S.190, An act relating to the Green Mountain Care Board, reference-based pricing, and studying the creation of a Public Employee Health Benefit Authority, as passed by Senate showing markup from House proposal of amendment

It is hereby enacted by the General Assembly of the State of Vermont:

* * * Reference-Based Pricing * * *

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

(1)(A) The Board shall establish reference-based prices that represent the maximum amounts that hospitals shall accept as payment in full for items provided and services delivered in Vermont. The Board may also implement reference-based pricing for services delivered outside a hospital by setting the minimum amounts that shall be paid for items provided and services delivered by nonhospital-based health care professionals. The Board shall consult with health insurers, hospitals, other health care professionals as applicable, the Office of the Health Care Advocate, and the Agency of Human Services in developing reference-based prices pursuant to this subsection (e), including on ways to achieve all-payer alignment on the design and implementation of reference-based pricing.

(B) **The Board shall utilize reference-based pricing to reduce hospital prices incrementally until they are equal to national median prices by hospital type by calendar year 2030. The Board shall use the highest quality, nonpartisan data demonstrating hospital prices as a**

percentage of Medicare to evaluate progress toward reducing hospital prices in Vermont to the national median.

(C) The Board shall implement reference-based pricing in a manner that does not allow health care professionals to charge or collect from patients or health insurers any amount in excess of the reference-based amount established by the Board.

* * *

(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)(i) For provider contracts entered into, amended, or renewed on or after ~~October 1, 2026~~ **January 1, 2028**, each hospital and health insurer shall begin expressing 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.

(ii) 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.

(iii) For purposes of subdivisions (i) and (ii) of this subdivision (3)(C), a hospital may express rates as a percentage of Medicare based on the actual reimbursement amounts the hospital receives from Medicare for items provided and services delivered to Medicare beneficiaries until such time as the Green Mountain Care Board adopts a rule establishing the methodology for determining Medicare rates for use as a benchmark in establishing reference-based prices pursuant to this subsection (e).

(D)(i) Each hospital shall apply for, obtain, and use a unique National Provider Identifier (NPI) on all claims filed after October 1, 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.

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

~~**§ 1815. LIMITATIONS ON HOSPITAL REIMBURSEMENTS**~~

Sec. 2. LIMITATIONS ON HOSPITAL REIMBURSEMENTS **FOR QUALIFIED HEALTH BENEFIT PLANS AND PLANS COVERING SCHOOL EMPLOYEES FOR HOSPITAL FISCAL YEAR 2027**

(a)~~(1)~~ As used in this section**:**

(1) "Health benefit association" has the same meaning as in 24 V.S.A. § 4947.

(2) "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.

(3) "Qualified health benefit plan" has the same meaning as in 33 V.S.A. § 1802.

(4) "Registered carrier" has the same meaning as in 33 V.S.A. § 1811.

(5) "School employee" has the same meaning as in 16 V.S.A. § 2101.

(b)~~(1)~~ **Notwithstanding any provision of 18 V.S.A. § 9375(b)(1)(A) to the contrary, for hospital fiscal year 2027, the Green Mountain Care Board may order hospitals to reduce their commercial reimbursement rates for qualified health benefit plans and for health benefit plans offered to school employees by a health benefit association pursuant to 24 V.S.A. § 4947 based on a percentage of the Medicare adjusted base rate**

determined by the Board for each item provided and service delivered in Vermont to enrollees in these plans.

(c)(1) A registered carrier **or health benefit association** shall not reimburse or agree to reimburse a hospital more than ~~250 percent~~ **the percentage** of the Medicare adjusted base rate **specified by the Green Mountain Care Board pursuant to subsection (b) of this section, if any, for the applicable hospital fiscal year** for any item provided or service delivered in Vermont to an enrollee in a qualified health benefit plan **or a health benefit plan offered to school employees by a health benefit association**.

(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 remain in effect unless and until the Green Mountain Care Board establishes a different reference-based price pursuant to 18 V.S.A. § 9376(e).~~

(d) A hospital or hospital provider that is reimbursed in accordance with subsection**s** (b) **and (c)** 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) To the extent that a hospital is required by the Board's budget order to reduce its commercial reimbursement rates by amounts greater than the reductions achieved pursuant to subsection (**b**) of this section, the hospital shall reduce 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 reducing its commercial reimbursement rates that are the highest in relation to the Medicare adjusted base rate.

(f)(1) In its reviews of premium rates in accordance with 8 V.S.A. § 4026, the Green Mountain Care Board shall ensure that the limitations on reimbursements established in this section are appropriately reflected in the premium rates for qualified health benefit plans.

(2) In its review of premium rates in accordance with 8 V.S.A. § 4026 and 24 V.S.A. chapter 121, subchapter 6, the Department of Financial Regulation shall ensure that the limitations on reimbursements established in this section are appropriately reflected in the premium rates for health benefit plans offered to school employees by a health benefit association.

~~Sec. 3. 18 V.S.A. chapter 221, subchapter 7 is amended to read:~~

~~Subchapter 7. Hospital Budgets and Budget Review~~

~~§ 9451. DEFINITIONS~~

~~As used in this subchapter:~~

~~* * *~~

~~(4)(A) "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.~~

~~(B) 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.~~

~~* * *~~

~~§ 9459. TARGETED COMMERCIAL REIMBURSEMENT RATE REDUCTIONS~~

~~(a) A hospital shall implement any commercial reimbursement rate reduction ordered by the Board pursuant to section 9456 of this title through the limitations on its commercial reimbursement rates for qualified health benefit plans in accordance with 33 V.S.A. § 1815.~~

~~(b) To the extent that a hospital is required by the Board's budget order to reduce its commercial reimbursement rates by amounts greater than the reductions achieved pursuant to subsection (a) of this section, the hospital shall reduce 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 reducing its commercial reimbursement rates that are the highest in relation to the Medicare adjusted base rate.~~

~~(c) Except as provided in subsections (a) and (b) of this section and in 33 V.S.A. § 1815, a hospital may increase the commercial reimbursement rates for one or more of its service lines, such as primary care, provided that in doing so the hospital remains compliant with the total budget ordered for the hospital by the Board pursuant to section 9456 of this subchapter.~~

~~Sec. 4. IMPLEMENTATION OF REFERENCE-BASED PRICING FOR CERTAIN PUBLIC EMPLOYEE HEALTH PLANS; REPORT~~

~~(a) The Green Mountain Care Board, in consultation with the Departments of Financial Regulation and of Human Resources and the Vermont Education Health Initiative (VEHI), shall analyze commercial health insurance claims for inpatient and outpatient hospital items provided and services delivered to active and retired members and their dependents enrolled in the State Employees' Health Benefit Plan and in the health benefit plans offered to~~

~~teachers and other school employees through VEHI to determine the opportunities available through the use of reference-based pricing and the projected impact on Vermont's hospitals. VEHI, the Department of Human Resources, and the administrator of the State Employees' Health Benefit Plan shall provide the Board with access to the claims data necessary to perform the analysis.~~

~~(b) On or before January 15, 2027, the Green Mountain Care Board shall provide to the House Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare and on Finance the Board's findings and any recommendations with respect to scope, timing, financial impacts, and other considerations in implementing reference-based pricing for items provided and services delivered to enrollees in the State Employees' Health Benefit Plan and in the health benefit plans offered by VEHI.~~

* * * Hospital Outsourcing * * *

Sec. 4. 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 Committees on Health Care and on Ways and Means and the Senate Committees on Health and Welfare and on Finance. 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.

*** * * Section 1332 Waiver for Reinsurance Program * * ***

Sec. 4a. REINSURANCE; AUTHORIZATION TO PURSUE SECTION 1332 WAIVER

The Department of Vermont Health Access, in consultation with the Department of Financial Regulation, is authorized to submit a State Innovation Waiver pursuant to Section 1332 of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, to establish a program for reinsurance and seek federal pass-through funding of amounts attributable to premium tax credits under 26 U.S.C. § 36B.

* * * Excluding Reference-Based Pricing from Scope of Health Care Professional Bargaining * * *

Sec. 5. 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. 6. 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.

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* * * 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 information regarding quality, access, and affordability.

(2) The Board shall update the information in the health system performance tool 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. 8 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. 10. 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 February 15, 2027, 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, to the extent funds are made available for this purpose.~~

~~(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 March 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 not receive per diem compensation and reimbursement of expenses for their participation on the Study Committee.~~

* * * Critical Access Hospitals; Medicare Outpatient Cost Sharing * * *

Sec. 9. CRITICAL ACCESS HOSPITALS; MEDICARE OUTPATIENT COST SHARING~~; WORKING GROUP; REPORT~~

(a) The General Assembly and the Green Mountain Care Board have recently become aware of a federal requirement that Medicare beneficiaries must bear financial responsibility for 20 percent of the amount charged for outpatient services delivered by critical access

hospitals, not 20 percent of the amount that Medicare pays for the service. While the General Assembly understands that it cannot invalidate this federal requirement, it also recognizes both that this requirement has a significant, unfair, and negative financial impact on Medicare beneficiaries in the State's most rural communities and that Vermont's critical access hospitals are some of the State's most financially vulnerable health care facilities. It is the intent of this section to provide information to Vermont's seniors and other Medicare beneficiaries about the federal requirement while a working group of interested stakeholders endeavors to develop appropriate and enduring solutions that do not undermine the financial sustainability of our critical access hospitals and that comply with federal law.

(b) On or before September 1, 2026, each critical access hospital shall do all of the following:

(1) Identify all the outpatient services for which the amount that the hospital charges equals five or more times the Medicare allowed amount for that service.

(2) Post prominently on its website and in outpatient departments of the hospital a disclosure about the federal requirement that Medicare beneficiaries must pay 20 percent of the charge for outpatient services at critical access hospitals, that Medicare beneficiaries may be able to receive

care with reduced out-of-pocket costs from other providers, and how to contact the hospital's patient financial assistance department for more information. The hospital shall file its proposed disclosure materials with the Green Mountain Care Board for the Board's approval prior to posting.

(c) To the extent that the Green Mountain Care Board engages in efforts to address the Medicare outpatient cost-sharing issue in hospital fiscal year 2027, the Board shall consider any proposals from the critical access hospitals and other interested stakeholders and shall ensure that its actions are consistent with ongoing hospital transformation efforts and the principles for health care reform expressed in 18 V.S.A. § 9371.

~~(a)(1) The Green Mountain Care Board shall convene a working group comprising representatives of the Board, of the Departments of Vermont Health Access and of Financial Regulation, of critical access hospitals, of health insurers offering Medicare supplement insurance policies, and of the Office of the Health Care Advocate to develop recommendations for ways to mitigate the effects of a federal requirement that Medicare beneficiaries bear financial responsibility for 20 percent of the amount charged for outpatient services delivered by critical access hospitals.~~

~~(2) On or before January 15, 2027, the Green Mountain Care Board shall provide the working group's recommendations, including the projected~~

~~impact of each recommendation on patients, critical access hospitals, and premiums for Medicare supplement insurance policies, and the State budget, to the House Committees on Health Care and on Appropriations and the Senate Committees on Health and Welfare, on Finance, and on Appropriations.~~

~~(b) The Green Mountain Care Board shall not address or attempt to address the effects of the federal Medicare cost-sharing requirements for outpatient services delivered by critical access hospitals through the Board's hospital budget review authority under 18 V.S.A. chapter 221, subchapter 7 in the fiscal year 2027 hospital budgets.~~

* * * Effective Date * * *

Sec. 10. EFFECTIVE DATE

This act shall take effect on passage.