1 S.190

2 An act relating to the Green Mountain Care Board, reference-based pricing,
3 and studying the creation of a Public Employee Health Benefit Authority

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

5 * * * Reference-Based Pricing * * *

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

7 (e) Reference-based pricing.

8 * * *

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

16 (B) The Board, in collaboration with the Department of Financial
17 Regulation, shall monitor the implementation of reference-based pricing to
18 ensure that any decreases in amounts paid to hospitals also result in decreases
19 in health insurance premiums. The Board shall post its findings regarding the
20 alignment between price decreases and premium decreases annually on its
21 website.

1 (C)(i) For provider contracts entered into, amended, or renewed on or
2 after October 1, 2026, each hospital and health insurer shall begin expressing
3 as a percentage of Medicare or of another benchmark, if another benchmark is
4 deemed appropriate by the Green Mountain Care Board, the rates for items and
5 services identified pursuant to a collaborative process between the Board and
6 representatives of Vermont hospitals.
7 (ii) When making public the charges for items and services
8 pursuant to 45 C.F.R. Part 180, each hospital shall include in its machine-
9 readable files pricing information shown as a percentage of Medicare rates, as
10 well as in dollars and cents, disaggregated by payer and by plan.
11 (iii) For purposes of subdivisions (i) and (ii) of this subdivision
12 (3)(C), a hospital may express rates as a percentage of Medicare based on the
13 actual reimbursement amounts the hospital receives from Medicare for items
14 provided and services delivered to Medicare beneficiaries until such time as
15 the Green Mountain Care Board adopts a rule establishing the methodology for
16 determining Medicare rates for use as a benchmark in establishing reference-
17 based prices pursuant to this subsection (e).
18 (D)(i) Each hospital shall apply for, obtain, and use a unique National
19 Provider Identifier (NPI) on all claims filed after October 1, 2027, for
20 reimbursement or payment of items provided and services delivered at an off-
21 campus department of the hospital that is distinct from the NPI used for

1 services delivered at the main hospital campus or at any other off-campus
2 hospital department.
3 (ii) As used in this subdivision (D):
4 (I) "Campus" has the same meaning as in 42 C.F.R. § 413.65.
5 (II) "Off-campus" means a facility located more than 250 yards
6 from the main hospital campus.
7 * * *
8 Sec. 2. 33 V.S.A. § 1815 is added to read:
9 § 1815. LIMITATIONS ON HOSPITAL REIMBURSEMENTS
10 (a)(1) As used in this section, "Medicare adjusted base rate" means the
11 standardized Medicare payment amount for a hospital inpatient, outpatient, or
12 professional service as determined under the Medicare program, calculated
13 prior to the application of any hospital-specific, patient-specific, or policy-
14 based payment adjustments and reflecting only the core payment methodology
15 used by the Centers for Medicare and Medicaid Services to establish baseline
16 payment levels, which include adjustments for geographic factors such as
17 wages.
18 (2) For items provided and services delivered at a critical access
19 hospital, the Medicare adjusted base rate shall be determined under the
20 applicable Medicare prospective payment system, using the Medicare payment

1 methodology that would apply if the hospital were not designated as a critical
2 access hospital.
3 (b)(1) A registered carrier shall not reimburse or agree to reimburse a
4 hospital more than 250 percent of the Medicare adjusted base rate for any item
5 provided or service delivered in Vermont to an enrollee in a qualified health
6 benefit plan.
7 (2) In the event that a registered carrier reimburses a hospital for an item
8 or service on a capitated or other non-fee-for-service basis, the carrier shall
9 ensure that its reimbursement method is adjusted to account for the
10 reimbursement limit set forth in subdivision (1) of this subsection.
11 (c) The reimbursement limit set forth in subsection (b) of this section shall
12 remain in effect unless and until the Green Mountain Care Board establishes a
13 different reference-based price pursuant to 18 V.S.A. § 9376(e).
14 (d) A hospital or hospital provider that is reimbursed in accordance with
15 subsection (b) of this section shall not charge or collect from the patient any
16 additional amounts other than the cost-sharing amounts authorized by the
17 terms of the health benefit plan.
18 (e) In its reviews of premium rates in accordance with 8 V.S.A. § 4026, the
19 Green Mountain Care Board shall ensure that the limitations on
20 reimbursements established in this section are appropriately reflected in the
21 premium rates for qualified health benefit plans.

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

2 Subchapter 7. Hospital Budgets and Budget Review

3 § 9451. DEFINITIONS

4 As used in this subchapter:

5 * * *

6 (4)(A) "Medicare adjusted base rate" means the standardized Medicare
7 payment amount for a hospital inpatient, outpatient, or professional service as
8 determined under the Medicare program, calculated prior to the application of
9 any hospital-specific, patient-specific, or policy-based payment adjustments
10 and reflecting only the core payment methodology used by the Centers for
11 Medicare and Medicaid Services to establish baseline payment levels, which
12 include adjustments for geographic factors such as wages.

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

18 * * *

19 § 9459. TARGETED COMMERCIAL REIMBURSEMENT RATE
20 REDUCTIONS

1 (a) A hospital shall implement any commercial reimbursement rate
2 reduction ordered by the Board pursuant to section 9456 of this title through
3 the limitations on its commercial reimbursement rates for qualified health
4 benefit plans in accordance with 33 V.S.A. § 1815.
5 (b) To the extent that a hospital is required by the Board's budget order to
6 reduce its commercial reimbursement rates by amounts greater than the
7 reductions achieved pursuant to subsection (a) of this section, the hospital shall
8 reduce its commercial reimbursement rates that exceed 500 percent of the
9 Medicare adjusted base rate or, if the hospital does not have any commercial
10 reimbursement rates that exceed 500 percent of the Medicare adjusted base
11 rate, by reducing its commercial reimbursement rates that are the highest in
12 relation to the Medicare adjusted base rate.
13 (c) Except as provided in subsections (a) and (b) of this section and in 33
14 V.S.A. § 1815, a hospital may increase the commercial reimbursement rates
15 for one or more of its service lines, such as primary care, provided that in
16 doing so the hospital remains compliant with the total budget ordered for the
17 hospital by the Board pursuant to section 9456 of this subchapter.
18 Sec. 4. IMPLEMENTATION OF REFERENCE-BASED PRICING FOR
19 CERTAIN PUBLIC EMPLOYEE HEALTH PLANS; REPORT
20 (a) The Green Mountain Care Board, in consultation with the Departments
21 of Financial Regulation and of Human Resources and the Vermont Education

1 Health Initiative (VEHI), shall analyze commercial health insurance claims for
2 inpatient and outpatient hospital items provided and services delivered to
3 active and retired members and their dependents enrolled in the State
4 Employees' Health Benefit Plan and in the health benefit plans offered to
5 teachers and other school employees through VEHI to determine the
6 opportunities available through the use of reference-based pricing and the
7 projected impact on Vermont's hospitals. VEHI, the Department of Human
8 Resources, and the administrator of the State Employees' Health Benefit Plan
9 shall provide the Board with access to the claims data necessary to perform the
10 analysis.
11 (b) On or before January 15, 2027, the Green Mountain Care Board shall
12 provide to the House Committees on Health Care and on Ways and Means and
13 the Senate Committees on Health and Welfare and on Finance the Board's
14 findings and any recommendations with respect to scope, timing, financial
15 impacts, and other considerations in implementing reference-based pricing for
16 items provided and services delivered to enrollees in the State Employees'
17 Health Benefit Plan and in the health benefit plans offered by VEHI.
18 * * * Hospital Outsourcing * * *
19 Sec. 5. HOSPITAL OUTSOURCING; HOSPITAL BUDGETS;
20 PROVIDER TAXES; REPORT

1 (a) For fiscal year 2027 hospital budgets, the Green Mountain Care Board
2 shall direct hospitals to provide such information as the Board may require
3 regarding the clinical services that the hospital outsources to external entities.
4 (b) On or before January 15, 2027, the Green Mountain Care Board, after
5 consulting with hospitals and their contracted independent providers and
6 assessing the impact of outsourcing on access to and the quality and
7 availability of care, shall provide findings and recommendations regarding
8 hospital outsourcing to the House Committees on Health Care and on Ways
9 and Means and the Senate Committees on Health and Welfare and on Finance.
10 In addition, the Board, in collaboration with the Agency of Human Services,
11 shall report on the extent to which hospital outsourcing affects provider tax
12 revenue and recommend any necessary modifications to 33 V.S.A. chapter 19,
13 subchapter 2 to appropriately reflect expenditures for patient care at Vermont
14 hospitals.
15 * * * Excluding Reference-Based Pricing from Scope of Health Care
16 Professional Bargaining * * *
17 Sec. 6. 18 V.S.A. § 9409 is amended to read:
18 § 9409. HEALTH CARE PROVIDER BARGAINING GROUPS
19 (a) The Green Mountain Care Board may approve the creation of one or
20 more health care provider bargaining groups, consisting of health care
21 providers who choose to participate. A bargaining group is authorized to

1 negotiate on behalf of all participating providers with the Secretary of
2 Administration, the Secretary of Human Services, the Green Mountain Care
3 Board, or the Commissioner of Labor with respect to any matter in this
4 chapter; chapter 13, 219, 220, or 222 of this title; 21 V.S.A. chapter 9; and 33
5 V.S.A. chapters 18 and 19 with respect to provider regulation, provider
6 reimbursement, administrative simplification, information technology,
7 workforce planning, or quality of health care.
8 (b) The Green Mountain Care Board shall adopt by rule criteria for forming
9 and approving bargaining groups and criteria and procedures for negotiations
10 authorized by this section.
11 (c) The rules relating to negotiations shall include a nonbinding arbitration
12 process to assist in the resolution of disputes. Nothing in this section shall be
13 construed to limit the authority of the Secretary of Administration, the
14 Secretary of Human Services, the Green Mountain Care Board, or the
15 Commissioner of Labor to reject the recommendation or decision of the
16 arbiter.
17 (d) Notwithstanding any provisions of this section to the contrary, the
18 Green Mountain Care Board shall not be required to negotiate with a provider
19 bargaining group or engage in a nonbinding arbitration process in connection
20 with the Board's establishment of reference-based prices in accordance with
21 subdivision 9375(b)(1)(A), subdivision 9375(b)(5), or section 9376 of this title.

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

Sec. 7. 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.

* * *

* * * Data Infrastructure * * *

Sec. 8. 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

1 services across the State. Using data from the Vermont Healthcare Claims
2 Uniform Reporting and Evaluation System (VHCURES) established pursuant
3 to section 9410 of this title, the dashboard shall provide the range of actual
4 allowed amounts for selected health care services, showing both the amount
5 paid by the health insurer or other payer and the amount of the member's
6 responsibility, and shall allow the consumer to sort the information by
7 geographic location, by health care provider, by payer type, and by the specific
8 health care procedure or health care service. The Board shall provide a link on
9 the dashboard to the statewide comparative hospital quality report published by
10 the Commissioner of Health pursuant to section 9405b of this title.
11 ~~(b)~~(2) The Board shall update the information in the interactive price
12 transparency dashboard at least annually.
13 (b)(1) The Board shall develop and maintain a public, interactive tool that
14 displays information on health system performance, including information
15 regarding quality, access, and affordability.
16 (2) The Board shall update the information in the health system
17 performance tool on a regular basis, to the extent operationally feasible.
18 Sec. 9. IMPLEMENTATION OF HEALTH SYSTEM PERFORMANCE
19 TOOL
20 The Green Mountain Care Board shall develop the health system
21 performance tool described in 18 V.S.A. § 9411(b), as added by Sec. 8 of this

1 act, only if the Board receives sufficient funding from the federal government
2 or another source for this purpose.
3 * * * Public Employee Health Benefit Authority Study Committee * * *
4 Sec. 10. PUBLIC EMPLOYEE HEALTH BENEFIT AUTHORITY
5 STUDY COMMITTEE; STATE TREASURER; REPORT
6 (a) Creation. There is created the Public Employee Health Benefit
7 Authority Study Committee to evaluate opportunities to establish a State
8 authority to develop and administer comprehensive and affordable health
9 benefits for all public-sector employees in Vermont.
10 (b) Membership. The Study Committee shall be composed of the
11 following members, who shall each be appointed by the entities they represent:
12 (1) the State Treasurer or designee;
13 (2) one member representing the Vermont State Employees'
14 Association;
15 (3) one member representing the Vermont-National Education
16 Association;
17 (4) one member representing the American Federation of Teachers;
18 (5) one member representing the United Electrical Workers;
19 (6) one member representing the American Federation of State, County
20 and Municipal Employees;

1 (7) one member representing the Vermont School Boards Association;
2 (8) one member representing the Vermont League of Cities and Towns;
3 (9) one member representing the Vermont State College system;
4 (10) one member representing the University of Vermont; and
5 (11) one member representing the Department of Human Resources.
6 (c) Powers and duties; report.
7 (1) The Study Committee shall consider the topics set forth in this
8 subsection and produce a report regarding the potential for establishing the
9 Public Employee Health Benefit Authority to provide and administer health
10 plans that would meet the health care and wellness needs of Vermont's
11 municipal, State, public school, and public college and university employees
12 and their dependents, including addressing all the following:
13 (A) the manner in which health benefits are provided to public
14 employees in other states, including Oregon and Washington;
15 (B) the similarities and differences in the level and scope of coverage
16 provided by current health plans offered to public employees;
17 (C) the similarities and differences in the current service or
18 contractual agreements negotiated by public-sector parties with commercial
19 health insurers, third-party administrators, and independent clinical and
20 analytical vendors;

1 (D) uniform design, coordination, and administration of medical and
2 pharmaceutical health plans, care networks, wellness initiatives, and medical
3 privacy protections;
4 (E) uniform standards and protocols for contract review and
5 negotiations with hospital facilities, nonhospital health care providers,
6 commercial health insurers, third-party administrators, independent clinical
7 and analytical vendors, and pharmacy benefit managers;
8 (F) streamlined, auditable processes to confirm the integrity and
9 accuracy of billing from and reimbursements to hospitals, nonhospital health
10 care providers, and vendors;
11 (G) opportunities to secure substantial and sustainable cost reductions
12 for employees, employers, and taxpayers;
13 (H) monitoring and management of fiduciary risk;
14 (I) Public Employee Health Benefit Authority governance structures,
15 deliberative processes, and equality of decision making by employer and
16 organized labor representatives; staff positions; member and patient advocacy;
17 and problem resolution on behalf of employees and employers;
18 (J) uniform standards and systems for collecting, analyzing, and
19 securely transmitting data on clinical, utilization, quality of care, and other
20 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.

1 (d) Assistance. The Study Committee shall have the administrative,
2 technical, and legal assistance of the Office of the State Treasurer and may
3 engage the services of one or more consultants or firms to assist with
4 facilitating meetings and public hearings and preparing its report, to the extent
5 funds are made available for this purpose.
6 (e) Meetings.
7 (1) The State Treasurer or designee shall call the first meeting of the
8 Study Committee to occur on or before August 15, 2026.
9 (2) The State Treasurer or designee shall be the chair.
10 (3) A majority of the membership shall constitute a quorum.
11 (4) The Study Committee shall cease to exist on March 1, 2027.
12 (f) Public hearings. The Study Committee shall schedule public hearings,
13 both remote and in person, to allow public-sector employers and employees the
14 opportunity to share their health care needs and concerns with the Study
15 Committee before the issuance of the Study Committee's report.
16 (g) Access to information. Commercial health insurers, third-party
17 administrators, the Vermont Education Health Initiative (VEHI), and clinical
18 and analytical vendors that serve the public sector shall provide full and timely
19 access to the Study Committee, with appropriate nondisclosure agreements in
20 place as needed, to:

1 (1) their service contracts or agreements with relevant public-sector
2 entities; and
3 (2) any data, including claims, actuarial, financial, and other data, that
4 the Study Committee requests.
5 (h) Compensation and reimbursement. Members of the Study Committee
6 shall not receive per diem compensation and reimbursement of expenses for
7 their participation on the Study Committee.
8 * * * Critical Access Hospitals; Medicare Outpatient Cost Sharing * * *
9 Sec. 11. CRITICAL ACCESS HOSPITALS; MEDICARE OUTPATIENT
10 COST SHARING; WORKING GROUP; REPORT
11 (a)(1) The Green Mountain Care Board shall convene a working group
12 comprising representatives of the Board, of the Departments of Vermont
13 Health Access and of Financial Regulation, of critical access hospitals, of
14 health insurers offering Medicare supplement insurance policies, and of the
15 Office of the Health Care Advocate to develop recommendations for ways to
16 mitigate the effects of a federal requirement that Medicare beneficiaries bear
17 financial responsibility for 20 percent of the amount charged for outpatient
18 services delivered by critical access hospitals.
19 (2) On or before January 15, 2027, the Green Mountain Care Board
20 shall provide the working group's recommendations, including the projected
21 impact of each recommendation on patients, critical access hospitals, and

1 premiums for Medicare supplement insurance policies, and the State budget, to
2 the House Committees on Health Care and on Appropriations and the Senate
3 Committees on Health and Welfare, on Finance, and on Appropriations.
4 (b) The Green Mountain Care Board shall not address or attempt to address
5 the effects of the federal Medicare cost-sharing requirements for outpatient
6 services delivered by critical access hospitals through the Board's hospital
7 budget review authority under 18 V.S.A. chapter 221, subchapter 7 in the fiscal
8 year 2027 hospital budgets.
9 * * * Effective Date * * *
10 Sec. 12. EFFECTIVE DATE
11 This act shall take effect on passage.