Side by side comparison of S.139 as passed by House and as passed by Senate

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Subject	S.139 as passed by House	S.139 as passed by Senate

All-payer model	[No similar provision]	**Sec. 1. (p. 1)**
		• Secretary of Administration or designee and Green Mountain Care Board (GMCB) must jointly explore all-payer model
		• Must consider the following models:
		  ○ including payment for broad array of health services
		  ○ hospitals only
		  ○ allowing for global hospital budgets for all Vermont hospitals

Pharmacy benefit managers	**Secs. 1-2. (pp. 1-2)** ***(SAME AS SENATE)***
	• Requires pharmacy benefit managers (PBMs) to:
	  ○ make available to pharmacists the actual maximum allowable cost (MAC) for each drug and the source used to determine the MAC
	  ○ update the MAC at least every 7 calendar days
	  ○ have a reasonable appeals process to contest a MAC
	  ○ respond in writing to an appealing pharmacy within 10 calendar days, provided pharmacy must file appeal within 10 calendar days from date its claim for reimbursement was adjudicated
		Secs. 2-3. (pp. 1-3) ***(SAME AS HOUSE)***
		• Requires pharmacy benefit managers (PBMs) to:
		  ○ make available to pharmacists the actual maximum allowable cost (MAC) for each drug and the source used to determine the MAC
		  ○ update the MAC at least every 7 calendar days
		  ○ have a reasonable appeals process to contest a MAC
		  ○ respond in writing to an appealing pharmacy within 10 calendar days, provided pharmacy must file appeal within 10 calendar days from date its claim for reimbursement was adjudicated

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Notice of hospital observation status	**Secs. 3-4a. (pp. 2-5)** ***(SAME AS SENATE)***
	• Requires hospitals to provide oral and written notices to Medicare beneficiaries placed in observation status
	• Notice must tell people:
	  ○ that they are on observation status and not admitted as an inpatient
	  ○ that observation status may affect their Medicare coverage for hospital services and nursing home stays
	  ○ whom they may contact for more information
	• Requests that interested stakeholders consider the appropriate notice of hospital observation status for patients with commercial insurance
	  ○ Report due by January 15, 2016
		Secs. 4-6. (pp. 3-5) ***(SAME AS HOUSE)***
		• Requires hospitals to provide oral and written notices to Medicare beneficiaries placed in observation status
		• Notice must tell people:
		  ○ that they are on observation status and not admitted as an inpatient
		  ○ that observation status may affect their Medicare coverage for hospital services and nursing home stays
		  ○ whom they may contact for more information
		• Requests that interested stakeholders consider the appropriate notice of hospital observation status for patients with commercial insurance
		  ○ Report due by January 15, 2016

Vermont Health Care Innovation Project updates	**Sec. 5. (pp. 5-6)** ***(SAME AS SENATE)*** • Requires the Vermont Health Care Innovation Project to provide updates at least quarterly on Project implementation and use of federal State Innovation Model (SIM) grant funds	**Sec. 26. (pp. 24-25)** ***(SAME AS HOUSE)*** • Requires the Vermont Health Care Innovation Project to provide updates at least quarterly on Project implementation and use of federal State Innovation Model (SIM) grant funds
Reducing duplication of services; report	**Sec. 6. (pp. 6-7)** ***(SAME AS SENATE)*** • Directs Agency of Human Services (AHS) to evaluate the services offered by each entity licensed, administered, or funded by the State to provide home- and community-based long-term care services or providing services to people with developmental disabilities, mental health needs, or substance use disorder • AHS must identify gaps in services and overlapping or duplicative services • Report due January 15, 2016	**Sec. 27. (PP. 25-26)** ***(SAME AS HOUSE)*** • Directs Agency of Human Services (AHS) to evaluate the services offered by each entity licensed, administered, or funded by the State to provide home- and community-based long-term care services or providing services to people with developmental disabilities, mental health needs, or substance use disorder • AHS must identify gaps in services and overlapping or duplicative services • Report due January 15, 2016

Subject	S.139 as passed by House	S.139 as passed by Senate
Exchange cost-sharing subsidies	**Secs. 7-8. (p. 7-9)** • Appropriates $761,308 (State) for base spending for cost-sharing subsidies • Increases Exchange cost-sharing subsidies to an 83% actuarial value for individuals between 200% and 250% FPL and to a 79% actuarial value for individuals between 250% and 300% FPL • Appropriates $2 million (State) for increased subsidies beginning January 1, 2016	**Sec. 48. (p. 64)** • Appropriates $761,308 (State) for base spending for cost-sharing subsidies
Increase for Medicaid primary care providers	**Sec. 9. (p. 9)** • Appropriates ***$7 million*** (gross) to increase Medicaid reimbursement rates for primary care providers	**Sec. 53. (pp. 66-67)** • Appropriates ***$2,732,677*** (gross) to increase Medicaid reimbursement rates for primary care providers ***beginning on January 1, 2016*** • Expresses legislative intent that amounts will be increased sufficiently on July 1, 2016 to provide a cumulative annualized increase of $7.5 million
Blueprint for Health increases	**Sec. 10. (pp. 9-10)** • Appropriates ***$4,085,826*** (gross) to increase payments to patient-centered medical homes and community health teams participating in the Blueprint for Health • Requires Blueprint to begin including family-centered approaches and adverse childhood experience screenings	**Sec. 52. (p.66)** • Appropriates ***$1,402,900*** (gross) to increase payments to patient-centered medical homes and community health teams participating in the Blueprint for Health ***beginning on January 1, 2016***
Area Health Education Centers (AHEC)	**Sec. 11. (p. 10)** • Appropriates ***$700,000*** (gross) to AHEC for repayment of educational loans for health care providers and health care educators	**Sec. 49. (p.64)** • Appropriates ***$667,111*** (gross) to AHEC for repayment of educational loans for health care providers and health care educators

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All-payer waiver, rate-setting	**Sec. 12. (pp. 10-11)**
	• Appropriates $862,767 (gross) to the GMCB
	  o $502,767 is for positions and operating expenses related to GMCB's provider rate-setting authority, the all-payer model, and Medicaid cost shift
	  o $300,000 is for contracts and third-party services related to provider rate-setting, the all-payer model, and Medicaid cost shift
	  o $60,000.00 is for oversight of VITL's budget and activities
		Sec. 51. (pp. 65-66)
		• Appropriates and adjusts funds to GMCB (result is $862,767) for positions and operating expenses related to GMCB's provider rate-setting authority, the all-payer model, and Medicaid cost shift
		• Appropriates $60,000.00 for oversight of VITL's budget and activities

Rate increases for other Medicaid providers	[No similar provision]	**Sec. 54. (pp. 67-68)**
		• Appropriates $3,394,058 (gross) to AHS to increase reimbursement rates beginning on January 1, 2016 for providers under contract with departments within AHS to provide services to Medicaid beneficiaries:
		  o $1,180,989 to DMH
		  o $284,376 to Dept. of Health, Division of ADAP
		  o $1,458,931 to DAIL for developmental disability services
		  o $469,763 to other departments' line items
		• Appropriates $569,543 (gross) to DVHA to increase Medicaid reimbursement rates for home- and community-based services in Choices for Care beginning on January 1, 2016

Green Mountain Care Board positions	**Sec. 13. (p. 11) (*SAME AS SENATE*)** • Adds three positions to the GMCB	**Sec. 58. (p. 69) (*SAME AS HOUSE*)** • Adds three positions to the GMCB

Subject	S.139 as passed by House	S.139 as passed by Senate
Office of the Health Care Advocate	**Sec. 14. (pp. 11-12)** ***(SAME AS SENATE)*** • Appropriates $40,000.00 (State) for the Office of the Health Care Advocate (HCA) • Expresses legislative intent that Governor's budget proposals include a line item showing the aggregate sum to be appropriated to the HCA from all State sources	**Sec. 50. (p. 65)** ***(SAME AS HOUSE)*** • Appropriates $40,000.00 (State) for the Office of the Health Care Advocate (HCA) • Expresses legislative intent that Governor's budget proposals include a line item showing the aggregate sum to be appropriated to the HCA from all State sources
Rate increases for independent mental health professionals	[No similar provision]	**Sec. 55. (p. 68)** • Appropriates $421,591 (gross) to DVHA to increase Medicaid reimbursement rates on January 1, 2016 to mental health professionals not affiliated with a designated agency
Intent regarding rate increases for dental services	[No similar provision]	**Sec. 56. (p. 68)** • Expresses legislative intent that Medicaid rates for providers of dental services be increased by $485,000 on July 1, 2016
Global Commitment appropriation	[No similar provision]	**Sec. 57. (pp. 68-69)** • Makes appropriations and adjustments to ensure that the AHS Global Commitment budget line item matches the appropriations made in Secs. 48-56
Consumer information and price transparency	**Sec. 15. (p.12)** • Directs GMCB to evaluate potential models for providing consumers with information on cost and quality of health care services • Requires GMCB to report findings and proposal by October 1, 2015	**Sec. 22. (pp. 20-21)** • Requires each health insurer with more than 200 covered lives in Vermont to establish an Internet-based tool to allow its members to compare the price of medical care by service or procedure • Must reflect cost-sharing applicable to a member's specific plan and reflect up-to-date deductible information

<table>
<tr><th>Subject</th><th>S.139 as passed by House</th><th>S.139 as passed by Senate</th></tr>
<tr><td>Universal Primary Care</td><td>Secs. 16–20. (pp. 13-15)
Introduces concept of universal primary care for all Vermonters
Directs Joint Fiscal Office to estimate costs of providing universal primary care to all Vermont residents, with and without cost-sharing, beginning in 2017
Estimate due October 15, 2015
Appropriates up to $200,000.00 to Joint Fiscal Office for the estimates</td><td>Secs. 18-21. (pp. 17-20)
Introduces concept of universal primary care for all Vermonters
Directs Secretary of Administration or designee to estimate costs of providing universal primary care to all Vermont residents, with and without cost-sharing, beginning in 2017
Draft estimate due to JFO by October 15, 2015
JFO must conduct an independent review, provide feedback by December 2, 2015
Final report due to General Assembly by December 16, 2015
JFO must present independent review to General Assembly by January 6, 2016
Requires Secretary of Administration or designee to arrange for actuarial services
Appropriates up to $100,000.00 to Agency of Administration for actuarial work</td></tr>
<tr><td>Green Mountain Care Board duties</td><td>Sec. 21. (pp. 15-16)
[No similar provision]
[No similar provision]
Requires GMCB to review and approve the criteria for health care providers and facilities to</td><td>Sec. 9. (pp. 8-10)
Requires GMCB’s payment reform and cost containment methodologies to involve collaboration with providers, include a transition plan, take into consideration current Medicare designations and payment methodologies, and encourage regional coordination and planning
Requires GMCB to consult with VITL when reviewing the statewide Health Information Technology Plan
Requires GMCB to review and approve criteria for health care providers and facilities to create or</td></tr>
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Subject	S.139 as passed by House	S.139 as passed by Senate
	create or maintain connectivity to health information exchange • ***Requires GMCB to annually review and approve VITL's budget and its core activities associated with public funding*** • ***Requires review to be conducted according to process established by GMCB by rule***	maintain connectivity to health information exchange • ***Requires GMCB to annually review VITL's budget and activities and to approve its budget and its core activities associated with public funding*** • ***Requires review to take into account VITL's responsibilities and the availability of funds***
Green Mountain Care Board rate-setting authority	**Sec. 21a. (p. 16)** ***(SAME AS SENATE)*** • Specifies that nothing about GMCB's rate-setting authority should be construed to reduce or limit covered services offered by Medicare or Medicaid	**Sec. 10. (p. 10)** ***(SAME AS HOUSE)*** • Specifies that nothing about GMCB's rate-setting authority should be construed to reduce or limit covered services offered by Medicare or Medicaid
Vermont Information Technology Leaders (VITL)	**Sec. 22. (pp. 16-19)** • Specifies makeup of VITL's Board of Directors, including one member of General Assembly • Allows Department of Information and Innovation to review VITL's technology	**Sec. 11. (pp. 11-13)** • Specifies makeup of VITL's Board of Directors, including one member of the General Assembly • Allows Department of Information and Innovation to review VITL's technology • ***Prohibits VITL from using any State funds for health care consumer advertising, marketing, lobbying, or similar services***
Referral registry	**Sec. 23. (p. 19)** • Directs Department of Mental Health and Division of Alcohol and Drug Abuse Programs to develop a registry of mental health and addiction services providers in Vermont	[No similar provision]
Ambulance reimbursement	**Sec. 24. (pp. 19-20)** ***(SAME AS SENATE)*** • Requires DVHA to evaluate the way it calculates ambulance and emergency medical services reimbursements in Medicaid to determine the basis for the current reimbursement amounts and rationale • DVHA must consider adjustments to change the methodology if they will be budget neutral or of	**Sec. 12. (p. 14)** ***(SAME AS HOUSE)*** • Requires DVHA to evaluate the way it calculates ambulance and emergency medical services reimbursements in Medicaid to determine the basis for the current reimbursement amounts and rationale • DVHA must consider adjustments to change the methodology if they will be budget neutral or of

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	minimal fiscal impact in FY 2016 • Report due December 1, 2015	minimal fiscal impact in FY 2016 • Report due December 1, 2015
Direct enrollment in Exchange plans	**Secs. 25-26. (pp. 20-21)** ***(SAME AS SENATE)*** • Allows individuals to purchase Exchange plans directly from the health insurers beginning with 2016 open enrollment	**Secs. 13-14. (pp. 14-15)** ***(SAME AS HOUSE)*** • Allows individuals to purchase Exchange plans directly from the health insurers beginning with 2016 open enrollment
Presuit mediation in medical malpractice claims	**Sec. 27. (pp. 21-24)** • Reenacts subchapter on presuit mediation, which expired on February 1, 2015, until • ***July 1, 2018*** • Allows potential plaintiffs to serve on potential defendants in medical malpractice cases a request to participate in presuit mediation before filing the lawsuit • Request would name all known potential defendants, contain a brief statement of the facts the plaintiff believes are grounds for relief, and include a certificate of merit • Sets forth process for potential defendants to accept or reject the request for presuit mediation • If mediation is unsuccessful, plaintiff can bring the medical malpractice lawsuit • Presuit mediation is confidential	**Secs. 32-33. (pp. 30-33)** • Reenacts subchapter on presuit mediation, which expired on February 1, 2015, until • ***July 1, 2020*** • Allows potential plaintiffs to serve on potential defendants in medical malpractice cases a request to participate in presuit mediation before filing the lawsuit • Request would name all known potential defendants, contain a brief statement of the facts the plaintiff believes are grounds for relief, and include a certificate of merit • Sets forth process for potential defendants to accept or reject the request for presuit mediation • If mediation is unsuccessful, plaintiff can bring the medical malpractice lawsuit • Presuit mediation is confidential • ***Secretary of Administration or designee must report by December 1, 2019 on the impacts of certificates of merit and presuit mediation***
Blueprint for Health	**Sec. 28. (p.25)** • Requires 2016 Blueprint for Health annual report to include an analysis of the value-added benefits and return on investment to Medicaid of the new funds appropriated in the fiscal year 2016 budget • Requires Blueprint to explore and report to	[No similar provision]

Subject	S.139 as passed by House	S.139 as passed by Senate
	General Assembly by January 15, 2016 on potential wellness incentives	
Preventable illnesses related to obesity	**Sec. 28a. (p. 25)** • Requires Health Reform Oversight to review data on expenditures and look at policy measures related to obesity in Vermont	[No similar provision]
Provider payment parity	[No similar provision]	**Sec. 24. (pp. 22-23)** • GMCB must consider methods to reduce or eliminate differential reimbursement between health care providers at academic medical centers and other providers • Requires insurers with more than 5,000 covered lives to submit to GMCB by July 1, 2016 a plan to promote parity between providers at academic medical centers and others 　o Plan must not increase premiums or public funding • If GMCB approves a plan, GMCB must require academic medical center to accept the reimbursements provided in the plan • GMCB will provide progress update in its annual report
Payment reform and differential payments to providers	**Sec. 29. (pp. 25-26)** ***(SAME AS SENATE)*** • In implementing an all-payer model and provider rate-setting, directs the Green Mountain Care Board to consider: 　o benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service 　o impact of hospital acquisitions of independent physicians on health system costs 　o effects of different reimbursements for	**Sec. 25. (pp. 23-24)** ***(SAME AS HOUSE)*** • In implementing an all-payer model and provider rate-setting, directs the Green Mountain Care Board to consider: 　o benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service 　o impact of hospital acquisitions of independent physicians on health system costs 　o effects of different reimbursements for

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	different types of providers for the same services billed under the same codes o advantages and disadvantages of allowing health care providers to continue setting their own rates for uninsured customers	different types of providers for the same services billed under the same codes o advantages and disadvantages of allowing health care providers to continue setting their own rates for uninsured customers
Independent analysis of Exchange alternatives	**Sec. 29a. (pp. 26-27)** • Directs Joint Fiscal Office (JFO) to conduct preliminary, independent risk analysis of advantages and disadvantages of alternative options for Exchange • Chief of Health Care Reform must provide JFO with regular updates on Agency of Administration's analysis of alternatives • JFO's report due by September 15, 2015 • $85,000 appropriated to JFO for the analysis	[No similar provision]
Vermont Health Connect Reports	**Sec. 29b. (pp. 27-28)** • Chief of Health Care Reform must provide monthly updates ***to committees of jurisdiction*** regarding: o schedule, cost, and scope status of Vermont Health Connect's (VHC) Release 1 and 2 development efforts o update on status of current risks in VHC implementation o update on actions taken to address Auditor's recommendations o update on preliminary analysis of alternatives to VHC	[No similar provision in S.139; ***H.490 as passed by Senate*** includes the following in Sec. C.106:] • Chief of Health Care Reform must provide monthly updates ***to JFO for distribution to HROC and JFC and to Legislative Council for distribution to committees of jurisdiction, and for posting on the web***, regarding: o schedule, cost, and scope status of Vermont Health Connect's (VHC) release 1 and 2 development efforts o update on status of current risks in VHC implementation o update on actions taken to address Auditor's recommendations o update on preliminary analysis of alternatives to VHC

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Independent review of Vermont Health Connect	**Sec. 29c. (p. 28)** • Chief of Health Care Reform must provide JFO with materials provided by Independent Verification and Validation firms evaluating VHC • ***Between July 1, 2015 and January 1, 2016,*** JFO must analyze reports and provide information about VHC information technology systems ***at least every other month to House Health Care, Senate Health & Welfare, Senate Finance***, HROC, and JFC	[No similar provision in S.139; ***H.490 as passed by Senate*** includes the following in Sec. C.106.1:] • Chief of Health Care Reform must provide JFO with materials provided by Independent Verification and Validation firms evaluating VHC • JFO must analyze reports and provide information about VHC information technology systems ***to*** HROC, JFC, ***Speaker of the House, President Pro Tem in July, September, and October 2015 and other times as appropriate***
Alternatives to Vermont Health Connect	**Sec. 29d. (pp. 29-34)** • Directs Agency of Administration to explore all feasible alternatives to VHC • Lists ***six*** milestones that the General Assembly expects VHC to meet • If VHC fails to meet one or more milestones, Agency of Administration must begin exploring with federal government a transition to a federally supported State-based marketplace (FSSBM) and report on status at next meetings of JFC and HROC • JFC may at any time direct Chief of Health Care Reform to prepare an analysis and potential implementation plan for transition from VHC to different model and present information about a transition • By November 15, 2015, Chief of Health Care Reform must provide JFC and HROC with a recommendation regarding the future of	[No similar provision in S.139; ***H.490 as passed by Senate*** includes the following:] **Sec. C.106.2** • Lists ***four*** milestones that the General Assembly expects VHC to meet **Sec. C.106.3** • If VHC fails to meet one or more milestones, Agency of Administration must ***identify and*** begin exploring with federal government ***all feasible alternatives to VHC, including*** a transition to a federally supported State-based marketplace (FSSBM) and report on status at next meetings of JFC and HROC • [No similar provision] • By November 15, 2015, Chief of Health Care Reform must provide JFC and HROC with a recommendation regarding the future of Vermont's

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	Vermont's exchange, including a proposed 2016 timeline ○ If Chief recommends requesting federal approval to transition to FSSBM, JFC must decide whether to concur by December 1, 2015 ○ If Chief recommends requesting federal approval to transition to FSSBM and JFC agrees, Chief and Commissioner of DVHA must request prior to December 31, 2015 that federal government begin approval process, and by January 15, 2016, provide committees of jurisdiction with recommended statutory changes ○ If Chief does not recommend transition to FSSBM or JFC does not agree with recommendation to transition to FSSBM, Chief must submit information to committees of jurisdiction by January 15, 2016 regarding advantages and disadvantages of alternatives and the proposed statutory changes that would be needed	exchange, including a proposed 2016 timeline ○ If Chief recommends requesting federal approval to transition to FSSBM, JFC ***after consultation with Speaker and Pro Tem,*** must decide whether to concur by December 1, 2015 ○ If Chief recommends requesting federal approval to transition to FSSBM and JFC agrees, Chief and Commissioner of DVHA must request prior to December 31, 2015 that federal government begin approval process, and by January 15, 2016, provide committees of jurisdiction with recommended statutory changes ○ If Chief does not recommend transition to FSSBM or JFC does not agree with recommendation to transition to FSSBM, Chief must submit information to committees of jurisdiction by January 15, 2016 regarding advantages and disadvantages of alternatives and the proposed statutory changes that would be needed
Cigarette tax	**Secs. 30-30e (pp. 34-42); 31h (p. 51)** • Increases cigarette tax by $0.10 per pack and other tobacco products by an equivalent amount on July 1, 2015; applies increase to floor stock on July 1, 2015 • Establishes tax on electronic cigarettes on July 1, 2015 at rate of 46% of wholesale price • Increases cigarette tax by an additional $0.23 per	[No similar provision]

Subject	S.139 as passed by House	S.139 as passed by Senate
	pack and other tobacco products by an equivalent amount on July 1, 2016; applies increase to floor stock on July 1, 2016	
Meals and rooms tax	**Secs. 30f-30g. (pp. 42-44)** • Imposes meals and rooms tax on food and beverage sold through vending machines	[No similar provision in S.139; H.489 as passed the Senate imposes meals and rooms tax on food and beverage sold through vending machines]
Sales tax on soft drinks and candy	**Sec. 30h. (pp. 44-45)** • Imposes sales tax on soft drinks and candy	[No similar provision in S.139; H.489 as passed the Senate imposes sales tax on soft drinks and bottled water]
Nonresidential education property tax rate	**Sec. 30i. (p. 45)** • Sets nonresidential education property tax rate for fiscal year 2016 at $1.515	[No similar provision]
Revenue from tax on electronic cigarettes	**Sec. 30j. (p. 45)** • Requires revenue from tax on electronic cigarettes in fiscal year 2016 to be reserved in the Tobacco Trust Fund	[No similar provision]
Displays of tobacco products and electronic cigarettes	**Secs. 31a. (pp. 46-47)** • Tobacco products and electronic cigarettes can only be displayed or stored behind a sales counter in an area accessible only to sales personnel or in a locked container not located on a sales counter	[No similar provision]

Prohibitions on use of electronic cigarettes	**Secs. 31b–31g. (pp. 47-51)**
	• Prohibits the use of electronic cigarettes anywhere lighted tobacco products are prohibited, including:
	  o in any workplace
	  o in common areas of indoor places of public access
	  o hotels and motels, including hotel and motel rooms
	  o designated smoke-free areas of land owned by or leased to the State
	  o any area within 25 feet of State-owned buildings and offices
		[No similar provision]

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	○ in a motor vehicle occupied by a child required to be restrained in federally approved child passenger restraining system • Exceptions for so-called "vapor rooms", Vermont Veterans' Home, and private areas of owner-operated businesses with no employees	
Medicaid coverage for primary care telemedicine	[No similar provision]	**Sec. 7. (pp. 6-7)** • Requires Medicaid coverage for primary care consultations delivered to Medicaid beneficiaries outside a health care facility beginning on October 1, 2015 • Coverage is only for services that have been determined by the Department of Vermont Health Access's (DVHA) Chief Medical Officer to be clinically appropriate
Telemedicine implementation report	[No similar provision]	**Sec. 8. (pp. 7-8)** • By April 15, 2016, DVHA must provide a report on the first six months of implementation of Medicaid coverage for primary care consultations delivered through telemedicine outside a health care facility
Large group insurance market	[No similar provision]	**Secs. 15-17. (pp. 15-17)** • Delays until 2018 the ability of large group market to purchase Exchange plans • Directs GMCB to analyze projected impact on rates in the large group market if large employers are allowed to buy Exchange plans beginning in 2018, including impact on premiums of the transition from experience rating to community rating

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Public employees' health benefits	[No similar provision]	**Sec. 23. (pp. 21-22)** • Director of Health Care Reform must identify options and considerations for providing health care coverage to all public employees, including State and judiciary employees, school employees, municipal employees, and State and teacher retirees • Coverage must be cost-effective and not trigger the excise ("Cadillac") tax • Report due by November 1, 2015
Repurposing excess hospital funds	[No similar provision]	**Sec. 28. (pp. 26-27)** • Describes reductions in rate of uninsured with no corresponding reduction in Disproportionate Share Hospital (DSH) payments and hospital "free care" charges • Directs GMCB to identify "stranded" dollars in hospital budgets, report findings to General Assembly by October 15, 2015 • Expresses legislative intent to repurpose those dollars for increases to the Blueprint
Provider rate setting in Medicaid	[No similar provision]	**Sec. 29. (p. 27)** • Directs Department of Disabilities, Aging, and Independent Living and AHS Division of Rate Setting to review current reimbursement rates for providers of certain long term home- and community-based care services and report findings and recommendations by December 1, 2015
Green Mountain Care Board review of designated agency budgets	[No similar provision]	**Sec. 30. (p. 28)** • Directs GMCB to analyze the budget and Medicaid rates of one or more designated agencies using criteria similar to hospital budget review • Directs GMCB to consider whether designated and specialized service agencies should be included in

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		the all-payer model • Report due by January 31, 2016 regarding Board's ongoing role in designated agency budget review and the designated and specialized service agencies' inclusion in the all-payer model
Effect of Medicaid rate increase for designated agencies	[No similar provision]	**Sec. 31. (pp. 28-29)** • Requires designated agencies and specialized service agencies to use any Medicaid increase to provide additional compensation or benefits, or both, to their direct care workers or other employees
Transferring Department of Financial Regulation (DFR) duties	[No similar provision]	**Secs. 34–47. (pp. 34-64)** • Sec. 34 (pp. 34-35) - requires public hearing in insurance rate review cases within 90-day period for the GMCB's review, rather than within 30 days after making rate filing available to public; maintains DFR's authority over Medicare supplemental rates • Sec. 35 (pp. 35-37) - eliminates requirement that insurers to file with DFR an annual report card regarding the plan's performance with respect to care and treatment for mental and substance abuse conditions, as well as its revenue loss and expense ratio relating to care and treatment of mental conditions under the plan • Sec. 36 (pp. 37-38) - deletes DFR's Division of Health Care Administration from definition section, makes conforming change with respect to GMCB's authority over health resource allocation plan • Sec. 37 (pp. 38-39) - makes conforming changes reflecting GMCB's role over procedures in 18 V.S.A. chapter 221; eliminates the special fund

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		DFR used when it regulated health care • Sec. 38 (pp. 39-41) - makes conforming changes reflecting GMCB's authority over VHCURES; deletes requirement that VHCURES include a consumer health care price and quality information system and deletes DFR's authority to require health insurers to file consumer health care price and quality information plans; transfers household health insurance survey to Department of Health, with next survey due by January 15, 2018 • Sec. 39 (pp. 42-44) - allows DFR to resolve certain consumer complaints about managed care organizations (MCOs) as though the MCO was an insurer; eliminates a requirement that DFR review an MCO's performance at least once every three years • Sec. 40 (pp. 44-45) - deletes references to rules adopted by DFR • Sec. 41 (p. 45) - deletes references to rules adopted by DFR • Sec. 42 (pp. 45-57) - GMCB replaces DFR as entity with authority over conversion of nonprofit hospitals • Sec. 43 (pp. 57-59) - makes changes to the public notice requirements for certificate of need applications • Sec. 44 (pp. 60-61) - clarifies GMCB's authority in enforcing certificate of need laws • Sec. 45 (pp. 61-62) - makes conforming change in hospital budget review statute • Sec. 46 (p. 62) - prohibits DFR from modifying existing common forms, procedures, and rules prior to January 1, 2017; allows DFR to review

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		and examine aspects of MCO administration • Sec. 47 (pp. 63-64) - requires Director of Health Care Reform to evaluate the need to maintain certain provisions in health insurance statutes, the need to maintain provisions requiring DFR to review and examine aspects of MCO administration, the appropriate entity to assume responsibility for any function that should be retained, and the requirements of federal law applicable to DVHA in its role as public MCO; report due by December 15, 2015
Repeals	**Sec. 32. (p. 51)** • Repeals presuit mediation provisions on ***July 1, 2018***	**Sec. 59. (p. 70)** • Repeals statute on other powers and duties of DFR Commissioner • Repeals statute on DFR bill-back authority • Prospective repeal of presuit mediation on ***July 1, 2020***
Effective dates	**Sec. 33. (pp. 51-53)**	**Sec. 60 (pp. 70-71)**