**Side by side comparison of S.135 *as passed by Finance and Appropriations(?)* and S.139 *as passed by House***

*Prepared by Jennifer Carbee, Legislative Counsel, Office of Legislative Council*

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| Subject | S.135 | S.139 |
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| **All-payer model** | **Sec. 1**<br>• Secretary of Administration or designee and Green Mountain Care Board (GMCB) must jointly explore all-payer model<br>• Must consider the following models:<br>  ○ including payment for broad array of health services<br>  ○ hospitals only<br>  ○ allowing for global hospital budgets for all Vermont hospitals | [No similar provision] |
| **St. Johnsbury accountable care community** | **Sec. 2 (*SAC may delete)***<br>• Directs the FQHC in St. Johnsbury to convene interested stakeholders to create a concept paper and implementation plan for an accountable care community program for the St. Johnsbury health service area<br>• Upon completion of implementation plan, it must be submitted to Agency of Human Services to determine feasibility of implementation | [No similar provision] |
| **Green Mountain Care Board duties** | **Sec. 3**<br>• 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<br>• Requires GMCB to consult with VITL when reviewing the statewide Health Information Technology Plan | **Sec. 21** |

| Subject | S.135 | S.139 |
|---|---|---|
| | • Requires GMCB to review and approve criteria for health care providers and facilities to create or maintain connectivity to health information exchange<br>• ***Requires GMCB to annually review VITL's budget and activities and to approve its budget and its core activities associated with public funding***<br>• ***Requires review to take into account availability of funds*** | • Requires GMCB to review and approve the criteria for health care providers and facilities to create or maintain connectivity to health information exchange<br>• ***Requires GMCB to annually review and approve VITL's budget and its core activities associated with public funding***<br>• ***Requires review to be conducted according to process established by GMCB by rule*** |
| **VITL** | **Sec. 4**<br>• Specifies makeup of VITL's Board of Directors, including one member of the General Assembly<br>• Allows Department of Information and Innovation to review VITL's technology<br>• ***Prohibits VITL from using any State funds for health care consumer advertising, marketing, lobbying, or similar services*** | **Sec. 22**<br>• Specifies makeup of VITL's Board of Directors, including one member of General Assembly<br>• Allows Department of Information and Innovation to review VITL's technology |
| **Telemedicine** | **Secs. 5-6**<br>• Requires Medicaid coverage for primary care consultations delivered to Medicaid beneficiaries outside a health care facility beginning on October 1, 2015<br>• 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<br>• 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 | [No similar provision] |

| Subject | S.135 | S.139 |
|---|---|---|
| **Direct enrollment in Exchange plans** | **Secs. 7-8**<br>• Allows individuals to purchase Exchange plans directly from the health insurers beginning with 2016 open enrollment | **Secs. 25-26**<br>• Allows individuals to purchase Exchange plans directly from the health insurers beginning with 2016 open enrollment |
| **Large group insurance market** | **Secs. 9-11**<br>• Delays until 2018 the ability of large group market to purchase Exchange plans<br>• 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 | [No similar provision] |
| **Health care quality and price comparison website** | **Sec. 12**<br>• 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<br>• Must reflect cost-sharing applicable to a member's specific plan and reflect<br>• up-to-date deductible information | **Sec. 15**<br>• Directs GMCB to evaluate potential models for providing consumers with information on cost and quality of health care services<br>• Requires GMCB to report findings and proposal by October 1, 2015 |
| **Public employees' health benefits** | **Sec. 13**<br>• 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<br>• Coverage must be cost-effective and not trigger the excise ("Cadillac") tax<br>• Report due by November 1, 2015 | [No similar provision] |

| Subject | S.135 | S.139 |
|---|---|---|
| **Provider payment parity** | **Secs. 14-15 (*SAC may delete/revise*)**<br>• Health plans must reimburse participating physicians, podiatrists, chiropractors, naturopathic physicians, psychologists, clinical social workers, advanced practice registered nurses, and physician assistants the same professional fee as applied to other participating providers providing same covered service<br>• Health plans must adjust reimbursement rates to ensure that parity is attained without increasing premiums<br>• GMCB must convene group of interested stakeholders to develop implementation plan for parity in 2017, which must be provided to committees of jurisdiction by January 15, 2016 | **Sec. 29**<br>• In implementing an all-payer model and provider rate-setting, directs the Green Mountain Care Board to consider:<br>o benefits of prioritizing and expediting payment reform in primary care that shifts away from fee-for-service<br>o impact of hospital acquisitions of independent physicians on health system costs<br>o effects of different reimbursements for different types of providers for the same services billed under the same codes<br>o advantages and disadvantages of allowing health care providers to continue setting their own rates for uninsured customers |
| **Transferring DFR duties** | **Secs. 16–29**<br>• Sec. 16 - 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<br>• Sec. 17 - 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<br>• Sec. 18 - deletes DFR's Division of Health Care Administration from definition section, makes conforming change with respect to GMCB's | [No similar provisions] |

| Subject | S.135 | S.139 |
|---|---|---|
| | authority over health resource allocation plan<br>• Sec. 19 - makes conforming changes reflecting GMCB's role over procedures in 18 V.S.A. chapter 221; eliminates the special fund DFR used when it regulated health care<br>• Sec. 20 - 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<br>• Sec. 21 - 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<br>• Sec. 22 - deletes references to rules adopted by DFR<br>• Sec. 23 - deletes references to rules adopted by DFR<br>• Sec. 24 - GMCB replaces DFR as entity with authority over conversion of nonprofit hospitals<br>• Sec. 25 - makes changes to the public notice requirements for certificate of need applications<br>• Sec. 26 - clarifies GMCB's authority in enforcing certificate of need laws<br>• Sec. 27 - makes conforming change in hospital budget review statute<br>• Sec. 28 - prohibits DFR from modifying existing | |

| Subject | S.135 | S.139 |
|---|---|---|
| | common forms, procedures, and rules prior to January 1, 2017; allows DFR to review and examine aspects of MCO administration<br>• Sec. 29 - 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 | |
| **Extension of presuit mediation in medical malpractice claims** | **Secs. 30-31**<br>• Reenacts subchapter on presuit mediation, which expired on February 1, 2015, until July 1, 2020<br>• Allows potential plaintiffs to serve on potential defendants in medical malpractice cases a request to participate in presuit mediation before filing the lawsuit<br>• 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<br>• Sets forth process for potential defendants to accept or reject the request for presuit mediation<br>• If mediation is unsuccessful, plaintiff can bring the medical malpractice lawsuit<br>• Presuit mediation is confidential<br>• ***Secretary of Administration or designee must report by December 1, 2019 on the impacts of certificates of merit and presuit mediation*** | **Sec. 27**<br>• Reenacts subchapter on presuit mediation, which expired on February 1, 2015, until July 1, 2018<br>• Allows potential plaintiffs to serve on potential defendants in medical malpractice cases a request to participate in presuit mediation before filing the lawsuit<br>• 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<br>• Sets forth process for potential defendants to accept or reject the request for presuit mediation<br>• If mediation is unsuccessful, plaintiff can bring the medical malpractice lawsuit<br>• Presuit mediation is confidential |

| Subject | S.135 | S.139 |
|---|---|---|
| **Provider rate setting in Medicaid long-term care** | **Sec. 32**<br>• 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 | [No similar provision] |
| **GMCB review of designated agency budgets** | **Sec. 33**<br>• Directs GMCB to analyze the budget and Medicaid rates of one or more designated agencies using criteria similar to hospital budget review<br>• Directs GMCB to consider whether designated and specialized service agencies should be included in the all-payer model<br>• 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 | [No similar provision] |
| **Universal primary care** | **Secs. 34-38**<br>• Introduces concept of universal primary care for all Vermonters, ***including findings***<br>• Directs Joint Fiscal Office to estimate costs of providing universal primary care to all Vermont residents, with and without cost-sharing, beginning in 2017<br>o Estimate due October 15, 2015<br>• ***Requires Secretary of Administration or designee to arrange for actuarial services***<br>• ***Appropriates up to $100,000.00 to Agency of Administration for actuarial work*** | **Secs. 16–20. Universal Primary Care**<br>• Introduces concept of universal primary care for all Vermonters<br>• Directs Joint Fiscal Office to estimate costs of providing universal primary care to all Vermont residents, with and without cost-sharing, beginning in 2017<br>o Estimate due October 15, 2015<br>• ***Appropriates up to $200,000.00 to Joint Fiscal Office for the estimates*** |

| Subject | S.135 | S.139 |
|---|---|---|
| **Repeals** | **Sec. 39**<br>• Repeals statute on other powers and duties of DFR Commissioner<br>• Repeals statute on DFR bill-back authority<br>• Prospective repeal of presuit mediation on July 1, 2020 | **Sec. 32. Repeal**<br>• Prospective repeal of presuit mediation provisions on July 1, 2018 |
| **Pharmacy benefit managers** | [No similar provision] | **Secs. 1-2**<br>• Requires pharmacy benefit managers (PBMs) to:<br>o make available to pharmacists the actual maximum allowable cost (MAC) for each drug and the source used to determine the MAC<br>o update the MAC at least every 7 calendar days<br>o have a reasonable appeals process to contest a MAC<br>o 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 |
| **Notice of hospital observation status** | [No similar provision] | **Secs. 3-4a**<br>• Requires hospitals to provide oral and written notices to Medicare beneficiaries placed in observation status<br>• Notice must tell people:<br>o that they are on observation status and not admitted as an inpatient<br>o that observation status may affect their Medicare coverage for hospital services and nursing home stays<br>o whom they may contact for more information<br>• Requests that interested stakeholders consider the |

| Subject | S.135 | S.139 |
|---|---|---|
| | | appropriate notice of hospital observation status for patients with commercial insurance<br>o Report due by January 15, 2016 |
| **VHCIP updates** | [No similar provision] | **Sec. 5**<br>• 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 AHS services** | [No similar provision] | **Sec. 6**<br>• 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<br>• AHS must identify gaps in services and overlapping or duplicative services<br>• Report due January 15, 2016 |
| **Exchange cost-sharing subsidies** | | **Secs. 7-8**<br>• 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<br>• Appropriates $761,308 (State) for base spending for cost-sharing subsidies<br>• Appropriates $2 million (State) for increased subsidies beginning January 1, 2016 |
| **Primary care provider rate increase** | | **Sec. 9**<br>• Appropriates $7 million (gross) to increase Medicaid reimbursement rates for primary care providers |

| Subject | S.135 | S.139 |
|---|---|---|
| **Blueprint for Health increase** | | **Sec. 10**<br>• Appropriates $4,085,826 (gross) to increase payments to patient-centered medical homes and community health teams participating in the Blueprint for Health<br>• Requires Blueprint to begin including family-centered approaches and adverse childhood experience screenings |
| **Appropriation to AHEC** | | **Sec. 11**<br>• Appropriates $700,000 (gross) to AHEC for repayment of educational loans for health care providers and health care educators |
| **Appropriation for all-payer waiver; rate-setting** | | **Sec. 12**<br>• Appropriates $862,767 (gross) to the GMCB<br>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<br>o $300,000 is for contracts and third-party services related to provider rate-setting, the all-payer model, and Medicaid cost shift<br>o $60,000 is for oversight of VITL's budget and activities |
| **GMCB positions** | [No similar provision] | **Sec. 13**<br>• Adds three positions to the GMCB |
| **Appropriation to Health Care Advocate** | | **Sec. 14**<br>• Appropriates $40,000.00 (State) for the Office of the Health Care Advocate (HCA)<br>• 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 |

| Subject | S.135 | S.139 |
|---|---|---|
| **GMCB rate-setting authority** | [No similar provision] | **Sec. 21a**<br>• Specifies that nothing about GMCB's rate-setting authority should be construed to reduce or limit covered services offered by Medicare or Medicaid |
| **Referral registry** | [No similar provision] | **Sec. 23**<br>• Directs Department of Health and Division of Alcohol and Drug Abuse Programs to develop a registry of mental health and addiction services providers in Vermont |
| **Ambulance reimbursement** | [No similar provision] | **Sec. 24**<br>• Requires DVHA to evaluate how it calculates ambulance and emergency medical services reimbursements in Medicaid to determine the basis and rationale<br>• DVHA must consider adjustments to change the methodology if they will be budget neutral or of minimal fiscal impact in FY 2016<br>• Report due December 1, 2015 |
| **Blueprint for Health** | [No similar provision] | **Sec. 28**<br>• 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<br>• Requires Blueprint to explore and report to General Assembly by January 15, 2016 on potential wellness incentives |
| **Preventable illnesses related to obesity** | [No similar provision] | **Sec. 28a**<br>• Requires Health Reform Oversight to review data on expenditures and look at policy measures related to obesity in Vermont |
| **Independent analysis of Exchange** | [No similar provision] | **Sec. 29a**<br>• Directs Joint Fiscal Office (JFO) to conduct preliminary, independent risk analysis of |

| Subject | S.135 | S.139 |
|---|---|---|
| **alternatives** | | advantages and disadvantages of alternative options for Exchange<br>• Chief of Health Care Reform must provide JFO with regular updates on Agency of Administration's analysis of alternatives<br>• JFO's report due by September 15, 2015<br>• $85,000 appropriated to JFO for the analysis |
| **Vermont Health Connect reports** | [No similar provision] | **Sec . 29b**<br>• Chief of Health Care Reform must provide monthly updates to committees of jurisdiction regarding:<br>o schedule, cost, and scope status of Vermont Health Connect's (VHC) Release 1 and 2 development efforts<br>o update on status of current risks in VHC implementation<br>o update on actions taken to address Auditor's recommendations<br>o update on preliminary analysis of alternatives to VHC |
| **Independent review of Vermont Health Connect** | [No similar provision] | **Sec. 29c**<br>• Chief of Health Care Reform must provide JFO with materials provided by Independent Verification and Validation firms evaluating VHC<br>• 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 |
| **Alternatives to Vermont Health Connect** | [No similar provision] | **Sec. 29d**<br>• Directs Agency of Administration to explore all feasible alternatives to VHC<br>• Lists milestones that the General Assembly expects VHC to meet |

| Subject | S.135 | S.139 |
|---|---|---|
| | | • If VHC fails to meet one or more milestones, Agency of Administration must begin exploring with federal government transition to federally supported State-based marketplace (FSSBM) and report on status at next meetings of Joint Fiscal Committee (JFC) and Health Reform Oversight Committee (HROC)<br>• JFC may at any time direct Chief of Health Care Reform to prepare analysis and potential implementation plan for transition from VHC to different model and present information about transition<br>• By November 15, 2015, Chief of Health Care Reform must provide JFC and HROC with a recommendation regarding the future of Vermont's exchange, including a proposed 2016 timeline<br>o If Chief recommends requesting federal approval to go to FSSBM, JFC must decide whether to concur by December 1, 2015<br>o 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 the federal government begin approval process, and by January 15, 2016, provide committees of jurisdiction with recommended statutory changes<br>o If Chief does not recommend transition to FSSBM or JFC does not agree with recommendation to transition to FSSBM, Chief must submit information by January 15, 2016 regarding advantages and disadvantages of alternatives and proposed |

| Subject | S.135 | S.139 |
|---|---|---|
| | | statutory changes that would be needed |
| **Cigarette tax** | [No similar provision] | **Secs. 30-30e; 31h**<br>• Increases cigarette tax by $0.10 per pack and other tobacco products by equivalent amount on July 1, 2015; applies increase to floor stock July 1, 2015<br>• Establishes tax on electronic cigarettes on July 1, 2015 at rate of 46% of wholesale price<br>• Increases cigarette tax by an additional $0.23 per 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** | [No similar provision] | **Secs. 30f-30g**<br>• Imposes meals and rooms tax on food and beverage sold through vending machines |
| **Sales tax on soft drinks and candy** | [No similar provision] | **Sec. 30h**<br>• Imposes sales tax on soft drinks and candy |
| **Nonresidential education property tax rate** | [No similar provision] | **Sec. 30i**<br>• Sets nonresidential education property tax rate for fiscal year 2016 at $1.515 |
| **Revenue from tax on electronic cigarettes** | [No similar provision] | **Sec. 30j**<br>• Requires revenue from tax on electronic cigarettes in fiscal year 2016 to be reserved in the Tobacco Trust Fund |
| **Displays of tobacco products and electronic cigarettes** | [No similar provision] | **Secs. 31a**<br>• Tobacco products and electronic cigarettes can only be displayed or stored behind a sales counter in an area accessibly only to sales personnel or in a locked container not located on a sales counter |
| **Prohibitions on use of electronic cigarettes** | [No similar provision] | **Secs. 31b–31g**<br>• Prohibits the use of electronic cigarettes anywhere lighted tobacco products are prohibited, including in: |

| Subject | S.135 | S.139 |
|---|---|---|
| | | ○ any workplace<br>○ common areas of indoor places of public access<br>○ hotels and motels, including hotel and motel rooms<br>○ designated smoke-free areas of land owned by or leased to the State<br>○ any area within 25 feet of State-owned buildings and offices<br>○ a motor vehicle occupied by a child required to be restrained in federally approved child passenger restraining system<br>• Exceptions for so-called "vapor rooms", Vermont Veterans' Home, and private areas of owner-operated businesses with no employees |