2025 Health Care Bills Passed by Senate Committee on Health & Welfare

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January 14, 2026

Act 2 (H.35): Unmerging individual and small group health insurance markets *

- Permanently unmerged individual and small group health insurance markets, effective January 1, 2026
  - These markets had been temporarily unmerged on a one- or two-year basis since 2022

*Not officially referred to SH&W, but relevant to the Committee's work

Act 3 (H.31): Claim edit standards and prior authorization requirements

- Exempts claims for health care services delivered outside Vermont from required claim edit standards that health insurers must follow unless insurer and out-of-state health care provider agree that one or more edit standards will apply
- Defines “primary care” for exemption from prior authorization requirements for services ordered by primary care provider as health care provider who is contracted and enrolled with health plan as a primary care provider

Act 6 (H.80) : Office of the Health Care Advocate

- Expands scope of Office of Health Care Advocate's (HCA) duties to include affordability and access to health care for all Vermonters
- Expands HCA's ability to ask questions about health insurance rate filings
- Requires Green Mountain Care Board to make entire record of health insurance rate review available to public after redacting confidential information
- Enlarges roles of HCA and Long-Term Care Ombudsman's Office when intervening in certificate of need application
- Requires State agencies to seek input from HCA when developing policies affecting health care access and affordability and to allow HCA access to confidential or proprietary information when appropriate

Act 9 (H.259): Preventing workplace violence in hospitals

- Requires hospitals to implement security plans for preventing workplace violence and managing aggressive behaviors based on results of a security risk assessment
- Requires hospitals to use a workplace violence incident reporting system to document, track, analyze, and evaluate incidents of workplace violence
- Excludes from certificate of need requirements hospital expenditures to implement hospital security plan
- Requires hospitals to report costs of implementing security plan as part of hospital budget review process, requires Green Mountain Care Board to take costs into account when establishing hospital budgets

Act 14 (H.13): Medicaid payment rates for community-based service providers*

- Requires Secretary of Human Services to calculate payment rates for providers of community-based services in Medicaid program that are reasonable and adequate to achieve required outcomes
- Requires Secretary to establish calculating methodology that includes schedule for conducting Medicaid rate studies, predictable timeline for redetermining base rates, and process for calculating annual inflationary rate adjustment
- Directs Secretary to recalculate payment rates at least annually and report rates and cost of funding them annually as part of AHS budget presentation
- Directs Secretary to establish process for providers to request provider stabilization from AHS if they are imminent risk of closure
- Requires AHS to provide an implementation update by January 15, 2026

*mostly in House Committee on Human Services but also relevant to House Committee on Health Care

Act 15 (H.96): Increasing monetary thresholds for certificates of need

- Increases monetary thresholds for when certificate of need (CON) is required for new health care project, purchase, or service
- Aligns CON triggers for hospitals with those for other health care facilities
- Adds new CON exclusions for:
  - Fully depreciated medical equipment
  - Ground ambulance services and emergency medical equipment and supplies
  - New services or construction projects for facilities owned/operated by State or funded by contract or grant from State
    - But Green Mountain Care Board must get notice of new State-owned, -operated, or -funded service or project

Act 19 (S.18): Licensure of freestanding birth centers

- Creates licensure requirements for freestanding birth centers
- Directs Department of Health to adopt rules for birth centers, including:
  - Requirements for operating a birth center
  - Allowable scope of services
  - Requirements for written practice guidelines and policies that include transfer procedures and collaboration with other providers
- Exempts birth centers from CON requirements
- Requires health insurance plans that cover maternity services to cover services provided at a birth center
- Requires AHS to seek federal approval for Medicaid coverage of prenatal, maternity, postpartum, and newborn services provided at a birth center

Act 20 (S.28): Certain legally protected health care services

- Creates reciprocity with other states that protect access to reproductive and gender-affirming care
- Exempts records held by State professional licensing entities from Public Records Act if contain personal contact information for applicant or licensee
- Amends unprofessional conduct laws for health care professions to add misleading advertising and letting name/license be used if not actively overseeing services
- Allows prescribing medication to terminate pregnancy based on adaptive questionnaire
- Expands scope of health-related conduct that violates Consumer Protection Act
- Adds federal investigations and proceedings to noncooperation provisions
- Modifies limits on disclosure of protected health information related to legally protected health care activity, including as relates to federal matters
- Allows prescribers and pharmacists to have their names removed from prescriptions for medications for reproductive and gender-affirming health care services

Act 21 (S.27): Medical debt relief and excluding medical debt from credit reports

- Appropriates $1 million to State Treasurer for contract with nonprofit entity to acquire and repay certain medical debts incurred by Vermonters
  - To be eligible, debtor must be Vermont resident who either has household income ≤ 400% FPL or owes medical debt that is 5% or more of household income and whose patient account still has outstanding balance even after provider completed routine efforts to collect amounts due
- Adds definition of "behavioral health" to Title 1 of V.S.A. for limited purposes
- Allows nonprofits to request consumer's credit report without consumer's permission to determine consumer's eligibility for abolition of medical debt
- Prohibits credit reporting agencies from reporting medical debt information or maintaining medical debt information in a consumer's file
- Prohibits large health care facilities and medical debt collectors from reporting medical debts to consumer reporting agencies

Act 49 (H.482): GMCB authority to adjust hospital reimbursement rates and appoint hospital observer

- Allows Green Mountain Care Board (GMCB) to reduce domestic health insurer's reimbursement rates to one or more Vermont hospitals if insurer faces acute and immediate threat of insolvency
  - GMCB can only reduce rates to hospitals that meet certain fiscal criteria and only to extent necessary to address threat of insurer's insolvency
- Directs GMCB, in setting hospital budgets, to account for any significant deviation in hospital's revenue during prior fiscal year in excess of its GMCB-approved budget
- Allows GMCB to adjust hospitals' commercial health insurance reimbursement rates at any time during year to ensure hospitals stay within approved budgets
- Allows GMCB to appoint independent hospital observer under certain circumstances
  - This authority is repealed on January 1, 2030

Act 50 (S.53): Certification of community-based perinatal doulas and Medicaid coverage for doula services

- Creates voluntary certification process for community-based perinatal doulas through the Office of Professional Regulation
- Requires Department of Vermont Health Access (DVHA) to reimburse certified community-based perinatal doulas for providing services to Medicaid beneficiaries during pregnancy, labor/delivery, and postpartum
- Expresses legislative intent that reimbursement rates be reasonable and adequate for the services provided and consistent with rates set by other states' Medicaid programs
- Directs DVHA to seek federal state plan amendment by July 1, 2026, to allow Vermont Medicaid to cover doula services

Act 55 (H.266): 340B prescription drug pricing program (and cap on outpatient administered drugs)

- Restricts certain actions by drug manufacturers regarding 340B contract pharmacies, 340B drugs, and patients of 340B covered entities; creates private right of action
- Requires hospitals to report information about participation in 340B program to GMCB by January 31 annually through January 1, 2031; directs GMCB to post reports on its website
- Caps amount hospitals can charge health insurers for prescription drugs administered in outpatient setting at 120% of April 1, 2025, average sales price (ASP)
  - If hospital charged <120% ASP on April 1, 2025, cap is actual percentage of ASP on that date
  - A hospital can ask GMCB to increase reimbursement rates for other service lines if price caps negatively affect access to care, quality of care, or rural health care sustainability
  - Price caps are in place unless/until GMCB sets different reference-based price
  - Price caps do not apply to independent, critical access hospitals not affiliated with another hospital or hospital network

Act 62 (S.63): Modifying the regulatory duties of the Green Mountain Care Board

- Eliminates GMCB duties related to health information technology and VITL
- Eliminates 8% allocation for accountable care organizations (ACOs) in GMCB billback formula
- Modifies ACO certification and budget review processes and sets fees
- Specifies that GMCB regulation of hospital budgets is not a contested case, and aggrieved parties can appeal pursuant to GMCB's existing appeal statute
- Modifies scope of requirements regarding meetings of ACO's governing body to apply only to ACOs that contract with Vermont Medicaid
- Eliminates GMCB advisory rate case review for all-inclusive population-based payment arrangements between DVHA and ACO

Act 68 (S.126): Health care payment and delivery system reform

- Requires GMCB to establish reference-based prices that represent maximum amounts Vermont hospitals can accept as payment in full for items/services delivered in Vermont
  - Reference-based prices will be based on percentage of Medicare rates for same or similar item or service, or on another benchmark as appropriate
  - Reference-based pricing will start as soon as practicable but not later than hospital FY 2027
  - GMCB will review reference-based prices for each hospital annually during budget review
  - Balance billing not be permitted
  - GMCB, with Department of Financial Regulation (DFR), will monitor implementation to ensure decreased payments to hospitals result in decreases in health insurance premiums
- Allows GMCB, in consultation with AHS and others, to set reference-based prices for services delivered outside hospital, like primary care services
- GMCB's reference-based pricing authority does not apply to Medicare or Medicaid

Act 68 (cont.)

- Requires GMCB to establish global hospital budgets, if resources available, for one or more non-critical access hospitals by hospital FY 2027, and for all Vermont hospitals by hospital FY 2030
- Requires a hospital proposing to reduce or eliminate service to comply with its budget order to provide notice of intent to GMCB, AHS, HCA, and area legislators at least 45 days in advance; GMCB can modify hospital's budget or take other action to preserve access to necessary services
- Gives GMCB authority to oversee hospital networks that derive 50% or more of operating revenue from Vermont hospitals; can recommend actions necessary to correct aspects of network or its financial operations that are inconsistent with principles for health care reform or Statewide Health Care Delivery Strategic Plan
- Requires payers and providers to provide unredacted copy of executed or proposed health care contract to Department of Financial Regulation (DFR) or GMCB upon request

Act 68 (cont.)

- Directs AHS, in collaboration with stakeholders, to lead development of Statewide Health Care Delivery Strategic Plan
  - Plan due to General Assembly by 1/15/2028
  - AHS must update Plan every three years; first updated Plan due by 12/1/2030
- Creates 18-member Health Care Delivery Advisory Committee
- Creates 16-member Vermont Steering Committee for Comprehensive Primary Health Care
- Directs AHS to collaborate with Health Information Exchange Steering Committee to develop Unified Health Data Space; specifies elements of development process, including determining whether to integrate clinical and claims data and, if so, how to protect proprietary information
  - Integration cannot begin before 1/1/2027, and then only if majority of Steering Committee votes in favor
  - Report on integration of clinical and claims data due by 1/15/2026; annual updates on development and implementation of Unified Health Data Space due beginning on 1/15/2027
- Authorizes GMCB to share any materials it receives pursuant to subpoena with AHS or DFR as appropriate to AHS's or DFR's work

Act 68 (cont.)

- Directs AHS to facilitate health care provider response to urgent financial pressures and identify opportunities to increase efficiency, improve quality, reduce prescription drug spending, and increase access to essential services while reducing hospital spending by not less than 2.5 percent for hospital FY2026
  - AHS report on proposed reductions it has approved due by 7/1/2025 – see report here - and monthly updates due 10/1/2025 – 9/30/2026 (see AHS website for reports)
  - AHS to identify specific outcome measures for meeting health care system transformation goals from Act 167 of 2022 and report those measures and related information monthly 8/1/2025 – 1/1/2027 see AHS website for reports)
  - Appropriates $2 million to AHS for incentive grants to hospitals to encourage transformation; AHS report due by 12/1/2025 on amounts obligated and disbursed as of 11/15/2025 – see report here
- Requires DFR to provide plan by 11/1/2025 for preserving sustainability of domestic health insurers in Vermont – see report here
- Directs AHS to report by 12/1/2025 on opportunities to retain useful capabilities developed by or on behalf of ACO and funded with public dollars – see report here

Act 68 (cont.)

- Requires GMCB to report on its implementation of this act by 2/15/2026
- GMCB's annual report must include updates on reference-based pricing and global hospital budgets beginning with 2027 report
- Requires AHS to provide update by February 15 annually on status of Statewide Health Care Delivery Strategic Plan and activities of Health Care Delivery Advisory Committee
- Creates three new positions at GMCB in FY 2026, two for reference-based pricing and one for operations, procurement, and contracting
- Appropriates $2.2 million to AHS for transformation work, creation of Statewide Health Care Delivery Strategic Plan, and developing alternative payment models
- Appropriates $1,212,500.00 to GMCB for new positions, contracts, and standardizing electronic hospital budget data submissions

Links to JFO Fiscal Notes

- Fiscal Note for Act 14
- Fiscal Note for Act 15
- Fiscal Note for Act 19
- Fiscal Note for Act 50
- Fiscal Note for Act 62
- Fiscal Note for Act 68