to applicants for employment in state service and employees in an initial probationary status including any extension or extensions thereof provided such rules and regulations are not discriminatory by reason of an applicant's race, color, creed, sex or national origin~~; and~~

~~(10) A collective bargaining service fee~~.

* * *

Sec. 3. 3 V.S.A. § 962 is amended to read:

§ 962. EMPLOYEES

It shall be an unfair labor practice for an employee organization or its agents:

* * *

(10) ~~To charge a collective bargaining fee negotiated pursuant to section 904 of this title unless such employee organization has established and maintained a procedure to provide nonmembers with:~~

~~(A) an audited financial statement that identifies the major categories of expenses, and divides them into chargeable and nonchargeable expenses;~~

~~(B) an opportunity to object to the amount of the agency fee sought, any amount reasonably in dispute to be placed in escrow;~~

~~(C) prompt arbitration by the board to resolve any objection over the amount of the collective bargaining fee.~~ [Repealed.]

Sec. 4. 3 V.S.A. § 1008 is added to read:

§ 1008. EMPLOYEE ORGANIZATION; MEMBERS AND NONMEMBERS; SEPARATE AGREEMENTS

Notwithstanding any provision of law to the contrary, the employee organization shall be the representative only of those employees that join the organization. The employee organization is not required to represent nonmembers in grievance proceedings. The State shall negotiate a separate agreement regarding the terms and conditions of employment with those employees who choose not to join the employee organization.

Sec. 5. 3 V.S.A. § 1011 is amended to read:

§ 1011. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

* * *

(4) ~~"Collective bargaining service fee," means a fee deducted by an employer from the salary or wages of an employee who is not a member of an employee organization, and that fee is paid to the employee organization that is the exclusive bargaining agent for the bargaining unit of the employee. A collective bargaining service fee shall not exceed 85 percent of the amount payable as dues by members of the employee organization; shall be deducted in the same manner as dues are deducted from the salary or wages of members of the employee organization; and shall be used to defray the costs incurred by the employee organization in fulfilling its duty to represent the employees in their employment relations with the employer.~~ [Repealed.]

* * *

(9) "Employee organization," means an organization of any kind in which employees participate and that exists for the purpose of representing its members, if certified by the board as ~~an exclusive~~ a representative for the purposes of collective bargaining.

* * *

Sec. 6. 3 V.S.A. § 1013 is amended to read:

§ 1013. SUBJECTS FOR BARGAINING

All matters relating to the relationship between the employer and employees are subject to collective bargaining, to the extent those matters are not prescribed or controlled by law, including:

* * *

(10) ~~A collective bargaining service fee.~~ [Repealed.]

Sec. 7. 3 V.S.A. § 1027 is amended to read:

§ 1027. EMPLOYEES

It shall be an unfair labor practice for an employee organization or its agents:

* * *

(10) ~~To charge a negotiated collective bargaining fee unless the employee organization has established and maintained a procedure to provide nonmembers with all the following:~~

~~(A) An audited financial statement that identifies the major categories of expenses and divides them into chargeable and nonchargeable expenses.~~

~~(B) An opportunity to object to the amount of the fee requested and to place in escrow any amount reasonably in dispute.~~

~~(C) Prompt arbitration by the board to resolve any objection over the amount of the collective bargaining fee.~~ [Repealed.]

Sec. 8. 3 V.S.A. § 1044 is added to read:

§ 1044. EMPLOYEE ORGANIZATION; MEMBERS AND NONMEMBERS; SEPARATE AGREEMENTS

Notwithstanding any provision of law to the contrary, the employee organization shall be the representative only of those employees that join the organization. The employee organization is not required to represent nonmembers in grievance proceedings. The State shall negotiate a separate agreement regarding the terms and conditions of employment with those employees who choose not to join the employee organization.

Sec. 9. 16 V.S.A. § 1981 is amended to read:

§ 1981. DEFINITIONS

As used in this chapter unless the context requires otherwise:

* * *

(7) ~~"Agency fee" means a fee for representation in collective bargaining, not exceeding teachers' or administrators' organization dues, payable to the organization which is the exclusive bargaining agent for teachers or administrators in a bargaining unit, from individuals who are not members of the organization.~~ [Repealed.]

* * *

Sec. 10. 16 V.S.A. § 1991 is amended to read:

§ 1991. SELECTION OF REPRESENTATION

(a) Teachers and administrators may select organizations to represent them on their negotiations council in collective negotiations with the school board negotiations council. The school board shall recognize an organization as ~~the exclusive~~ a representative of the teachers or of the administrators in the school district ~~when that organization has proved its claim to sole and exclusive representative status of the respective group as hereinafter provided~~. The superintendent, the assistant superintendent, and the principal shall not serve as negotiating agents for the teachers' organization.

(b) When close or disputed questions of eligibility to vote and inclusion in the unit to be represented by the teachers' organization arise, the general principle to be adhered to shall be that eligibility to vote and inclusion in that negotiating unit will be limited to all teachers in the school district under contract and actually engaged in full-time or part-time positions which are not that of administrator.

(c) ~~The organizations selected to represent teachers or administrators shall represent without discrimination or prejudice all of those eligible for inclusion in the negotiating unit without regard to organizational affiliation or membership.~~ [Repealed.]

Sec. 11. 16 V.S.A. § 2028 is added to read:

§ 2028. EMPLOYEE ORGANIZATION; MEMBERS AND NONMEMBERS; SEPARATE AGREEMENTS

Notwithstanding any provision of law to the contrary, the teachers' or administrators' organization shall be the representative only of those teachers or administrators that join the organization. The organization is not required to represent nonmembers in grievance proceedings. The school board negotiations council shall negotiate a separate agreement regarding the terms and conditions of employment with those teachers or administrators who choose not to join the organization.

Sec. 12. 21 V.S.A. § 1583 is amended to read:

§ 1583. POWERS OF REPRESENTATIVES

Representatives designated or selected for the purposes of collective bargaining by the majority of the employees in a unit appropriate for such purposes shall be the ~~exclusive~~ representatives of all ~~the employees~~ members of the labor organization in such unit for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment. However, any individual employee or group of employees shall have the right at any time to present grievances to their employer and to have

such grievances adjusted, without the intervention of the bargaining representative, as long as the adjustment is not inconsistent with the terms of a collective bargaining contract or agreement then in effect, provided that the bargaining representative has been given an opportunity to be present at such adjustment.

Sec. 13. 21 V.S.A. § 1624 is added to read:

§ 1624. LABOR ORGANIZATION; MEMBERS AND NONMEMBERS; SEPARATE AGREEMENTS

Notwithstanding any provision of law to the contrary, the labor organization shall be the representative only of those employees that join the organization. The labor organization is not required to represent nonmembers in grievance proceedings. The State shall negotiate a separate agreement regarding the terms and conditions of employment with those employees who choose not to join the labor organization.

Sec. 14. 21 V.S.A. § 1722 is amended to read:

§ 1722. DEFINITIONS

~~For the purposes of~~ As used in this chapter:

(1) "~~Agency service fee" means a fee for representation in collective bargaining not exceeding employee organization dues, payable to an employee organization which is the exclusive bargaining agent for employees in a bargaining unit from individuals who are not members of the employee organization.~~ [Repealed.]

* * *

(8) "Exclusive bargaining agent" means the employee organization certified by the board or recognized by the employer as ~~the only~~ an organization to bargain collectively for all ~~employees in the bargaining unit, including persons who are not~~ members of the employee organization.

* * *

Sec. 15. 21 V.S.A. § 1736 is added to read:

§ 1736. EMPLOYEE ORGANIZATION; MEMBERS AND NONMEMBERS; SEPARATE AGREEMENTS

Notwithstanding any provision of law to the contrary, the employee organization shall be the representative only of those employees that join the organization. The employee organization is not required to represent nonmembers in grievance proceedings. The State shall negotiate a separate agreement regarding the terms and conditions of employment with those employees who choose not to join the employee organization.

Sec. 16. EFFECTIVE DATE

This act shall take effect on July 1, 2013.

**Amendment to be offered by Rep. Browning of Arlington to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

By striking Sec. 19 in its entirety and inserting in lieu thereof a new Sec. 19 to read:

Sec. 19. RETIREMENT FUNDS; PROCEEDS OF AGENCY FEE

Any increased revenue resulting from the implementation of this act shall be paid into the appropriate retirement fund for employees organized pursuant to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22. In the event that there is no retirement fund, the increased revenue shall be used to reduce the dues paid by union members.

**Amendment to be offered by Rep. Browning of Arlington to the recommendation of amendment of the Committee on General, Housing and Military Affairs to S. 14**

By striking out Sec. 20 in its entirety and inserting in lieu thereof a new Sec. 20 to read:

Sec. 20. EFFECTIVE DATES; TRANSISTIONAL PROVISIONS

This act shall take effect on June 30, 2013 and apply to employees subject to 3 V.S.A. chapters 27 and 28, 16 V.S.A. chapter 57, and 21 V.S.A. chapters 19 and 22 only when the employer and the employee organization enter into a collective bargaining agreement that contains an explicit provision regarding merit pay. The provision shall contain factors for determining merit pay and pay increases and shall include a factor based on employee performance as evaluated by standards determined by the employer.

**S. 30**

An act relating to siting of electric generation plants

**Rep. Klein of East Montpelier,** for the Committee on **Natural Resources and Energy,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. LEGISLATIVE REVIEW; SITING POLICY COMMISSION REPORT

During adjournment between the 2013 and 2014 sessions of the General

Assembly:

(1) The House and Senate Committees on Natural Resources and Energy (the Committees) jointly shall review the report and recommendations of the Governor's Energy Siting Policy Commission created by Executive Order No. 10-12 dated October 2, 2012; may consider any issue related to electric generation plants, including their development, siting, and operation; and may recommend legislation to the General Assembly concerning electric generation plants.

(2) The Committees shall meet jointly for the purposes of this section no more than six times at the call of the chairs. For attendance at these meetings, members of the Committees shall be entitled to compensation and reimbursement for expenses as provided in 2 V.S.A. § 406.

Sec. 2. EFFECTIVE DATE

This act shall take effect on passage.

**(Committee vote: 11-0-0 )**

**(For text see Senate Journal 2/28/2013 and 3/26/2013 )**

**Amendment to be offered by Rep. Johnson of Canaan to S. 30**

By inserting a new section 2 to read:

Sec. 2. 30 V.S.A. § 248(b)(5) is amended to read:

(5) with respect to an in-state facility, will not have an undue adverse effect on esthetics, historic sites, air and water purity, the natural environment, the use of natural resources, and the public health and safety, with due consideration having been given to the criteria specified in 10 V.S.A. §§ 1424a(d) and 6086(a)(1) through (8), (9)(B), and (9)(K), the mitigation requirements of 10 V.S.A. § 6093, and greenhouse gas impacts;

and by renumbering the remaining section to be numerically correct.

**S. 77**

An act relating to patient choice and control at end of life

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

Sec. 1. 18 V.S.A. chapter 113 is added to read:

CHAPTER 113. RIGHTS OF QUALIFIED PATIENTS

SUFFERING A TERMINAL CONDITION

§ 5281. DEFINITIONS

As used in this chapter:

(1) "Capable" means that in the opinion of a court or in the opinion of the patient's prescribing physician, consulting physician, psychiatrist, psychologist, or clinical social worker, a patient has the ability to make and communicate health care decisions to health care providers, including communication through persons familiar with the patient's manner of communicating if those persons are available.

(2) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's illness and who is willing to participate in the provision to a qualified patient of medication to hasten his or her death in accordance with this chapter.

(3) "Dispense" means to prepare and deliver pursuant to a lawful order of a physician a prescription drug in a suitable container appropriately labeled for subsequent use by a patient entitled to receive the prescription drug. The term shall not include the actual administration of a prescription drug to the patient.

(4) "Evaluation" means a consultation between a psychiatrist, psychologist, or clinical social worker licensed in Vermont and a patient for the purpose of confirming that the patient:

(A) is capable; and

(B) does not have impaired judgment.

(5) "Good faith" means objective good faith.

(6) "Health care facility" shall have the same meaning as in section 9432 of this title.

(7) "Health care provider" means a person, partnership, corporation, facility, or institution, licensed or certified or authorized by law to administer health care or dispense medication in the ordinary course of business or practice of a profession.

(8) "Hospice care" means a program of care and support provided by a Medicare-certified hospice provider to help an individual with a terminal condition to live comfortably by providing palliative care, including effective pain and symptom management. Hospice care may include services provided by an interdisciplinary team that are intended to address the physical, emotional, psychosocial, and spiritual needs of the individual and his or her family.

(9) "Informed decision" means a decision by a patient to request and obtain a prescription for medication to be self-administered to hasten his or her death based on the patient's understanding and appreciation of the relevant facts that was made after the patient was fully informed by the prescribing physician of all the following:

(A) the patient's medical diagnosis;

(B) the patient's prognosis, including an acknowledgement that the physician's prediction of the patient's life expectancy is an estimate based on the physician's best medical judgment and is not a guarantee of the actual time remaining in the patient's life, and that the patient may live longer than the time predicted;

(C) the range of treatment options appropriate for the patient and the patient's diagnosis;

(D) all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;

(E) the range of possible results, including potential risks associated with taking the medication to be prescribed; and

(F) the probable result of taking the medication to be prescribed.

(10) "Palliative care" shall have the same meaning as in section 2 of this title.

(11) "Patient" means a person who is 18 years of age or older, a resident of Vermont, and under the care of a physician.

(12) "Physician" means a physician licensed pursuant to 26 V.S.A. chapter 23 or 33.

(13) "Prescribing physician" means the physician whom the patient has designated to have primary responsibility for the care of the patient and who is willing to participate in the provision to a qualified patient of medication to hasten his or her death in accordance with this chapter.

(14)(A) "Qualified patient" means a patient who:

(i) is capable;

(ii) is physically able to self-administer medication;

(iii) has executed an advance directive in accordance with chapter 231 of this title;

(iv) is enrolled in hospice care; and

(v) has satisfied the requirements of this chapter in order to obtain

a prescription for medication to hasten his or her death.

(B) An individual shall not qualify under the provisions of this chapter solely because of age or disability.

(15) "Terminal condition" means an incurable and irreversible disease which would, within reasonable medical judgment, result in death within six months.

§ 5282. REQUESTS FOR MEDICATION

(a) In order to qualify under this chapter:

(1) A patient who is capable, who has been determined by the prescribing physician and consulting physician to be suffering from a terminal condition, and who has voluntarily expressed a wish to hasten the dying process may request medication to be self-administered for the purpose of hastening his or her death in accordance with this chapter.

(2) A patient shall have made an oral request and a written request and shall have reaffirmed the oral request to his or her prescribing physician not less than 15 days after the initial oral request. At the time the patient makes the second oral request, the prescribing physician shall offer the patient an opportunity to rescind the request.

(b) Oral requests for medication by the patient under this chapter shall be made in the physical presence of the prescribing physician.

(c) A written request for medication shall be signed and dated by the patient and witnessed by at least two persons, at least 18 years of age, who, in the presence of the patient, sign and affirm that the patient appears to understand the nature of the document and to be free from duress or undue influence at the time the request was signed. Neither witness shall be any of the following persons:

(1) the patient's prescribing physician, consulting physician, or any person who has conducted an evaluation of the patient pursuant to section 5285 of this title;

(2) a person who knows that he or she is a relative of the patient by blood, civil marriage, civil union, or adoption;

(3) a person who at the time the request is signed knows that he or she would be entitled upon the patient's death to any portion of the estate or assets of the patient under any will or trust, by operation of law, or by contract; or

(4) an owner, operator, or employee of a health care facility, nursing home, or residential care facility where the patient is receiving medical treatment or is a resident.

(d) A person who knowingly fails to comply with the requirements in subsection (c) of this section is subject to prosecution under 13 V.S.A. § 2004.

(e) The written request shall be completed only after the patient has been examined by a consulting physician as required under section 5284 of this title.

(f)(1) Under no circumstances shall a guardian or conservator be permitted to act on behalf of a ward for purposes of this chapter.

(2) Under no circumstances shall an agent under an advance directive be permitted to act on behalf of a principal for purposes of this chapter.

§ 5283. PRESCRIBING PHYSICIAN; DUTIES

The prescribing physician shall perform all the following:

(1) determine whether a patient:

(A) is suffering a terminal condition, based on the prescribing physician's physical examination of the patient and review of the patient's relevant medical records;

(B) is capable;

(C) has executed an advance directive in accordance with chapter 231 of this title;

(D) is enrolled in hospice care;

(E) is making an informed decision; and

(F) has made a voluntary request for medication to hasten his or her death;

(2) require proof of Vermont residency, which may be shown by:

(A) a Vermont driver's license or photo identification card;

(B) proof of Vermont voter's registration; or

(C) a Vermont resident personal income tax return for the most recent tax year;

(3) inform the patient in person, both verbally and in writing, of all the following:

(A) the patient's medical diagnosis;

(B) the patient's prognosis, including an acknowledgement that the physician's prediction of the patient's life expectancy is an estimate based on the physician's best medical judgment and is not a guarantee of the actual time remaining in the patient's life, and that the patient may live longer than the time predicted;

(C) the range of treatment options appropriate for the patient and the patient's diagnosis;

(D) all feasible end-of-life services, including palliative care, comfort care, hospice care, and pain control;

(E) the range of possible results, including potential risks associated with taking the medication to be prescribed; and

(F) the probable result of taking the medication to be prescribed;

(4) refer the patient to a consulting physician for medical confirmation of the diagnosis, prognosis, and a determination that the patient is capable and is acting voluntarily;

(5) verify that the patient does not have impaired judgment or refer the patient for an evaluation under section 5285 of this chapter;

(6) with the patient's consent, consult with the patient's primary care physician, if the patient has one;

(7) recommend that the patient notify the next of kin or someone with whom the patient has a significant relationship;

(8) counsel the patient about the importance of ensuring that another individual is present when the patient takes the medication prescribed pursuant to this chapter and the importance of not taking the medication in a public place;

(9)(A) inform the patient that the patient has an opportunity to rescind the request at any time and in any manner; and

(B) offer the patient an opportunity to rescind after the patient's second oral request;

(10) verify, immediately prior to writing the prescription for medication under this chapter, that the patient is making an informed decision;

(11) fulfill the medical record documentation requirements of section 5290 of this title;

(12) ensure that all required steps are carried out in accordance with this chapter prior to writing a prescription for medication to hasten death; and

(13)(A) dispense medication directly, including ancillary medication intended to facilitate the desired effect while minimizing the patient's discomfort, provided the prescribing physician is licensed to dispense medication in Vermont, has a current Drug Enforcement Administration certificate, and complies with any applicable administrative rules; or

(B) with the patient's written consent:

(i) contact a pharmacist and inform the pharmacist of the prescription; and

(ii) deliver the written prescription personally or by mail or facsimile to the pharmacist, who will dispense the medication to the patient, the prescribing physician, or an expressly identified agent of the patient.

§ 5284. MEDICAL CONSULTATION REQUIRED

Before a patient is qualified in accordance with this chapter, a consulting physician shall physically examine the patient, review the patient's relevant medical records, and confirm in writing the prescribing physician's diagnosis that the patient is suffering from a terminal condition and verify that the patient is capable, is acting voluntarily, and has made an informed decision. The consulting physician shall either verify that the patient does not have impaired judgment or refer the patient for an evaluation under section 5285 of this chapter.

§ 5285. REFERRAL FOR EVALUATION

If, in the opinion of the prescribing physician or the consulting physician, a patient may have impaired judgment, either physician shall refer the patient for an evaluation. A medication to end the patient's life shall not be prescribed until the person conducting the evaluation determines that the patient is capable and does not have impaired judgment.

§ 5286. INFORMED DECISION

A person shall not receive a prescription for medication to hasten his or her death unless the patient has made an informed decision. Immediately prior to writing a prescription for medication in accordance with this chapter, the prescribing physician shall verify that the patient is making an informed decision.

§ 5287. RECOMMENDED NOTIFICATION

The prescribing physician shall recommend that the patient notify the patient's next of kin or someone with whom the patient has a significant relationship of the patient's request for medication in accordance with this chapter. A patient who declines or is unable to notify the next of kin or the person with whom the patient has a significant relationship shall not be refused medication in accordance with this chapter.

§ 5288. RIGHT TO RESCIND

A patient may rescind the request for medication in accordance with this chapter at any time and in any manner regardless of the patient's mental state.

A prescription for medication under this chapter shall not be written without the prescribing physician's offering the patient an opportunity to rescind the request.

§ 5289. WAITING PERIOD

The prescribing physician shall write a prescription no less than 48 hours after the last to occur of the following events:

(1) the patient's written request for medication to hasten his or her death;

(2) the patient's second oral request; or

(3) the prescribing physician's offering the patient an opportunity to rescind the request.

§ 5290. MEDICAL RECORD DOCUMENTATION

(a) The following shall be documented and filed in the patient's medical record:

(1) the date, time, and wording of all oral requests of the patient for medication to hasten his or her death;

(2) all written requests by a patient for medication to hasten his or her death;

(3) the prescribing physician's diagnosis, prognosis, and basis for the determination that the patient is capable, is acting voluntarily, and has made an informed decision;

(4) the consulting physician's diagnosis, prognosis, and verification, pursuant to section 5284 of this title, that the patient is capable, is acting voluntarily, and has made an informed decision;

(5) a copy of the patient's advance directive;

(6) the prescribing physician's attestation that the patient was enrolled in hospice care at the time of the patient's oral and written requests for medication to hasten his or her death;

(7) the prescribing physician's and consulting physician's verifications that the patient either does not have impaired judgment or that the prescribing or consulting physician, or both, referred the patient for an evaluation pursuant to section 5285 of this title and the person conducting the evaluation has determined that the patient does not have impaired judgment;

(8) a report of the outcome and determinations made during any evaluation which the patient may have received;

(9) the date, time, and wording of the prescribing physician's offer to the patient to rescind the request for medication at the time of the patient's second oral request; and

(10) a note by the prescribing physician indicating that all requirements under this chapter have been satisfied and describing all of the steps taken to carry out the request, including a notation of the medication prescribed.

(b) Medical records compiled pursuant to this chapter shall be subject to discovery only if the court finds that the records are:

(1) necessary to resolve issues of compliance with or limitations on actions under this chapter; or

(2) essential to proving individual cases of civil or criminal liability and are otherwise unavailable.

§ 5291. REPORTING REQUIREMENT

(a) The Department of Health shall require:

(1) that any physician who writes a prescription pursuant to this chapter promptly file a report with the Department covering all the prerequisites for writing a prescription under this chapter; and

(2) physicians to report on an annual basis the number of written requests for medication received pursuant to this chapter, regardless of whether a prescription was actually written in each instance.

(b) The Department shall review annually the medical records of qualified patients who hastened their deaths in accordance with this chapter during the previous year.

(c) The Department shall adopt rules pursuant to 3 V.S.A. chapter 25 to facilitate the collection of information regarding compliance with this chapter and to enable the Department to report information as required by subsection (d) of this section. Individually identifiable health information collected under this chapter, as well as reports filed pursuant to subdivision (a)(1) of this section, are confidential and are exempt from public inspection and copying under the Public Records Act.

(d) The Department shall generate and make available to the public an annual statistical report of information collected under subsections (a) and (b) of this section, including:

(1) demographic information regarding patients who hastened their deaths in accordance with this chapter, including the underlying illness and the type of health insurance or other health coverage, if any;

(2) reasons given by patients for their use of medication to hasten their deaths in accordance with this chapter, including whether patients expressed concerns about:

(A) being a burden to family or caregivers;

(B) the financial implications of treatment; and

(C) inadequate pain control;

(3) information regarding physicians prescribing medication in accordance with this chapter, including physicians' compliance with the requirements of this chapter;

(4) the number of patients who did not take the medication prescribed pursuant to this chapter and died of other causes; and

(5) the length of time between when a patient ingested the medication and when death occurred and the number of instances in which medication was taken by a qualified patient to hasten death but failed to have the intended effect.

§ 5292. SAFE DISPOSAL OF UNUSED MEDICATIONS

The Department of Health shall adopt rules providing for the safe disposal of unused medications prescribed under this chapter.

(1) The Department initially shall adopt rules under this section as emergency rules pursuant to 3 V.S.A. § 844. The General Assembly determines that adoption of emergency rules pursuant to this subdivision is necessary to address an imminent peril to public health and safety.

(2) Contemporaneously with the initial adoption of emergency rules under subdivision (1) of this section, the Department shall propose permanent rules under this section for adoption pursuant to 3 V.S.A. §§ 836–843. The Department subsequently may revise these rules in accordance with the Vermont Administrative Procedure Act.

§ 5293. PROHIBITIONS; CONTRACT CONSTRUCTION; INSURANCE POLICIES

(a) A provision in a contract, will, trust, or other agreement, whether written or oral, shall not be valid to the extent the provision would affect whether a person may make or rescind a request for medication to hasten his or her death in accordance with this chapter.

(b) The sale, procurement, or issue of any life, health, or accident insurance or annuity policy or the rate charged for any policy shall not be conditioned upon or affected by the making or rescinding of a request by a person for

medication to hasten his or her death in accordance with this chapter or the act by a qualified patient to hasten his or her death pursuant to this chapter. Neither shall a qualified patient's act of ingesting medication to hasten his or her death have an effect on a life, health, or accident insurance or annuity policy.

(c) The sale, procurement, or issue of any medical malpractice insurance policy or the rate charged for the policy shall not be conditioned upon or affected by whether the physician is willing or unwilling to participate in the provision to a qualified patient of medication to hasten his or her death in accordance with this chapter.

§ 5294. LIMITATIONS ON ACTIONS

(a) A person shall not be subject to civil or criminal liability or professional disciplinary action for actions taken in good faith reliance on the provisions of this chapter. This includes being present when a qualified patient takes the prescribed medication to hasten his or her death in accordance with this chapter.

(b) A health care provider shall not subject a person to discipline, suspension, loss of license, loss of privileges, or other penalty for actions taken in good faith reliance on the provisions of this chapter or refusals to act under this chapter.

(c) The provision by a prescribing physician of medication in good faith reliance on the provisions of this chapter shall not constitute patient neglect for any purpose of law.

(d) A request by a patient for medication under this chapter shall not provide the sole basis for the appointment of a guardian or conservator.

(e) A health care provider shall not be under any duty, whether by contract, by statute, or by any other legal requirement, to participate in the provision to a qualified patient of medication to hasten his or her death in accordance with this chapter. If a health care provider is unable or unwilling to carry out a patient's request in accordance with this chapter and the patient transfers his or her care to a new health care provider, the previous health care provider, upon request, shall transfer a copy of the patient's relevant medical records to the new health care provider. A decision by a health care provider not to participate in the provision of medication to a qualified patient shall not constitute the abandonment of the patient or unprofessional conduct under 26 V.S.A. § 1354.

§ 5295. HEALTH CARE FACILITY EXCEPTION

Notwithstanding any other provision of law to the contrary, a health care

facility may prohibit a prescribing physician from writing a prescription for medication under this chapter for a patient who is a resident in its facility and intends to use the medication on the facility's premises, provided the facility has notified the prescribing physician in writing of its policy with regard to the prescriptions. Notwithstanding subsection 5294(b) of this title, any health care provider who violates a policy established by a health care facility under this section may be subject to sanctions otherwise allowable under law or contract.

§ 5296. LIABILITIES AND PENALTIES

(a) With the exception of the limitations on actions established by section 5294 of this title and with the exception of the provisions of section 5298 of this title, nothing in this chapter shall be construed to limit liability for civil damages resulting from negligent conduct or intentional misconduct by any person.

(b) With the exception of the limitations on actions established by section 5294 of this title and with the exception of the provisions of section 5298 of this title, nothing in this chapter or in 13 V.S.A. § 2312 shall be construed to limit criminal prosecution under any other provision of law.

(c) A health care provider is subject to review and disciplinary action by the appropriate licensing entity for failing to act in accordance with this chapter, provided such failure is not in good faith.

§ 5297. FORM OF THE WRITTEN REQUEST

A written request for medication as authorized by this chapter shall be substantially in the following form:

REQUEST FOR MEDICATION TO HASTEN MY DEATH

I, _____, am an adult of sound mind.

I am suffering from _____, which my prescribing physician has determined is a terminal disease and which has been confirmed by a consulting physician.

I have been fully informed of my diagnosis, prognosis, the nature of medication to be prescribed and potential associated risks, and the expected result. I am enrolled in hospice care and have completed an advance directive.

I request that my prescribing physician prescribe medication that will hasten my death.

INITIAL ONE:

_____ I have informed my family or others with whom I have a significant relationship of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family or others with whom I have a significant relationship of my decision.

_____ I have no family or others with whom I have a significant relationship to inform of my decision.

I understand that I have the right to change my mind at any time.

I understand the full import of this request, and I expect to die when I take the medication to be prescribed. I further understand that although most deaths occur within three hours, my death may take longer, and my physician has counseled me about this possibility.

I make this request voluntarily and without reservation, and I accept full moral responsibility for my actions.

Signed: _____ Dated: _____

AFFIRMATION OF WITNESSES

We affirm that, to the best of our knowledge and belief:

(1) the person signing this request:

(A) is personally known to us or has provided proof of identity;

(B) signed this request in our presence;

(C) appears to understand the nature of the document and to be free from duress or undue influence at the time the request was signed; and

(2) that neither of us:

(A) is under 18 years of age;

(B) is a relative (by blood, civil marriage, civil union, or adoption) of the person signing this request;

(C) is the patient's prescribing physician, consulting physician, or a person who has conducted an evaluation of the patient pursuant to 18 V.S.A. § 5285;

(D) is entitled to any portion of the person's assets or estate upon death; or

(E) owns, operates, or is employed at a health care facility where the person is a patient or resident.

Witness 1/Date _____

Witness 2/Date _____

NOTE: A knowingly false affirmation by a witness may result in criminal

penalties.

§ 5298. STATUTORY CONSTRUCTION

Nothing in this chapter shall be construed to authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active euthanasia. Action taken in accordance with this chapter shall not be construed for any purpose to constitute suicide, assisted suicide, mercy killing, or homicide under the law.

Sec. 2. 13 V.S.A. § 2312 is added to read:

§ 2312. VIOLATION OF PATIENT CHOICE AND CONTROL AT END OF LIFE ACT

A person who violates 18 V.S.A. chapter 113 with the intent to cause the death of a patient as defined in subdivision 5281(11) of that title may be prosecuted under chapter 53 of this title (homicide).

Sec. 3. 13 V.S.A. § 2004 is added to read:

§ 2004. FALSE WITNESSING

A person who knowingly violates the requirements of 18 V.S.A. § 5282(c) shall be imprisoned for not more than 10 years or fined not more than $2,000.00, or both.

Sec. 4. EFFECTIVE DATES

This act shall take effect on September 1, 2013, except that 18 V.S.A. § 5292 (rules for safe disposal of unused medications) in Sec. 1 of this act shall take effect on passage. The Department of Health shall ensure that emergency rules adopted under Sec. 1 of this act, 18 V.S.A. § 5292, are in effect on or before September 1, 2013.

**(Committee vote: 7-4-0 )**
**(For text see Senate Journal 2/13/2013 and 2/14/2013 )**

**Action Postponed Until April 30, 2013**
**Favorable with Amendment**

**H. 535**

An act relating to the approval of the adoption and to the codification of the charter of the Town of Woodford

**Rep. Mook of Bennington,** for the Committee on **Government Operations,** recommends the bill be amended as follows:

amended in Sec. 2, in 24 V.S.A. chapter 162, in § 6 (open meetings), by striking out the last sentence in its entirety and inserting in lieu thereof the

following: "No executive session shall be held except in accordance with the terms of the general law."

**( Committee Vote: 10-0-1)**

**NOTICE CALENDAR**
**Favorable with Amendment**

**S. 31**

An act relating to prohibiting a court from consideration of interests in revocable trusts or wills when making a property settlement in a divorce proceeding

**Rep. Koch of Barre Town,** for the Committee on **Judiciary,** recommends that the House propose to the Senate that the bill be amended by striking all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. 15 V.S.A. § 751 is amended to read:

§ 751. PROPERTY SETTLEMENT

(a) Upon motion of either party to a proceeding under this chapter, the court shall settle the rights of the parties to their property, by including in its judgment provisions which equitably divide and assign the property. All property owned by either or both of the parties, however and whenever acquired, shall be subject to the jurisdiction of the court. Title to the property, whether in the names of the husband, the wife, both parties, or a nominee, shall be immaterial, except where equitable distribution can be made without disturbing separate property.

(b) In making a property settlement the court may consider all relevant factors, including ~~but not limited to~~:

(1) the length of the civil marriage;

(2) the age and health of the parties;

(3) the occupation, source, and amount of income of each of the parties;

(4) vocational skills and employability;

(5) the contribution by one spouse to the education, training, or increased earning power of the other;

(6) the value of all property interests, liabilities, and needs of each party;

(7) whether the property settlement is in lieu of or in addition to maintenance;

(8) the opportunity of each for future acquisition of capital assets and

income~~;~~. For purposes of this subdivision:

(A) The court may consider the parties' lifestyle and decisions made during the marriage and any other competent evidence as related to their expectations of gifts or an inheritance. The court shall not speculate as to the value of an inheritance or make a finding as to its value unless there is competent evidence of such value.

(B) A party's interest in an inheritance that has not yet vested and is capable of modification or divestment shall not be included in the marital estate.

(C) Notwithstanding any other provision of this subdivision (8), a person who is not a party to the divorce shall not be subject to any subpoena to provide documentation or to give testimony about:

(i) his or her assets, income, or net worth, unless it relates to a party's interest in an instrument that is vested and not capable of modification or divestment; or

(ii) his or her revocable estate planning instruments, including interests that pass at death by operation of law or by contract, unless a party's interest in an instrument is vested and not capable of modification or divestment.

(D) This subdivision (8) shall not be construed to limit the testimony given by the parties themselves or what can be obtained through discovery of the parties;

(9) the desirability of awarding the family home or the right to live there for reasonable periods to the spouse having custody of the children;

(10) the party through whom the property was acquired;

(11) the contribution of each spouse in the acquisition, preservation, and depreciation or appreciation in value of the respective estates, including the nonmonetary contribution of a spouse as a homemaker; and

(12) the respective merits of the parties.

Sec. 2. EFFECTIVE DATE

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 consideration of interests in revocable estate planning instruments when making a property settlement in a divorce proceeding"

**(Committee vote: 11-0-0 )**

**(For text see Senate Journal 2/22/2013 and 2/26/2013 )**

**S. 152**

An act relating to the Green Mountain Care Board's rate review authority

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

* * * Health Insurance Rate Review * * *

Sec. 1. 8 V.S.A. § 4062 is amended to read:

§ 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS

(a)(1) No policy of health insurance or certificate under a policy filed by an insurer offering health insurance as defined in subdivision 3301(a)(2) of this title, a nonprofit hospital or medical service corporation, health maintenance organization, or a managed care organization and not exempted by subdivision 3368(a)(4) of this title shall be delivered or issued for delivery in this ~~state~~ State, nor shall any endorsement, rider, or application which becomes a part of any such policy be used, until~~:~~

~~(A)~~ a copy of the form~~,~~ and of the rules for the classification of risks has been filed with the Department of Financial Regulation and a copy of the premium rates~~, and rules for the classification of risks pertaining thereto have~~ has been filed with the ~~commissioner of financial regulation~~ Green Mountain Care Board; and

~~(B) a decision by~~ the Green Mountain Care ~~board~~ Board has ~~been applied by the commissioner as provided in subdivision (2) of this subsection~~ issued a decision approving, modifying, or disapproving the proposed rate.

(2)(A) ~~Prior to approving a rate pursuant to this subsection, the commissioner shall seek approval for such rate from the Green Mountain Care board established in 18 V.S.A. chapter 220. The commissioner shall make a recommendation to the Green Mountain Care board about whether to approve, modify, or disapprove the rate within 30 days of receipt of a completed application from an insurer. In the event that the commissioner does not make a recommendation to the board within the 30-day period, the commissioner shall be deemed to have recommended approval of the rate, and the Green Mountain Care board shall review the rate request pursuant to subdivision (B) of this subdivision (2).~~

~~(B)~~ The Green Mountain Care ~~board~~ Board shall review rate requests ~~forwarded by the commissioner pursuant to subdivision (A) of this subdivision (2)~~ and shall approve, modify, or disapprove a rate request within ~~30~~ 90 calendar days ~~of receipt of the commissioner's recommendation or, in the absence of a recommendation from the commissioner, the expiration of the~~

~~30-day period following the department's receipt of the completed application. In the event that the board does not approve or disapprove a rate within 30 days, the board shall be deemed to have approved the rate request~~ after receipt of an initial rate filing from an insurer. If an insurer fails to provide necessary materials or other information to the Board in a timely manner, the Board may extend its review for a reasonable additional period of time, not to exceed 30 calendar days.

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

(B) Prior to the Board's decision on a rate request, the Department of Financial Regulation shall provide the Board with an analysis and opinion on the impact of the proposed rate on the insurer's solvency and reserves.

(3) The ~~commissioner~~ Board shall ~~review policies and rates to~~ determine whether a ~~policy or~~ rate is affordable, promotes quality care, promotes access to health care, protects insurer solvency, and is not unjust, unfair, inequitable, misleading, or contrary to the laws of this ~~state~~ State. ~~The commissioner shall notify in writing the insurer which has filed any such form, premium rate, or rule if it contains any provision which does not meet the standards expressed in this section. In such notice, the commissioner shall state that a hearing will be granted within 20 days upon written request of the insurer.~~ In making this determination, the Board shall consider the analysis and opinion provided by the Department of Financial Regulation pursuant to subdivision (2)(B) of this subsection.

(b) ~~The commissioner may, after a hearing of which at least 20 days' written notice has been given to the insurer using such form, premium rate, or rule, withdraw approval on any of the grounds stated in this section. For premium rates, such withdrawal may occur at any time after applying the decision of the Green Mountain Care board pursuant to subdivision (a)(2)(C) of this section. Disapproval pursuant to this subsection shall be effected by written order of the commissioner which shall state the ground for disapproval and the date, not less than 30 days after such hearing when the withdrawal of approval shall become effective.~~

~~(c)~~ In conjunction with a rate filing required by subsection (a) of this section, an insurer shall file a plain language summary of ~~any requested rate increase of five percent or greater. If, during the plan year, the insurer files for rate increases that are cumulatively five percent or greater, the insurer shall file a summary applicable to the cumulative rate increase~~ the proposed rate. All summaries shall include a brief justification of any rate increase requested, the information that the Secretary of the U.S. Department of Health and Human

Services (HHS) requires for rate increases over 10 percent, and any other information required by the ~~commissioner~~ Board. The plain language summary shall be in the format required by the Secretary of HHS pursuant to the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and shall include notification of the public comment period established in subsection ~~(d)~~(c) of this section. In addition, the insurer shall post the summaries on its website.

~~(d)~~(c)(1) The ~~commissioner~~ Board shall provide information to the public on the ~~department's~~ Board's website about the public availability of the filings and summaries required under this section.

(2)(A) Beginning no later than January 1, ~~2012~~ 2014, the ~~commissioner~~ Board shall post the rate filings pursuant to subsection (a) of this section and summaries pursuant to subsection ~~(c)~~(b) of this section on the ~~department's~~ Board's website within five calendar days of filing. The Board shall also establish a mechanism by which members of the public may request to be notified automatically each time a proposed rate is filed with the Board.

(B) The ~~department~~ Board shall provide an electronic mechanism for the public to comment on ~~proposed rate increases over five percent~~ all rate filings. The ~~public shall have 21 days from the posting of the summaries and filings to provide~~ Board shall accept public comment on each rate filing from the date on which the Board posts the rate filing on its website pursuant to subdivision (A) of this subdivision (2) until 15 calendar days after the Board posts on its website the analyses and opinions of the Department of Financial Regulation and of the Board's consulting actuary, if any, as required by subsection (d) of this section. The ~~department~~ Board shall review and consider the public comments prior to ~~submitting the policy or rate for the Green Mountain Care board's approval pursuant to subsection (a) of this section. The department shall provide the Green Mountain Care board with the public comments for its consideration in approving any rates~~ issuing its decision.

(3)(A) In addition to the public comment provisions set forth in this subsection, the Office of the Health Care Advocate established in 18 V.S.A. chapter 229 may, within 30 calendar days after the Board receives an insurer's rate request pursuant to this section, submit questions regarding the filing to the insurer and to the Board's contracting actuary, if any.

(B) The Office of the Health Care Advocate may also submit to the Board written comments on an insurer's rate request. The Board shall post the comments on its website and shall consider the comments prior to issuing its decision.

~~(e)~~(d)(1) No later than 60 calendar days after receiving an insurer's rate request pursuant to this section, the Green Mountain Care Board shall make available to the public the insurer's rate filing, the Department's analysis and opinion of the effect of the proposed rate on the insurer's solvency, and the analysis and opinion of the rate filing by the Board's contracting actuary, if any.

(2) The Board shall post on its website, after redacting any confidential or proprietary information relating to the insurer or to the insurer's rate filing:

(A) all questions the Board poses to its contracting actuary, if any, and the actuary's responses to the Board's questions;

(B) all questions the Office of the Health Care Advocate poses to the Board's contracting actuary, if any, and the actuary's responses to the Office's questions; and

(C) all questions the Board, the Board's contracting actuary, if any, the Department, or the Office of the Health Care Advocate poses to the insurer and the insurer's responses to those questions.

(e) Within 30 calendar days after making the rate filing and analysis available to the public pursuant to subsection (d) of this section, the Board shall:

(1) conduct a public hearing, at which the Board shall:

(A) call as witnesses the Commissioner of Financial Regulation or designee and the Board's contracting actuary, if any, unless all parties agree to waive such testimony; and

(B) provide an opportunity for testimony from the insurer, the Office of the Health Care Advocate, and members of the public;

(2) at a public hearing, announce the Board's decision of whether to approve, modify, or disapprove the proposed rate; and

(3) issue its decision in writing.

(f)(1) The insurer shall notify its policyholders of the Board's decision in a timely manner, as defined by the Board by rule.

(2) Rates shall take effect on the date specified in the insurer's rate filing.

(3) If the Board has not issued its decision by the effective date specified in the insurer's rate filing, the insurer shall notify its policyholders of its pending rate request and of the effective date proposed by the insurer in its rate filing.

(g) An insurer, the Office of the Health Care Advocate, and any member of the public with party status, as defined by the Board by rule, may appeal a decision of the Board approving, modifying, or disapproving the insurer's proposed rate to the Vermont Supreme Court.

(h)~~(1) The following provisions of this~~ This section shall apply only to policies for major medical insurance coverage and shall not apply to policies for specific disease, accident, injury, hospital indemnity, dental care, vision care, disability income, long-term care, or other limited benefit coverage~~:~~; to Medicare supplemental insurance; or

~~(A) the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests;~~

~~(B) the review standards in subdivision (a)(3) of this section as to whether a policy or rate is affordable, promotes quality care, and promotes access to health care; and~~

~~(C) subsections (c) and (d) of this section.~~

~~(2) The exemptions from the provisions described in subdivisions (1)(A) through (C) of this subsection shall also apply~~ to benefit plans that are paid directly to an individual insured or to his or her assigns and for which the amount of the benefit is not based on potential medical costs or actual costs incurred.

~~(3) Medicare supplemental insurance policies shall be exempt only from the requirement in subdivisions (a)(1) and (2) of this section for the Green Mountain Care board's approval on rate requests and shall be subject to the remaining provisions of this section.~~

(i) Notwithstanding the procedures and timelines set forth in subsections (a) through (e) of this section, the Board may establish, by rule, a streamlined rate review process for certain rate decisions, including proposed rates affecting fewer than a minimum number of covered lives and proposed rates for which a de minimis increase, as defined by the Board by rule, is sought.

Sec. 2. 8 V.S.A. § 4062a is amended to read:

§ 4062a. FILING FEES

Each filing of a policy, contract, or document form or premium rates or rules, submitted pursuant to section 4062 of this title, shall be accompanied by payment to the ~~commissioner~~ Commissioner or the Green Mountain Care Board, as appropriate, of a nonrefundable fee of ~~$50.00~~ $150.00.

Sec. 3. 8 V.S.A. § 4089b(d)(1)(A) is amended to read:

(d)(1)(A) A health insurance plan that does not otherwise provide for

management of care under the plan, or that does not provide for the same degree of management of care for all health conditions, may provide coverage for treatment of mental health conditions through a managed care organization provided that the managed care organization is in compliance with the rules adopted by the ~~commissioner~~ Commissioner that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. In reviewing rates and forms pursuant to section 4062 of this title, the ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall consider the compliance of the policy with the provisions of this section.

Sec. 4. 8 V.S.A. § 4512(b) is amended to read:

(b) Subject to the approval of the ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, a hospital service corporation may establish, maintain, and operate a medical service plan as defined in section 4583 of this title. The ~~commissioner~~ Commissioner or the Board may refuse approval if the ~~commissioner~~ Commissioner or the Board finds that the rates submitted are excessive, inadequate, or unfairly discriminatory, fail to protect the hospital service corporation's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. The contracts of a hospital service corporation which operates a medical service plan under this subsection shall be governed by chapter 125 of this title to the extent that they provide for medical service benefits, and by this chapter to the extent that the contracts provide for hospital service benefits.

Sec. 5. 8 V.S.A. § 4513(c) is amended to read:

(c) In connection with a rate decision, the ~~commissioner~~ Green Mountain Care Board may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as ~~he~~ the Board finds, on the basis of competent and substantial evidence, necessary to ~~insure~~ ensure that benefits and services are provided at minimum cost under efficient and economical management of the corporation. The ~~commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and 9376, the Green Mountain Care Board, shall not set the rate of payment or reimbursement made by the corporation to any physician, hospital, or other health care provider.

Sec. 6. 8 V.S.A. § 4515a is amended to read:

§ 4515a. FORM AND RATE FILING; FILING FEES

Every contract or certificate form, or amendment thereof, including the rates charged therefor by the corporation shall be filed with the ~~commissioner~~

Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, for ~~his or her~~ the Commissioner's or the Board's approval prior to issuance or use. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. In addition, each such filing shall be accompanied by payment to the ~~commissioner~~ Commissioner or the Board, as appropriate, of a nonrefundable fee of ~~$50.00~~ $150.00 and the plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 7. 8 V.S.A. § 4584(c) is amended to read:

(c) In connection with a rate decision, the ~~commissioner~~ Green Mountain Care Board may also make reasonable supplemental orders to the corporation and may attach reasonable conditions and limitations to such orders as ~~he or she~~ the Board finds, on the basis of competent and substantial evidence, necessary to ~~insure~~ ensure that benefits and services are provided at minimum cost under efficient and economical management of the corporation. The ~~commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and 9376, the Green Mountain Care Board, shall not set the rate of payment or reimbursement made by the corporation to any physician, hospital, or other health care provider.

Sec. 8. 8 V.S.A. § 4587 is amended to read:

§ 4587. FILING AND APPROVAL OF CONTRACTS

A medical service corporation which has received a permit from the ~~commissioner of financial regulation~~ Commissioner of Financial Regulation under section 4584 of this title shall not thereafter issue a contract to a subscriber or charge a rate therefor which is different from copies of contracts and rates originally filed with such ~~commissioner~~ Commissioner and approved by him or her at the time of the issuance to such medical service corporation of its permit, until it has filed copies of such contracts which it proposes to issue and the rates it proposes to charge therefor and the same have been approved by ~~such commissioner~~ the Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. Each such filing of a contract or the rate therefor shall be accompanied by payment to the ~~commissioner~~ Commissioner or the Board, as appropriate, of a nonrefundable fee of ~~$50.00~~ $150.00. A medical service corporation shall file a plain language summary of rate increases pursuant to section 4062 of this title.

Sec. 9. 8 V.S.A. § 5104 is amended to read:

§ 5104. FILING AND APPROVAL OF RATES AND FORMS;

SUPPLEMENTAL ORDERS

(a)(1) A health maintenance organization which has received a certificate of authority under section 5102 of this title shall file and obtain approval of all policy forms and rates as provided in sections 4062 and 4062a of this title. This requirement shall include the filing of administrative retentions for any business in which the organization acts as a third party administrator or in any other administrative processing capacity. The ~~commissioner~~ Commissioner or the Green Mountain Care Board, as appropriate, may request and shall receive any information that the ~~commissioner~~ Commissioner or the Board deems necessary to evaluate the filing. In addition to any other information requested, the ~~commissioner~~ Commissioner or the Board shall require the filing of information on costs for providing services to the organization's Vermont members affected by the policy form or rate, including Vermont claims experience, and administrative and overhead costs allocated to the service of Vermont members. Prior to approval, there shall be a public comment period pursuant to section 4062 of this title. A health maintenance organization shall file a summary of rate filings pursuant to section 4062 of this title.

(2) The ~~commissioner~~ Commissioner or the Board shall refuse to approve~~, or to seek the Green Mountain Care board's approval of,~~ the form of evidence of coverage, filing, or rate if it contains any provision which is unjust, unfair, inequitable, misleading, or contrary to the law of the ~~state~~ State or plan of operation, or if the rates are excessive, inadequate or unfairly discriminatory, fail to protect the organization's solvency, or fail to meet the standards of affordability, promotion of quality care, and promotion of access pursuant to section 4062 of this title. No evidence of coverage shall be offered to any potential member unless the person making the offer has first been licensed as an insurance agent in accordance with chapter 131 of this title.

(b) In connection with a rate decision, the ~~commissioner~~ Board may also~~, with the prior approval of the Green Mountain Care board established in 18 V.S.A. chapter 220,~~ make reasonable supplemental orders and may attach reasonable conditions and limitations to such orders as the ~~commissioner~~ Board finds, on the basis of competent and substantial evidence, necessary to ~~insure~~ ensure that benefits and services are provided at reasonable cost under efficient and economical management of the organization. The ~~commissioner~~ Commissioner and, except as otherwise provided by 18 V.S.A. §§ 9375 and 9376, the Green Mountain Care Board, shall not set the rate of payment or reimbursement made by the organization to any physician, hospital, or health care provider.

Sec. 10. 18 V.S.A. § 9375(b) is amended to read:

(b) The ~~board~~ Board shall have the following duties:

* * *

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 ~~within 30 days of receipt of a request for approval from the commissioner of financial regulation~~, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, protecting insurer solvency, and other issues at the discretion of the ~~board~~ Board;

* * *

Sec. 11. 18 V.S.A. § 9381 is amended to read:

§ 9381. APPEALS

(a)~~(1)~~ The Green Mountain Care ~~board~~ Board shall adopt procedures for administrative appeals of its actions, orders, or other determinations. Such procedures shall provide for the issuance of a final order and the creation of a record sufficient to serve as the basis for judicial review pursuant to subsection (b) of this section.

~~(2) Only decisions by the board shall be appealable under this subsection. Recommendations to the board by the commissioner of financial regulation pursuant to 8 V.S.A. § 4062(a) shall not be subject to appeal.~~

(b) Any person aggrieved by a final action, order, or other determination of the Green Mountain Care ~~board~~ Board may, upon exhaustion of all administrative appeals available pursuant to subsection (a) of this section, appeal to the ~~supreme court~~ Supreme Court pursuant to the Vermont Rules of Appellate Procedure.

(c) If an appeal or other petition for judicial review of a final order is not filed in connection with an order of the Green Mountain Care ~~board~~ Board pursuant to subsection (b) of this section, the ~~chair~~ Chair may file a certified copy of the final order with the clerk of a court of competent jurisdiction. The order so filed has the same effect as a judgment of the court and may be recorded, enforced, or satisfied in the same manner as a judgment of the court.

(d) A decision of the Board approving, modifying, or disapproving a health insurer's proposed rate pursuant to 8 V.S.A. § 4062 shall be considered a final action of the Board and may be appealed to the Supreme Court pursuant to subsection (b) of this section.

Sec. 12. 33 V.S.A. § 1811(j) is amended to read:

(j) The ~~commissioner~~ Commissioner or the Green Mountain Care Board established in 18 V.S.A. chapter 220, as appropriate, shall disapprove any rates

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

* * * Office of the Health Care Advocate * * *

Sec. 13. 18 V.S.A. chapter 229 is added to read:

CHAPTER 229. OFFICE OF THE HEALTH CARE ADVOCATE

§ 9601. DEFINITIONS

As used in this chapter:

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

(2) "Health insurance plan" means a policy, service contract, or other health benefit plan offered or issued by a health insurer and includes beneficiaries covered by the Medicaid program unless they are otherwise provided with similar services.

(3) "Health insurer" shall have the same meaning as in section 9402 of this title.

§ 9602. OFFICE OF THE HEALTH CARE ADVOCATE; COMPOSITION

(a) The Agency of Administration shall establish the Office of the Health Care Advocate by contract with any nonprofit organization.

(b) The Office shall be administered by the Chief Health Care Advocate, who shall be an individual with expertise and experience in the fields of health care and advocacy. The Advocate may employ legal counsel, administrative staff, and other employees and contractors as needed to carry out the duties of the Office.

§ 9603. DUTIES AND AUTHORITY

(a) The Office of the Health Care Advocate shall:

(1) Assist health insurance consumers with health insurance plan selection by providing information, referrals, and assistance to individuals and employers with not more than 10 full-time equivalent employees about means of obtaining health insurance coverage and services. The Office shall accept referrals from the Vermont Health Benefit Exchange and Exchange navigators created pursuant to 33 V.S.A. chapter 18, subchapter 1, to assist consumers experiencing problems related to the Exchange.

(2) Assist health insurance consumers to understand their rights and

responsibilities under health insurance plans.

(3) Provide information to the public, agencies, members of the General Assembly, and others regarding problems and concerns of health insurance consumers as well as recommendations for resolving those problems and concerns.

(4) Identify, investigate, and resolve complaints on behalf of individual health insurance consumers and employers with not more than 10 full-time equivalent employees who purchase insurance for their employees, and assist those consumers with filing and pursuit of complaints and appeals.

(5) Provide information to individuals and employers regarding their obligations and responsibilities under the Patient Protection and Affordable Care Act (Public Law 111-148).

(6) Analyze and monitor the development and implementation of federal, state, and local laws, rules, and policies relating to patients and health insurance consumers.

(7) Facilitate public comment on laws, rules, and policies, including policies and actions of health insurers.

(8) Suggest policies, procedures, or rules to the Green Mountain Care Board in order to protect patients' and consumers' interests.

(9) Promote the development of citizen and consumer organizations.

(10) Ensure that patients and health insurance consumers have timely access to the services provided by the Office.

(11) Submit to the General Assembly and the Governor on or before January 1 of each year a report on the activities, performance, and fiscal accounts of the Office during the preceding calendar year.

(b) The Office of the Health Care Advocate may:

(1) Review the health insurance records of a consumer who has provided written consent. Based on the written consent of the consumer or his or her guardian or legal representative, a health insurer shall provide the Office with access to records relating to that consumer.

(2) Pursue administrative, judicial, and other remedies on behalf of any individual health insurance consumer or group of consumers.

(3) Represent the interests of the people of the State in cases requiring a hearing before the Green Mountain Care Board established in chapter 220 of this title.

(4) Adopt policies and procedures necessary to carry out the provisions

of this chapter.

(5) Take any other action necessary to fulfill the purposes of this chapter.

(c) The Office of the Health Care Advocate shall be able to speak on behalf of the interests of health care and health insurance consumers and to carry out all duties prescribed in this chapter without being subject to any disciplinary or retaliatory action; provided, however, that nothing in this subsection shall limit the authority of the Agency of Administration to enforce the terms of the contract.

§ 9604. DUTIES OF STATE AGENCIES

All state agencies shall comply with reasonable requests from the Office of the Health Care Advocate for information and assistance. The Agency of Administration may adopt rules necessary to ensure the cooperation of state agencies under this section.

§ 9605. CONFIDENTIALITY

In the absence of written consent by a complainant or an individual using the services of the Office or by his or her guardian or legal representative or the absence of a court order, the Office of the Health Care Advocate, its employees, and its contractors shall not disclose the identity of the complainant or individual.

§ 9606. CONFLICTS OF INTEREST

The Office of the Health Care Advocate, its employees, and its contractors shall not have any conflict of interest relating to the performance of their responsibilities under this chapter. For the purposes of this chapter, a conflict of interest exists whenever the Office of the Health Care Advocate, its employees, or its contractors or a person affiliated with the Office, its employees, or its contractors:

(1) have a direct involvement in the licensing, certification, or accreditation of a health care facility, health insurer, or health care provider;

(2) have a direct ownership interest or investment interest in a health care facility, health insurer, or health care provider;

(3) are employed by or participating in the management of a health care facility, health insurer, or health care provider; or

(4) receive or have the right to receive, directly or indirectly, remuneration under a compensation arrangement with a health care facility, health insurer, or health care provider.

§ 9607. CONSUMER ASSISTANCE ASSESSMENT

(a) The premium for each health insurance policy issued in this state shall include a monthly consumer assistance assessment of $0.22 per covered life to fund the activities of the Office of the Health Care Advocate. Each health insurer shall remit the assessments collected during the preceding calendar quarter to the Commissioner of Financial Regulation by January 15, April 15, July 15, and October 15 of each year.

(b) There is established pursuant to 32 V.S.A. chapter 7, subchapter 5 a special fund called the "Consumer Assistance Assessment Fund" into which shall be deposited the funds collected under this section. The fund shall be administered by the Secretary of Administration and disbursements are authorized to fund the activities of the Office of the Health Care Advocate as appropriated by the General Assembly.

(c) Health insurers and the Vermont Health Benefit Exchange shall clearly communicate to all applicants and enrollees on materials such as enrollment forms, member handbooks, and the Exchange website information regarding the consumer assistance assessment established by this section and contact information for the Office of the Health Care Advocate.

(d) As used in this section:

(1) "Health insurance" means any group or individual health care benefit policy, contract, or other health benefit plan offered, issued, renewed, or administered by any health insurer, including any health care benefit plan offered, issued, renewed, or administered by any health insurance company, any nonprofit hospital and medical service corporation, or any managed care organization as defined in section 9402 of this title. The term includes comprehensive major medical policies, contracts, or plans but does not include Medicaid or any other state health care assistance program financed in whole or in part through a federal program. The term does not include policies issued for specified disease, accident, injury, hospital indemnity, dental care, long-term care, disability income, or other limited benefit health insurance policies.

(2) "Health insurer" means any person who offers, issues, renews, or administers a health insurance policy, contract, or other health benefit plan in this State and includes third-party administrators or pharmacy benefit managers who provide administrative services only for a health benefit plan offering coverage in this State. The term does not include a third-party administrator or pharmacy benefit manager to the extent that a health insurer has collected and remitted the surcharges which would otherwise be imposed on the covered lives attributed to the third-party administrator or pharmacy benefit manager. The term also does not include a health insurer with a

monthly average of fewer than 200 Vermont insured lives.

Sec. 14. 18 V.S.A. § 9374(f) is amended to read:

(f) In carrying out its duties pursuant to this chapter, the ~~board~~ Board shall seek ~~the~~ advice ~~of the state health care ombudsman established in 8 V.S.A. § 4089w~~ from the Office of the Health Care Advocate. The ~~state health care ombudsman~~ Office shall advise the ~~board~~ Board regarding the policies, procedures, and rules established pursuant to this chapter. The ~~ombudsman~~ Office shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the ~~board~~ Board in order to protect patients' and consumers' interests.

Sec. 15. 18 V.S.A. § 9377(e) is amended to read:

(e) The ~~board~~ Board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the ~~state health care ombudsman~~ Office of the Health Care Advocate, and state and local governments, to advise the ~~board~~ Board in developing and implementing the pilot projects and to advise the Green Mountain Care ~~board~~ Board in setting overall policy goals.

Sec. 16. 18 V.S.A. § 9410(a)(2) is amended to read:

(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~~ Commissioner determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.

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

* * *

Sec. 17. 18 V.S.A. § 9440(c) is amended to read:

(c) The application process shall be as follows:

* * *

(9) The ~~health care ombudsman's office~~ Office of the Health Care Advocate established under ~~8 V.S.A. chapter 107, subchapter 1A~~ chapter 229 of this title or, in the case of nursing homes, the ~~long-term care ombudsman's office~~ Long-Term Care Ombudsman's Office established under 33 V.S.A. § 7502~~,~~ is authorized but not required to participate in any administrative or judicial review of an application under this subchapter and shall be considered an interested party in such proceedings upon filing a notice of intervention with the ~~board~~ Board.

Sec. 18. 18 V.S.A. § 9445(b) is amended to read:

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

Sec. 19. 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:

* * *

(16) Referring consumers to the ~~office of health care ombudsman~~ Office of the Health Care Advocate for assistance with grievances, appeals, and other issues involving the Vermont ~~health benefit exchange~~ Health Benefit Exchange.

* * *

Sec. 20. 33 V.S.A. § 1807(b) is amended to read:

(b) Navigators shall have the following duties:

* * *

(4) Provide referrals to the ~~office of health care ombudsman~~ Office of the Health Care Advocate and any other appropriate agency for any enrollee with a grievance, complaint, or question regarding his or her health benefit plan, coverage, or a determination under that plan or coverage;

* * *

* * * Allocation of Expenses * * *

Sec. 21. 18 V.S.A. § 9374(h) is amended to read:

(h)(1) ~~Expenses~~ Except as otherwise provided in subdivision (2) of this subsection, expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the ~~board~~ Board shall be borne as follows:

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

(B) 15 percent by the hospitals;

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

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

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

(2) The Board may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subdivision (1) of this subsection if, in the Board's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

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

Sec. 22. 18 V.S.A. § 9415 is amended to read:

§ 9415. ALLOCATION OF EXPENSES

(a) ~~Expenses~~ Except as otherwise provided in subsection (b) of this section, expenses incurred to obtain information and to analyze expenditures, review

hospital budgets, and for any other related contracts authorized by the ~~commissioner~~ Commissioner shall be borne as follows:

(1) 40 percent by the ~~state~~ State from state monies~~,~~;

(2) 15 percent by the hospitals~~,~~;

(3) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125~~,~~;

(4) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101~~,~~; and

(5) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

(b) The Commissioner may determine the scope of the incurred expenses to be allocated pursuant to the formula set forth in subsection (a) of this section if, in the Commissioner's discretion, the expenses to be allocated are in the best interests of the regulated entities and of the State.

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

Sec. 23. BILL-BACK REPORT

(a) Annually on or before September 15, the Green Mountain Care Board and the Department of Financial Regulation shall report to the House Committee on Health Care, the Senate Committees on Health and Welfare and on Finance, and the House and Senate Committees on Appropriations the total amount of all expenses eligible for allocation pursuant to 18 V.S.A. §§ 9374(h) and 9415 during the preceding state fiscal year and the total amount actually billed back to the regulated entities during the same period.

(b) The Board and the Department shall also present the information required by subsection (a) of this section to the Joint Fiscal Committee annually at its September meeting.

* * * Prior Authorizations * * *

Sec. 24. 18 V.S.A. § 9377a is added to read:

§ 9377a. PRIOR AUTHORIZATION PILOT PROGRAM

(a) The Green Mountain Care Board shall develop and implement a pilot program or programs for the purpose of measuring the change in system costs

within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The program shall be designed to measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. In developing the pilot program proposal, the Board shall collaborate with health care professionals and health insurers throughout the State or regionally.

(b) The Board shall submit an update regarding implementation of prior authorization pilot programs as part of its annual report under subsection 9375(d) of this title.

Sec. 25. 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~~ House Committee on ~~health care~~ Health Care and the ~~senate committee~~ Senate Committee on ~~health and welfare~~ Health and Welfare. The report shall include any changes to the payment rates for health care professionals pursuant to section 9376 of this title, any new developments with respect to health information technology, the evaluation criteria adopted pursuant to subdivision (b)(8) of this section and any related modifications, the results of the systemwide performance and quality evaluations required by subdivision (b)(8) of this section and any resulting recommendations, the process and outcome measures used in the evaluation, an update regarding implementation of any prior authorization pilot programs under section 9377a of this title, any recommendations for modifications to Vermont statutes, and any actual or anticipated impacts on the work of the ~~board~~ Board as a result of modifications to federal laws, regulations, or programs. The report shall identify how the work of the ~~board~~ Board comports with the principles expressed in section 9371 of this title.

Sec. 26. 18 V.S.A. § 9414b is added to read:

§ 9414b. ANNUAL REPORTING BY THE DEPARTMENT OF VERMONT HEALTH ACCESS

(a) The Department of Vermont Health Access shall annually report the following information, in plain language, to the House Committee on Health Care and the Senate Committee on Health and Welfare, as well as posting the information on its website:

(1) the total number of Vermont lives covered by Medicaid;

(2) the total number of claims submitted to the Department for services

provided to Medicaid beneficiaries;

(3) the total number of claims denied by the Department;

(4) the total number of denials of service by the Department at the preauthorization level, the total number of denials that were appealed, and of those, the total number overturned;

(5) the total number of adverse determinations made by the Department;

(6) the total number of claims denied by the Department because the service was experimental, investigational, or an off-label use of a drug; was not medically necessary; or involved access to a provider that is inconsistent with the limitations imposed by Medicaid;

(7) the total number of claims denied by the Department as duplicate claims, as coding errors, or for services or providers not covered;

(8) the Department's legal expenses related to claims or service denials during the preceding year; and

(9) the effects of the Department's policy of allowing automatic approval of certain prior authorizations on the number of requests for imaging, medical procedures, prescription drugs, and home care.

(b) The Department may indicate the extent of overlap or duplication in reporting the information described in subsection (a) of this section.

(c) To the extent practicable, the Department shall model its report on the standardized form created by the Department of Financial Regulation for use by health insurers under subsection 9414a(c) of this title.

(d) The Department of Financial Regulation shall post on its website, in the same location as the forms posted under subdivision 9414a(d)(1) of this title, a link to the information reported by the Department of Vermont Health Access under subsection (a) of this section.

Sec. 27. 18 V.S.A. § 9414a(a)(5) is amended to read:

(5) data regarding the number of denials of service by the health insurer at the preauthorization level, including:

(A) the total number of denials of service by the health insurer at the preauthorization level~~, including:~~;

~~(A)~~(B) the total number of denials of service at the preauthorization level appealed to the health insurer at the first-level grievance and, of those, the total number overturned;

~~(B)~~(C) the total number of denials of service at the preauthorization

level appealed to the health insurer at any second-level grievance and, of those, the total number overturned;

~~(C)~~(D) the total number of denials of service at the preauthorization level for which external review was sought and, of those, the total number overturned;

* * * Additional Provisions * * *

Sec. 28. RATE FILINGS FOR 2014

In reviewing health insurance rate filings to take effect in calendar year 2014 pursuant to 8 V.S.A. § 4062, the Department of Financial Regulation and the Green Mountain Care Board shall take into account the consumer assistance assessment established by this act in 18 V.S.A. § 9607.

Sec. 29. REPEAL

8 V.S.A. § 4089w (Health Care Ombudsman) is repealed.

Sec. 30. APPROPRIATION

The sum of $250,000.00 is appropriated from the Consumer Assistance Assessment Fund established by 18 V.S.A. § 9607 to the Agency of Administration in fiscal year 2014 for the purposes of a contract with Vermont Legal Aid to carry out the duties of the Office of the Health Care Advocate established in 18 V.S.A. chapter 229.

Sec. 31. APPLICABILITY AND EFFECTIVE DATES

(a) Secs. 1–12 (rate review) of this act shall take effect on January 1, 2014 and shall apply to all insurers filing rates and forms for major medical insurance plans on and after January 1, 2014, except that the Green Mountain Care Board and the Department of Financial Regulation may amend their rules and take such other actions before that date as are necessary to ensure that the revised rate review process will be operational on January 1, 2014.

(b) Secs. 13–20 (Office of the Health Care Advocate) shall take effect on January 1, 2014.

(c) Sec. 28 (2014 rate filings) of this act and this section shall take effect on passage.

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

**(Committee vote: 8-3-0 )**

**(For text see Senate Journal 3/27/2013 )**

## Senate Proposal of Amendment

### H. 280

An act relating to payment of wages

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

First: In Sec. 1, 21 V.S.A. § 341, in subdivision (5), by striking out the word "bonuses" and inserting in lieu thereof incentive pay

Second: By striking Sec. 2 in its entirety and inserting in lieu thereof a new Sec. 2 to read:

Sec. 2. 21 V.S.A. § 342 is amended to read:

§ 342. WEEKLY PAYMENT OF WAGES

(a)(1) Any ~~person~~ employer having one or more employees doing and transacting business within the ~~state~~ State shall pay each week, in lawful money or checks, the wages earned by each employee to a day not more than six days prior to the date of such payment.

(2) After giving written notice to the employee or employees, any ~~person~~ employer having an employee or employees doing and transacting business within the ~~state~~ State may, notwithstanding subdivision (1) of this subsection, pay biweekly or semimonthly in lawful money or checks~~,~~ each employee the wages earned by the employee to a day not more than six days prior to the date of the payment. If a collective bargaining agreement so provides, the payment may be made to a day not more than 13 days prior to the date of payment.

* * *

Third: In Sec. 3, 21 V.S.A. § 342a, in subsection (f), by inserting a sentence at the end of the subsection to read: The costs of transcription shall be paid by the requesting party.

(For text see House Journal 3/21/2013 )

### H. 401

An act relating to municipal and regional planning and flood resilience

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

First: In Sec. 1, 24 V.S.A. § 4302, in subdivision (c)(14)(A), in the second sentence, by striking out the words "should be constructed to withstand flooding and fluvial erosion and", and by inserting after the words "exacerbate flooding" the words and fluvial erosion

Second: In Sec. 3, 24 V.S.A. § 4348a, in subdivision (a)(11)(A)(i), by striking out the words "that should" and inserting in lieu thereof the word to

Third: In Sec. 4, 24 V.S.A. § 4382, in subdivision (a)(12)(A)(i), by striking out the words "that should" and inserting in lieu thereof the word to

Fourth: By striking out Sec. 8 in its entirety and inserting in lieu thereof:

Sec. 8. EFFECTIVE DATES

(a) This section and Secs. 5 (required provisions and prohibited effects) and 6 (regulation of accessory dwelling units) of this act shall take effect on passage.

(b) Secs. 1 (purpose; goals), 2 (flood hazard area), 3 (elements of a regional plan), 4 (the plan for a municipality), and 7 (river corridors and buffers) of this act shall take effect on July 1, 2014.

( No House Amendments )

**H. 406**

An act relating to listers and assessors

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

First: By adding a new section to be Sec. 3a to read:

Sec. 3a. 17 V.S.A. § 2651b is amended to read:

§ 2651b. ELIMINATION OF OFFICE OF AUDITOR; APPOINTMENT OF PUBLIC ACCOUNTANT

* * *

(c) The authority to vote to eliminate the office of town auditor as provided in this section shall extend to all towns except those towns that have a charter that specifically provides for the election or appointment of the office of town auditor.

Second: By adding a new section to be Sec. 3b to read:

Sec. 3b. REPEAL

1998 Acts and Resolves No. 83, Sec. 9 (municipal charters) is repealed.

Third: In Sec. 4 (amending 17 V.S.A. § 2651c), by striking out subdivision (4) in its entirety and inserting in lieu thereof the following:

(4) The authority to vote to eliminate the office of lister as provided in this subsection shall extend to all towns except those towns that have a charter that specifically provides for the election or appointment of the office of lister.

and that after passage the title of the bill be amended to read: "An act relating to town listers, assessors, and auditors".

( No House Amendments )

## Consent Calendar

## Concurrent Resolutions

The following concurrent resolutions have been introduced for approval by the Senate and House and will be adopted automatically unless a Senator or Representative requests floor consideration before the end of the session of the next legislative day. Requests for floor consideration in either chamber should be communicated to the Secretary's office and/or the House Clerk's office, respectively. For text of resolutions, see Addendum to House Calendar and Senate Calendar.

**H.C.R. 116**

House concurrent resolution commemorating the second annual Turkic Cultural Day in Vermont

**H.C.R. 117**

House concurrent resolution designating April 19, 2013 as Alzheimer's Awareness Day at the State House

**H.C.R. 118**

House concurrent resolution designating April 2013 as the month of the military child in Vermont

**H.C.R. 119**

House concurrent resolution in memory of Richard Swift of Barre Town

**H.C.R. 120**

House concurrent resolution commemorating the sestercentennial of the Town of Stowe

**H.C.R. 121**

House concurrent resolution celebrating Latchis Arts' 10th anniversary as the owner of the Latchis Hotel and Theatre

**H.C.R. 122**

House concurrent resolution commemorating the sestercentennial of the Town of Swanton

## Information Notice

The Joint Fiscal Committee recently received the following items:

**JFO #2621** – Request to establish one (1) limited service position in the Department of Health. This position will provide case management services to women who test positive during breast cancer screenings. This grant-funded service is currently provided via a personal services contract, but the Attorney General is recommending conversion to a limited service position.

[*JFO received 04/15/13*]

**JFO #2622** – $45,009,480 grant from the U.S. Department of Health and Human Service to the Department of Vermont Health Access. These funds will be used to design and test new savings models that integrate payment and services across providers, and develop pay-for-performance models to improve quality and efficiency of services. Twenty-two (22) limited service positions are associated with this request. Expedited review has been requested. Joint Fiscal Committee members will be contacted by May 3th with a request to waive the balance of the review period and accept this grant.

[*JFO received 04/18/13*]

**JFO #2623** – $15,000 grant from the Lintilhac Foundation to the Vermont Department of Environmental Conservation. These funds will be used to support the Flood Resilient Communities Program mandated by Act 138 of 2012. This program is intended to publicize incentives for communities to adopt local flood hazard bylaws and improve flood resilience.

[*JFO received 04/23/13*]

**JFO #2624** – $10,000 grant from the Vermont Community Foundation to the Vermont Department of Environmental Conservation. These funds will be used to develop a "Focus on Floods" website to support community efforts to assess flood vulnerability and identify opportunities to increase flood resilience.

[*JFO received 04/23/13*]