TO THE HONORABLE SENATE:

The Committee on Health and Welfare to which was referred Senate Bill No. 190 entitled "An act relating to the Green Mountain Care Board, reference-based pricing, and hospital outsourcing of clinical care" respectfully reports that it has considered the same and recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

* * * Reference-Based Pricing * * *

Sec. 1. 18 V.S.A. § 9376(e) is amended to read:

(e) Reference-based pricing.

* * *

(3)(A) The Board shall begin implementing reference-based pricing as soon as practicable but not later than hospital fiscal year 2027 by establishing the maximum amounts that Vermont hospitals shall accept as payment in full for items provided and services delivered. After initial implementation, the Board shall review the reference-based prices for each hospital annually as part of the hospital budget review process set forth in chapter 221, subchapter 7 of this title.

(B) The Board, in collaboration with the Department of Financial Regulation, shall monitor the implementation of reference-based pricing to ensure that any decreases in amounts paid to hospitals also result in decreases

in health insurance premiums. The Board shall post its findings regarding the alignment between price decreases and premium decreases annually on its website.

(C) For provider contracts entered into**, amended, or renewed (GMCB)** on or after October 1, 2026, each hospital and health insurer shall **begin** expressing ~~the rates for all items and services~~ as a percentage of Medicare or of another benchmark, if another benchmark is deemed appropriate by the Green Mountain Care Board**, the rates for items and services identified pursuant to a collaborative process between the Board and representatives of Vermont hospitals**.

(D)(i) Each hospital shall apply for, obtain, and use a unique National Provider Identifier (NPI) on all claims filed after October 1, ~~2026~~ **2027**, for reimbursement or payment of items provided and services delivered at an off-campus department of the hospital that is distinct from the NPI used for services delivered at the main hospital campus or at any other off-campus hospital department.

(ii) As used in this subdivision (D):

(I) "Campus" has the same meaning as in 42 C.F.R. § 413.65.

(II) "Off-campus" means a facility located more than 250 yards from the main hospital campus.

(E) When making public the charges for items and services pursuant to 45 C.F.R. Part 180, each hospital shall include in its machine-readable files pricing information shown as a percentage of Medicare rates, as well as in dollars and cents, disaggregated by payer and by plan.

~~(F) The Board shall establish a default percentage of Medicare above which a hospital shall not accept payment for an item or service under any newly established Current Procedural Terminology (CPT) code unless and until the Board establishes a specific reference-based price for the item or service pursuant to this chapter.~~

~~(G) The Board shall establish a default maximum percentage of Medicare above which a hospital shall not accept payment for any individual inpatient or outpatient item or service.~~

(F)(i) Until the applicability date specified in the Green Mountain Care Board rule establishing the reference-based pricing methodology for all items provided and services delivered in Vermont hospitals:

(I) a hospital shall implement any commercial reimbursement rate reduction ordered by the Board pursuant to section 9456 of this title by first reducing its commercial reimbursement rates that exceed 500 percent of the Medicare adjusted base rate or, if the hospital does not have any commercial reimbursement rates that exceed 500 percent of the Medicare adjusted base rate, by first reducing its

commercial reimbursement rates that are the highest in relation to the Medicare adjusted base rate; and

(II) a hospital shall not increase any commercial reimbursement rate that, as of July 1, 2026, exceeded 250 percent of the Medicare adjusted base rate.

(ii) As used in this subdivision (F) of this subdivision (e)(3), "Medicare adjusted base rate" means the standardized Medicare payment amount for a hospital inpatient, outpatient, or professional service as determined under the Medicare program, calculated prior to the application of any hospital-specific, patient-specific, or policy-based payment adjustments and reflecting only the core payment methodology used by the Centers for Medicare and Medicaid Services to establish baseline payment levels, which include adjustments for geographic factors such as wages.

* * *

Sec. 2. 33 V.S.A. § 1815 is added to read:

§ 1815. LIMITATIONS ON HOSPITAL REIMBURSEMENTS

(a)(1) As used in this section, "Medicare adjusted base rate" means the standardized Medicare payment amount for a hospital inpatient, outpatient, or professional service as determined under the Medicare program, calculated prior to the application of any hospital-specific,

patient-specific, or policy-based payment adjustments and reflecting only the core payment methodology used by the Centers for Medicare and Medicaid Services to establish baseline payment levels, which include adjustments for geographic factors such as wages.

(2) For items provided and services delivered at a critical access hospital, the Medicare adjusted base rate shall be determined under the applicable Medicare prospective payment system, using the Medicare payment methodology that would apply if the hospital were not designated as a critical access hospital.

(b)(1) A registered carrier shall not reimburse or agree to reimburse a hospital more than 250 percent of the Medicare adjusted base rate for any item provided or service delivered in Vermont to an individual enrolled in a qualified health benefit plan.

(2) In the event that a registered carrier reimburses a hospital for an item or service on a capitated or other non-fee-for-service basis, the carrier shall ensure that its reimbursement method is adjusted to account for the reimbursement limit set forth in subdivision (1) of this subsection.

(c) The reimbursement limit set forth in subsection (b) of this section shall apply until the applicability date specified in the Green Mountain Care Board rule establishing the reference-based pricing methodology for all items provided and services delivered in Vermont hospitals.

(d) A hospital or hospital provider that is reimbursed in accordance with subsection (b) of this section shall not charge or collect from the patient any additional amounts other than the cost-sharing amounts authorized by the terms of the health benefit plan.

(e) The purpose of this section is to reduce health care costs. A hospital shall not increase the amounts the hospital charges other commercial plans or private payers for prescription drugs, procedures, tests, imaging, or other health care goods or services in an effort to offset revenue reduced as a result of this section.

* * * Hospital Outsourcing * * *

~~Sec. 2. HOSPITAL OUTSOURCING; FINDINGS; PURPOSE~~

~~(a) The General Assembly finds that:~~

~~(1) Hospitals are increasingly outsourcing their clinical services, such as emergency medicine, anesthesiology, radiology, laboratory services, and other specialized care, to outside entities.~~

~~(2) Revenue from outsourced clinical services is not consistently reported in the hospital budget process and has been excluded from the Green Mountain Care Board's regulatory oversight.~~

~~(3) Outsourced revenue may circumvent hospital revenue caps and spending limitations, undermining budget transparency and accountability.~~

~~(4) Without oversight, outsourced services may operate outside price controls, including reference-based pricing, which contributes to cost inflation and market inefficiencies.~~

~~(5) Patients may face network adequacy issues, surprise medical bills, and inconsistent access to financial assistance when receiving care from outsourced providers.~~

~~(b) The purposes of 18 V.S.A. § 9415, as enacted in Sec. 3 of this act, are:~~

~~(1) to bring all hospital-affiliated revenue within the Green Mountain Care Board's regulatory purview, thus closing gaps in spending accountability;~~

~~(2) to ensure that reference-based pricing applies to outsourced services, thus preventing cost inflation and creating transparent rate structures that apply across all hospital services; and~~

~~(3) to apply network adequacy requirements and billing protections to shield patients from surprise medical bills and ensure consistent access to legally required financial assistance policies.~~

~~Sec. 3. 18 V.S.A. § 9415 is added to read:~~

~~§ 9415. HOSPITAL OUTSOURCING OF CLINICAL CARE~~

~~(a) Definitions. As used in this section, "outsourcing" means an arrangement in which a hospital contracts with an external entity that assumes sole control of direct clinical care offered within the hospital facility.~~

~~"Outsourced services" may include emergency medicine, anesthesiology,~~

~~hospitalist services, and other direct patient care services provided on-site at the hospital by a contracted entity. "Outsourced services" do not include services provided by a nurse on a short-term contract with a hospital in which the hospital retains oversight and control over patient care; off-site diagnostic services, including off-site diagnostic interpretation of radiologic images and off-site laboratory testing; or nonclinical services such as laundry services, nutrition services, information technology, or cybersecurity.~~

~~(b) Regulatory oversight and accountability.~~

~~(1) Revenue from outsourced services shall be included in a hospital's net patient revenue limits, commercial rate limits, operating expense limits, and other limitations as specified by the Green Mountain Care Board in its annual hospital budget guidance.~~

~~(2) The Green Mountain Care Board's rate-setting authority, including reference-based pricing established pursuant to section 9376 of this title and global hospital budgets developed pursuant to section 9456 of this title, shall apply to outsourced services.~~

~~(3) Revenue generated by outsourced services delivered in a hospital-owned facility shall be deemed to be part of the net patient revenue of the hospital for purposes of the annual assessment on hospitals pursuant to 33 V.S.A. § 1953 and other applicable State assessments.~~

~~(c) Consumer protections.~~

~~(1) In order to ensure continuity of coverage and prevent surprise medical bills, a hospital shall be responsible for billing the health insurance claims for all outsourced services delivered to a patient at the hospital by a contracted provider who would otherwise be out-of-network under the patient's health insurance plan.~~

~~(2) A hospital contracting for outsourced services shall minimize billing complexity for patients and shall coordinate billing processes with outsourced service providers to the greatest extent possible.~~

~~(3) Hospital financial assistance policies developed in accordance with subchapter 10 of this chapter and any other policies regarding bad debt or charity care shall apply to outsourced services to ensure that patients receive consistent financial protections regardless of service delivery model.~~

~~Sec. 4. 18 V.S.A. § 9482 is amended to read:~~

~~§ 9482. FINANCIAL ASSISTANCE POLICIES FOR LARGE HEALTH CARE FACILITIES~~

~~(a) Each large health care facility in this State shall develop a written financial assistance policy that, at a minimum, complies with the provisions of this subchapter and any applicable federal requirements.~~

~~(b) The financial assistance policy shall:~~

~~(1) apply, at a minimum, to all emergency and other medically necessary health care services that the large health care facility offers, including outsourced services, as defined in section 9415 of this title, that are delivered at the facility;~~

~~* * *~~

~~Sec. 5. 33 V.S.A. § 1951 is amended to read:~~

~~§ 1951. DEFINITIONS~~

~~As used in this subchapter:~~

~~* * *~~

~~(10) "Net patient revenues" means a provider's gross charges related to patient care services less any deductions for bad debts, charity care, contractual allowances, and other payer discounts, and includes outsourced services, as defined in 18 V.S.A. § 9415, that are delivered at the hospital.~~

~~* * *~~

Sec. 3. HOSPITAL OUTSOURCING; HOSPITAL BUDGETS; PROVIDER TAXES; REPORT

(a) For fiscal year 2027 hospital budgets, the Green Mountain Care Board shall direct hospitals to provide such information as the Board may require regarding the clinical services that the hospital outsources to external entities.

(b) On or before January 15, 2027, the Green Mountain Care Board, after consulting with hospitals and their contracted independent providers and assessing the impact of outsourcing on access to and the quality and availability of care, shall provide findings and recommendations regarding hospital outsourcing to the House Committee on Health Care and the Senate Committee on Health and Welfare. In addition, the Board, in collaboration with the Agency of Human Services, shall report on the extent to which hospital outsourcing affects provider tax revenue and recommend any necessary modifications to 33 V.S.A. chapter 19, subchapter 2 to appropriately reflect expenditures for patient care at Vermont hospitals.

* * * ~~Repeal of~~ **Excluding Reference-Based Pricing from Scope of** Health Care Professional Bargaining ~~Group Authorizing Language~~ * * *

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

~~§ 9373. DEFINITIONS~~

~~As used in this chapter:~~

~~* * *~~

~~(12) "Payment reform" means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other~~

~~health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.~~

~~* * *~~

~~Sec. 7. 18 V.S.A. § 9376 is amended to read:~~

~~§ 9376. PAYMENT AMOUNTS; METHODS~~

~~* * *~~

~~(b) Rate-setting.~~

~~(1) The Board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the Board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the Board may consider legitimate differences in costs among health care professionals, such as the cost of~~

~~providing a specific necessary service or services that may not be available elsewhere in the State, and the need for health care professionals in particular areas of the State, particularly in underserved geographic or practice shortage areas.~~

~~* * *~~

~~(d) Supervision. To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the Board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.~~

~~* * *~~

~~Sec. 8. REPEAL~~

~~18 V.S.A. § 9409 (health care provider bargaining groups) is repealed.~~

Sec. 4. 18 V.S.A. § 9409 is amended to read:

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

(a) The Green Mountain Care Board may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. A bargaining group is authorized to negotiate on behalf of all participating providers with the Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the Commissioner of Labor with respect to any matter in this

chapter; chapter 13, 219, 220, or 222 of this title; 21 V.S.A. chapter 9; and 33 V.S.A. chapters 18 and 19 with respect to provider regulation, provider reimbursement, administrative simplification, information technology, workforce planning, or quality of health care.

(b) The Green Mountain Care Board shall adopt by rule criteria for forming and approving bargaining groups and criteria and procedures for negotiations authorized by this section.

(c) The rules relating to negotiations shall include a nonbinding arbitration process to assist in the resolution of disputes. Nothing in this section shall be construed to limit the authority of the Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the Commissioner of Labor to reject the recommendation or decision of the arbiter.

(d) Notwithstanding any provisions of this section to the contrary, the Green Mountain Care Board shall not be required to negotiate with a provider bargaining group or engage in a nonbinding arbitration process in connection with the Board's establishment of reference-based prices in accordance with subdivision 9375(b)(1)(A), subdivision 9375(b)(5), or section 9376 of this title.

* * * Appeals of Green Mountain Care Board Orders * * *

Sec. 5. 18 V.S.A. § 9381 is amended to read:

§ 9381. APPEALS

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

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

* * *

* * * Hospital Audits * * *

Sec. 6. 18 V.S.A. § 9453 is amended to read:

§ 9453. POWERS AND DUTIES

(a) The Board shall:

(1) adopt uniform formats that hospitals shall use to report financial, scope-of-services, and utilization data and information;

(2) designate a data organization with which hospitals shall file financial, scope-of-services, and utilization data and information; and

(3) designate a data organization or organizations to process, analyze, store, or retrieve data or information.

(b) The Chair of the Board may:

(1) conduct investigations and examinations, including audits, of hospitals that are reasonably necessary or helpful to the Board's administration of this subchapter or any rules adopted or orders issued pursuant to this subchapter;

(2) retain experts or other persons to assist in any investigation or examination conducted pursuant to subdivision (1) of this subsection; and

(3) require a hospital subject to an investigation or examination conducted pursuant to this subsection to pay the reasonable costs and expenses of the investigation or examination.

(c) To effectuate the purposes of this subchapter, the Board may adopt rules under 3 V.S.A. chapter 25.

* * * Data Infrastructure * * *

Sec. 7. 18 V.S.A. § 9411 is amended to read:

§ 9411. INTERACTIVE PRICE TRANSPARENCY DASHBOARD AND HEALTH SYSTEM PERFORMANCE TOOL

(a)(1) The Green Mountain Care Board shall develop and maintain a public, interactive, ~~Internet-based~~ internet-based price transparency dashboard that allows consumers to compare health care prices for certain health care services across the State. Using data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) established pursuant to section 9410 of this title, the dashboard shall provide the range of actual allowed amounts for selected health care services, showing both the amount paid by the health insurer or other payer and the amount of the member's responsibility, and shall allow the consumer to sort the information by geographic location, by health care provider, by payer type, and by the specific health care procedure or health care service. The Board shall provide a link on the dashboard to the statewide comparative hospital quality report published by the Commissioner of Health pursuant to section 9405b of this title.

~~(b)~~(2) The Board shall update the information in the interactive price transparency dashboard at least annually.

(b)(1) The Board shall develop and maintain a public, interactive tool that displays information on health system performance, including ~~hospital prices relative to Medicare rates, both as a percentage of Medicare and in dollars and cents. The tool shall enable the user to sort the information by service line and by payer~~ **information regarding quality, access, and affordability**.

(2) The Board shall update the information in the health system performance tool ~~at least quarterly~~ **on a regular basis, to the extent operationally feasible**.

Sec. 8. IMPLEMENTATION OF HEALTH SYSTEM PERFORMANCE TOOL

The Green Mountain Care Board shall develop the health system performance tool described in 18 V.S.A. § 9411(b), as added by Sec. 7 of this act, only if the Board receives sufficient funding from the federal government or another source for this purpose.

*** * * Public Employee Health Benefit Authority Study Committee * * ***

Sec. 9. PUBLIC EMPLOYEE HEALTH BENEFIT AUTHORITY STUDY COMMITTEE; STATE TREASURER; REPORT

(a) Creation. There is created the Public Employee Health Benefit Authority Study Committee to evaluate opportunities to establish a State authority to develop and administer comprehensive and affordable health benefits for all public-sector employees in Vermont.

(b) Membership. The Study Committee shall be composed of the following members, who shall each be appointed by the entities they represent:

(1) the State Treasurer or designee;

(2) one member representing the Vermont State Employees' Association;

(3) one member representing the Vermont-National Education Association;

(4) one member representing the American Federation of Teachers;

(5) one member representing the United Electrical Workers;

(6) one member representing the American Federation of State, County and Municipal Employees;

(7) one member representing the Vermont School Boards Association;

(8) one member representing the Vermont League of Cities and Towns;

(9) one member representing the Vermont State College system;

(10) one member representing the University of Vermont; and

(11) one member representing the Department of Human Resources.

(c) Powers and duties; report.

(1) The Study Committee shall consider the topics set forth in this subsection and produce a report regarding the potential for establishing the Public Employee Health Benefit Authority to provide and administer health plans that would meet the health care and wellness needs of

Vermont's municipal, State, public school, and public college and university employees and their dependents, including addressing all the following:

(A) the manner in which health benefits are provided to public employees in other states, including Oregon and Washington;

(B) the similarities and differences in the level and scope of coverage provided by current health plans offered to public employees;

(C) the similarities and differences in the current service or contractual agreements negotiated by public-sector parties with commercial health insurers, third-party administrators, and independent clinical and analytical vendors;

(D) uniform design, coordination, and administration of medical and pharmaceutical health plans, care networks, wellness initiatives, and medical privacy protections;

(E) uniform standards and protocols for contract review and negotiations with hospital facilities, nonhospital health care providers, commercial health insurers, third-party administrators, independent clinical and analytical vendors, and pharmacy benefit managers;

(F) streamlined, auditable processes to confirm the integrity and accuracy of billing from and reimbursements to hospitals, nonhospital health care providers, and vendors;

(G) opportunities to secure substantial and sustainable cost reductions for employees, employers, and taxpayers;

(H) monitoring and management of fiduciary risk;

(I) Public Employee Health Benefit Authority governance structures, deliberative processes, and equality of decision making by employer and organized labor representatives; staff positions; member and patient advocacy; and problem resolution on behalf of employees and employers;

(J) uniform standards and systems for collecting, analyzing, and securely transmitting data on clinical, utilization, quality of care, and other essential metrics to support health benefit plan management and vendor needs;

(K) opportunities to expand participant access to primary care, mental health, and community-based health care services; redirect care from hospitals and their emergency departments to less costly settings; and improve chronic disease management and medication therapy adherence; and

(L) alignment of Public Employee Health Benefit Authority operations and health benefit plans with the transition to reference-based pricing, global hospital budgets, and regional care transformations

directed by acts of the General Assembly, including 2024 Acts and Resolves No. 134 and 2025 Acts and Resolves Nos. 55 and 68.

(2) The Study Committee shall provide recommendations regarding:

(A) a detailed blueprint, with timelines, to design, build, and launch the Public Employee Health Benefit Authority;

(B) the need, if any, for independent consultants or advisory personnel for establishing the Public Employee Health Benefit Authority and, going forward, to support its mission, on a regular or intermittent basis; and

(C) the projected costs of creating and annually funding the Public Employee Health Benefit Authority.

(3) On or before December 15, 2026, the Study Committee shall submit a report detailing the information set forth in subdivisions (1) and (2) of this subsection to the General Assembly and the Governor.

(d) Assistance. The Study Committee shall have the administrative, technical, and legal assistance of the Office of the State Treasurer and may engage the services of one or more consultants or firms to assist with facilitating meetings and public hearings and preparing its report.

(e) Meetings.

(1) The State Treasurer or designee shall call the first meeting of the Study Committee to occur on or before August 15, 2026.

(2) The State Treasurer or designee shall be the chair.

(3) A majority of the membership shall constitute a quorum.

(4) The Study Committee shall cease to exist on January 1, 2027.

(f) Public hearings. The Study Committee shall schedule public hearings, both remote and in person, to allow public-sector employers and employees the opportunity to share their health care needs and concerns with the Study Committee before the issuance of the Study Committee's report.

(g) Access to information. Commercial health insurers, third-party administrators, the Vermont Education Health Initiative (VEHI), and clinical and analytical vendors that serve the public sector shall provide full and timely access to the Study Committee, with appropriate nondisclosure agreements in place as needed, to:

(1) their service contracts or agreements with relevant public-sector entities; and

(2) any data, including claims, actuarial, financial, and other data, that the Study Committee requests.

(h) Compensation and reimbursement. Members of the Study Committee shall be entitled to per diem compensation and reimbursement of expenses? as permitted under 32 V.S.A. § 1010 for not more than ## meetings.

(i) Appropriation. The sum of $XXX is appropriated to the Office of the State Treasurer from the General Fund in fiscal year 2027 for per diem compensation and reimbursement of expenses? for members of the Study Committee and for the services of one or more consultants or firms.

* * * Effective Date * * *

Sec. 10. EFFECTIVE DATE

This act shall take effect on passage.

(Committee vote: _____)

_____

Senator _____

FOR THE COMMITTEE