Submitted 3/8/2024

S. 151 Draft 2.1

This memorandum provides GMCB's positions on the provisions of S. 151 as currently drafted (Draft 2.1). The Committee should consider this bill in the context of our current healthcare affordability and sustainability crises. Since 2019, Vermonters on qualified health plans (QHP) have seen an enormous increase in their insurance costs. Notably, Vermont QHP premium increases *far* outpace national trends. Vermonters' property tax bills are rising exorbitantly, with healthcare costs serving as one of the primary accelerants. Healthcare costs are eating into and straining school budgets. Our mental health, primary care, and long-term care providers are under immense financial pressure, as are many hospitals. In recent years Vermont hospitals—which do not operate in a competitive market—have obtained commercial insurance increases that are generally significantly greater than rates received by other types of providers.

Vermont should be proud that it has intentionally—and wisely—crafted a regulatory structure that is independent, apolitical, transparent, and accountable. GMCB has 5 voting members as opposed to a single decision maker, and regulatory decisions are made in a court-like setting with public access to relevant submissions, and live participation in hearings and the opportunity to submit public comment. Written public opinions are issued describing the factual findings and Board conclusions.

This past year saw that regulatory process save Vermonters $145m in requested hospital price increases. System-wide, Vermont had a 4.1% increase in hospital charges, a large increase to be sure but far more aligned with Vermonters' wages than the more than 10% increase that was requested (the second consecutive year of requests for double digit price increases). In an effort to promote affordability and sustain our system, the GMCB also mandated in 2024 that commercial rate increases be awarded based on affordability, access, and quality—as opposed to simply market power.

With this context in mind, the positions provided below are based on prioritizing access, affordability, and quality of care for Vermonters while simultaneously strengthening the sustainability of Vermont's healthcare system. Importantly, the Legislature already took significant steps in this direction through Act 167 of 2022 by planning for and clarifying roles as Vermont continues to improve our healthcare system, including directing GMCB to "determine how best to incorporate value-based payments, including global payments to hospitals or accountable care organizations, or both, into the Board's hospital budget review, accountable care organization certification and budget review, and other regulatory processes, including assessing the impacts of regulatory processes on the financial sustainability of Vermont hospitals and identifying potential opportunities to use regulatory processes to improve hospitals' financial health."

We thank the Committee for the opportunity to provide input on the draft bill and greatly appreciate your thoughtful consideration of these important issues at this critical juncture. GMCB is available to provide any other information the Committee may need in reviewing S. 151. Below you will find GMCB's positions as to the specific provisions of S. 151:

Section of S.151 Draft 2.1	**GMCB Comments**
Sec. 1 – § 4062. FILING AND APPROVAL OF POLICY FORMS AND PREMIUMS	Neutral

Sec. 2 – COLORECTAL CANCER SCREENING, COVERAGE REQUIRED	No position
Sec. 3 – INSURER PARTICIPATION IN MULTIPAYER ALTERNATIVE PAYMENT MODELS	Neutral • Language regarding participation has been added to Section 11a (intent language).
Sec. 4 – CONSENT TO PREVENTIVE SERVICES AND TREATMENT BY MINORS	No position
Sec. 5 – CONFORMING REVISION	No position
Sec. 6 – ANNUAL REPORTING BY HEALTH INSURER	No position
Sec. 7 – INCREASING PRIMARY CARE SPENDING ALLOCATIONS	Support with modifications: • Suggest clarifying the phrase "payer's overall annual health care spending." Specifically, is this the insurer's overall spending for those covered by major medical health insurance (as opposed to the insurer's full book of business)? • New "baseline percentages" should be established as the referenced report is dated and hospital and pharmaceutical expenses have likely outpaced primary care spending since the report was issued. Moreover, the report did not analyze spending at this level of granularity (see page 10). • Consideration should be given to the proper methodology for calculating an appropriate baseline as this could greatly impact the amount of increased primary care spend and the impact of that spend on affordability, quality, and access to care.
Sec. 8 – 18 V.S.A. chapter 220 is amended to read: § 9372. PURPOSE § 9374. BOARD MEMBERSHIP; AUTHORITY § 9391. NOMINATION AND APPOINTMENT PROCESS	*GMCB Purpose* – Oppose • GMCB has duties related to the purposes that are proposed to be deleted (purposes 3 – 5) and thus it is illogical to strike these purposes. For example, the GMCB approves AHS's workforce strategic plan and Health Information Technology Plan. • If changes are made to the purpose section, we suggest that it at least address all the GMCB's duties (as opposed to a limited set). ○ Suggested change: "It is the intent of the General Assembly to create an independent board that, by performing the duties outlined in 18 V.S.A. §

	9375 and elsewhere in this title, promotes the general good of the State by improving the health of the population and reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers, while ensuring that access to care and quality of care are not compromised." *GMCB Nominating Process* Neutral • (c) This provision could be impracticable in practice as Board members may not know 4 months prior to a term ending whether they will be seeking reappointment. • (d) This provision could be impracticable as potential incoming Board members may not be able to leave their positions and/or have their appointments made public within 45 days of the Governor receiving the list.
Sec. 8a – § 9406 GREEN MOUNTAIN CARE BOARD; MEDIATION PRIOR TO TERMINATION OR NONRENEWAL	Support with modification: • Requiring mediation between providers and insurers would protect consumers who may be left without coverage in situations where insurer and providers cannot reach agreement. Suggested alternative language: "In the event that a contract between a health insurer and a hospital, as defined in 18 V.S.A. 9451, is not renewed or is terminated by either party, and the termination or non-renewal results in a change in the hospital's network status, the parties shall continue to abide by the terms of such contract for a period of two months from the effective date of termination or, in the case of non-renewal, from the end of the contract period, and must utilize the mediation services of a mutually agreed upon mediator to assist in resolving any outstanding contractual issues. The results of the mediation shall not be binding on either party. This section shall not apply to terminations for cause."
Sec. 8b. 18 V.S.A. § 9453 is amended to read: § 9453. POWERS AND DUTIES	Support with modification: • "(a) The Board shall . . . (4) develop a methodology for establishing hospital global budgets or global payments, establish such budgets and payments, and regulate such budgets and payments consistent with the State's goals of ensuring affordability and improving access and quality." • The proposed language makes this provision consistent with Act 167 which instructs GMCB to "build on successful health care delivery system reform efforts by

	developing value-based payments, including global payments, from all payers to Vermont hospitals or accountable care organizations, or both . . . .” and to “determine how best to incorporate value-based payments, including global payments to hospitals or accountable care organizations, or both, into the Board’s hospital budget review, accountable care organization certification and budget review, and other regulatory processes . . . .” • Proposed language is also consistent with definitions used in 18 V.S.A. 9373(4) (defining “global payment” as “a payment from a health insurer, Medicaid, Medicare, or other payer for the health services of a defined population of patients for a defined period of time.”). • Proposed language also protects against efforts to go backwards and move regulation *away* from a transparent, independent, apolitical body. Given our healthcare costs are rising faster than national we should strengthen our ability to protect against increased healthcare costs and GMCB’s above proposed language supports that.
Sec. 9 – § 9456. BUDGET REVIEW	Oppose • (d)(1) could frustrate State’s goals to target hospital spending increases at 3.5-4.3% as in the All-Payer model, could conflict with goal that growth in healthcare costs should be consistent with Vermonters’ ability to pay for care, and could conflict with potential new AHEAD goals. • GMCB uses national comparisons to peers as factors to consider in making budget decisions; requiring budget decisions to be within a defined range would put comparison data above other considerations such as affordability, access, and quality. • Based on FY24 budget reviews this change would likely lead to too drastic a reduction in hospital budgets as many Vermont hospitals compared poorly to peer hospitals. This proposed change could threaten the ability of some hospitals to maintain solvency. • Unclear how language re: “protects solvency,” would be applied given solvency can be protected by containing expense growth, improving utilization and access, making wise strategic decisions and investments, and solvency is not merely a function of an increased budget. Likewise, unclear how language regarding “not unjust, unfair, inequitable, misleading, or contrary to the laws of this State” would apply or be interpreted. • (e)(1) removes GMCB authority and elevates regulated entities’ authorities by requiring their agreement to any

	regulatory process. Regulated entities are already extensively consulted prior to establishment of benchmarks and guidance. Adjustments may be important if information changes between when guidance is established in March and when decisions are rendered by October 1st. • Avoiding benchmarks at the cost-center or service-level could override the GMCB's ability to connect hospital budget and rate review processes, articulating budget constraints at the inpatient vs. outpatient level, and could be interpreted as prohibiting any targets for administrative vs clinical spending, or hospital owned primary care.
Sec. 10 – § 640. MEDICAL BENEFITS; ASSISTIVE DEVICES; HOME AND AUTOMOBILE MODIFICATIONS	No position
Sec. 11 – § 1901a. MEDICAID BUDGET	Support in concept, noting technical changes raised in testimony from provider organizations
Sec. 11a – AHEAD MODEL; LEGISLATIVE INTENT	Neutral with proposed modification • To the extent the Committee and legislature support this section, GMCB recommends a modification to the last paragraph to recognize the Legislature's significant expenditure of taxpayer funds to pass Act 167 and ensure a sustainable and affordable health system. Vermont must address mental health, primary care, and long-term care and thus suggest the Committee consider the below language as a replacement for the existing last paragraph: "Upon the finalization of negotiations between the State of Vermont and the Centers for Medicare and Medicaid Services over the agreement, and a decision to participate by the Administration and the Green Mountain Care Board, it is the intent of the General Assembly to evaluate and implement any needed changes in Vermont law to ensure a transparent, accessible, affordable, and sustainable healthcare system, that supports transformation recommendations from Act 167 of 2022 and strengthens the infrastructure of Vermont's mental health care, primary care, and long term health care systems."
Sec. 12 – GREEN MOUNTAIN CARE BOARD; HEALTH CARE CONTRACTS; FEE SCHEDULES; REPORT	Support

Sec. 12b. GREEN MOUNTAIN CARE BOARD REGULATORY REVIEW; REALIGNMENT REPORT	Oppose • Unnecessary, time consuming, and expensive to implement as written. GMCB previously prepared and provided a regulatory alignment white paper studying this topic and believes in and practices continuous improvement as to all its regulatory processes. Additional regulatory adjustments in lieu of AHEAD may be necessary, but without a clear understanding of the outcomes of AHEAD development and negotiations, it is premature to specify these changes. This would be a multi-year process. • This provision would also be inconsistent with Vermont's historical position that healthcare regulation should be performed by an independent body and could create conflicts of interest.

HCA Rate Review Suggested Amendments	
8 V.S.A. 4062(c)(3)(A)	Neutral: • If GMCB can't modify the questions, it is not clear why they need to come through the GMCB. The HCA is a party in these proceedings, unlike in hospital or ACO budget review.
8 V.S.A. 4062(d)(1)	Suggest revision: • Replace "contemporaneously" with "promptly." "Contemporaneously" suggests that the items will be posted when received, which is not possible. GMCB does not have a case management system and so people need to physically post documents on our website. These people may be out of the office or have other work that takes priority. Confidentiality issues may also take a few days to be resolved. Prompt posting will not take away from the public's ability to follow the proceedings and offer comments. The HCA gets the materials directly, so it does not need to access the information on the GMCB's website.

GMCB Proposals	
Ability to deliberate in private on hospital budgets and ACO budgets.	Propose amending 18 V.S.A. 9382 and 9456 by adding the following: "Notwithstanding anything to the contrary in 1 V.S.A. chapter 5, subchapter 2 (Vermont Open Meeting Law), the Board may deliberate in connection with its consideration of [hospital budgets OR ACO budgets] outside of a public hearing or meeting." • Private deliberations allow for and encourage robust debate and discussion amongst Board Members. This is why deliberations in connection with quasi-judicial

	proceedings are exempted from the Open Meeting Law. GMCB issues written decisions with findings of fact and conclusions of law that can be appealed; regulated entities do not need to rely on public deliberations to understand GMCB's reasoning. • Board rate review decisions are treated as quasi-judicial and GMCB's proposal here would continue to allow for full public participation in hearings as with rate review.
Require Medicare-only ACOs to be certified, but not subject foreign Medicare-only ACOs to budget review.	Carry over language from section 8 of S.211 that would add a new subsection (f) to 18 V.S.A. 9382 and require GMCB to adopt rules for certifying Medicare-only ACOs. Amend 18 V.S.A. 9382 by exempting Medicare-only ACOs that are organized out of state from GMCB's ACO budget review process. • Medicare-only ACOs are participating in a federal program that GMCB has no control over. • To date, Medicare-only ACOs in Vermont have been out-of-state organizations whose operations span multiple states. They do not have a Vermont-specific budget. Certification and reporting are better tools for regulating these ACOs.
Add resources providing for an additional analyst for the GMCB ($125k) and for an outside auditor to assist in hospital budget review ($250-500k)	Given the dramatic increase in the GMCB's workload through Act 167, potentially through S. 151, and through possible participation in the AHEAD model, the Board needs additional resources. GMCB's cost-effective regulatory efforts contain healthcare costs and saved Vermonters $145m in FY24. This request is important for Vermonters given the healthcare affordability crisis and GMCB's significant return-on-investment for Vermonters. While this request is insufficient for GMCB's current and additional workload, the additional resources could be used to: • Alleviate the large burden having two regulatory processes (fee for service and global budgets) would impose should AHEAD be pursued; • Support the review of reimbursement rates as provided for in S. 151; • Support the equitable reimbursement provisions provided for in S. 151; • Support the increase in primary care spend provision of S. 151; • Ensure hospitals are correctly billing (this past year a hospital revealed that it believed that for a lengthy period it was not accurately billing Medicare); • Improve timing of data shared with hospitals; • Increase opportunity to discuss hospitals' comparison data and unique circumstances; and

	• Support better regulation of hospital prices, operating efficiency requirements, allow the Board to identify additional opportunities to control growth in healthcare spending, and ensure more accessible, sustainable, and affordable care. It's important to consider that: • Vermont healthcare costs are rising far faster than national, and Vermonters are experiencing high levels of medical debt and we have a high underinsured rate. • GMCB currently reviews 14 hospital budget submissions totaling more than 3.6b dollars, and annual requests for very large rate increases that significantly contribute to increased healthcare costs to Vermonters. • Our hospital budget staff is extremely lean, with only 4 staff members, each of whom has other roles and responsibilities. • Hospital budgets are submitted on June 30th and by September 15th, just 2.5 months later, our staff of 4 must complete its review of all 14 budgets, conduct 14 hearings, conduct 14 deliberations, analyze voluminous and complex financial information including in hospital budget submissions, responses to questions, analytical data, HCA submissions, and public comment. • By October 1st, just 2 weeks after decisions are rendered, the Board must publish 14 lengthy budget orders that include complex financial and legal analysis. • Board staff are talented, dedicated, and hard-working, yet the hours and demands of this process are grueling, with many staffers working well into the early morning hours and weekends for prolonged periods.