

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 The House proposes to the Senate to amend the bill by striking out all after  
5 the enacting clause and inserting in lieu thereof the following:

6 \* \* \* Reference-Based Pricing \* \* \*

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

8 (e) Reference-based pricing.

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

20 (B) The Board shall utilize reference-based pricing to reduce hospital  
21 prices incrementally until they are equal to national median prices by hospital

1 type by calendar year 2030. The Board shall use the highest quality,  
2 nonpartisan data demonstrating hospital prices as a percentage of Medicare to  
3 evaluate progress toward reducing hospital prices in Vermont to the national  
4 median.

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

9 \* \* \*

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

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

1 alignment between price decreases and premium decreases annually on its  
2 website.

3 (C)(i) For provider contracts entered into, amended, or renewed on or  
4 after January 1, 2028, each hospital and health insurer shall begin expressing  
5 as a percentage of Medicare or of another benchmark, if another benchmark is  
6 deemed appropriate by the Green Mountain Care Board, the rates for items and  
7 services identified pursuant to a collaborative process between the Board and  
8 representatives of Vermont hospitals.

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

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

20 (D)(i) Each hospital shall apply for, obtain, and use a unique National  
21 Provider Identifier (NPI) on all claims filed after October 1, 2027, for

1 reimbursement or payment of items provided and services delivered at an off-  
2 campus department of the hospital that is distinct from the NPI used for  
3 services delivered at the main hospital campus or at any other off-campus  
4 hospital department.

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

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

7 (II) “Off-campus” means a facility located more than 250 yards  
8 from the main hospital campus.

9 \* \* \*

10 Sec. 2. LIMITATIONS ON HOSPITAL REIMBURSEMENTS FOR  
11 QUALIFIED HEALTH BENEFIT PLANS AND PLANS  
12 COVERING SCHOOL EMPLOYEES FOR HOSPITAL FISCAL  
13 YEAR 2027

14 (a) As used in this section:

15 (1) “Health benefit association” has the same meaning as in 24 V.S.A.  
16 § 4947.

17 (2)(A) “Medicare adjusted base rate” means the standardized Medicare  
18 payment amount for a hospital inpatient, outpatient, or professional service as  
19 determined under the Medicare program, calculated prior to the application of  
20 any hospital-specific, patient-specific, or policy-based payment adjustments  
21 and reflecting only the core payment methodology used by the Centers for

1 Medicare and Medicaid Services to establish baseline payment levels, which  
2 include adjustments for geographic factors such as wages.

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

8 (3) “Qualified health benefit plan” has the same meaning as in  
9 33 V.S.A. § 1802.

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

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

12 (b) Notwithstanding any provision of 18 V.S.A. § 9375(b)(1)(A) to the  
13 contrary, for hospital fiscal year 2027, the Green Mountain Care Board may  
14 order hospitals to reduce their commercial reimbursement rates for qualified  
15 health benefit plans and for health benefit plans offered to school employees  
16 by a health benefit association pursuant to 24 V.S.A. § 4947 based on a  
17 percentage of the Medicare adjusted base rate determined by the Board for  
18 each item provided and service delivered in Vermont to enrollees in these  
19 plans.

20 (c)(1) A registered carrier or health benefit association shall not reimburse  
21 or agree to reimburse a hospital more than the percentage of the Medicare

1 adjusted base rate specified by the Green Mountain Care Board pursuant to  
2 subsection (b) of this section, if any, for the applicable hospital fiscal year for  
3 any item provided or service delivered in Vermont to an enrollee in a qualified  
4 health benefit plan or a health benefit plan offered to school employees by a  
5 health benefit association.

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

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

15 (e) To the extent that a hospital is required by the Board's budget order to  
16 reduce its commercial reimbursement rates by amounts greater than the  
17 reductions achieved pursuant to subsection (b) of this section, the hospital shall  
18 reduce its commercial reimbursement rates that exceed 500 percent of the  
19 Medicare adjusted base rate or, if the hospital does not have any commercial  
20 reimbursement rates that exceed 500 percent of the Medicare adjusted base

1 rate, by reducing its commercial reimbursement rates that are the highest in  
2 relation to the Medicare adjusted base rate.

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

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

12 Sec. 3. [Deleted.]

13 \* \* \* Hospital Outsourcing \* \* \*

14 Sec. 4. HOSPITAL OUTSOURCING; HOSPITAL BUDGETS;  
15 PROVIDER TAXES; REPORT

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

19 (b) On or before January 15, 2027, the Green Mountain Care Board, after  
20 consulting with hospitals and their contracted independent providers and  
21 assessing the impact of outsourcing on access to and the quality and

1 availability of care, shall provide findings and recommendations regarding  
2 hospital outsourcing to the House Committees on Health Care and on Ways  
3 and Means and the Senate Committees on Health and Welfare and on Finance.  
4 In addition, the Board, in collaboration with the Agency of Human Services,  
5 shall report on the extent to which hospital outsourcing affects provider tax  
6 revenue and recommend any necessary modifications to 33 V.S.A. chapter 19,  
7 subchapter 2 to appropriately reflect expenditures for patient care at Vermont  
8 hospitals.

9 \* \* \* Section 1332 Waiver for Reinsurance Program \* \* \*

10 Sec. 4a. REINSURANCE; AUTHORIZATION TO PURSUE SECTION  
11 1332 WAIVER

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



1 Commissioner of Labor to reject the recommendation or decision of the  
2 arbiter.

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

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

9 Sec. 6. 18 V.S.A. § 9381 is amended to read:

10 § 9381. APPEALS

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

16 (b) of this section.

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

21

\* \* \*



1       (b)(1) The Board shall develop and maintain a public, interactive tool that  
2       displays information on health system performance, including information  
3       regarding quality, access, and affordability.

4       (2) The Board shall update the information in the health system  
5       performance tool on a regular basis, to the extent operationally feasible.

6       Sec. 8. IMPLEMENTATION OF HEALTH SYSTEM PERFORMANCE  
7       TOOL

8       The Green Mountain Care Board shall develop the health system  
9       performance tool described in 18 V.S.A. § 9411(b), as added by Sec. 8 of this  
10       act, only if the Board receives sufficient funding from the federal government  
11       or another source for this purpose.

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

13       Sec. 9. CRITICAL ACCESS HOSPITALS; MEDICARE OUTPATIENT  
14       COST SHARING

15       (a) The General Assembly and the Green Mountain Care Board have  
16       recently become aware of a federal requirement that Medicare beneficiaries  
17       must bear financial responsibility for 20 percent of the amount charged for  
18       outpatient services delivered by critical access hospitals, not 20 percent of the  
19       amount that Medicare pays for the service. While the General Assembly  
20       understands that it cannot invalidate this federal requirement, it also recognizes  
21       both that this requirement has a significant, unfair, and negative financial

1 impact on Medicare beneficiaries in the State's most rural communities and  
2 that Vermont's critical access hospitals are some of the State's most financially  
3 vulnerable health care facilities. It is the intent of this section to provide  
4 information to Vermont's seniors and other Medicare beneficiaries about the  
5 federal requirement while a working group of interested stakeholders  
6 endeavors to develop appropriate and enduring solutions that do not undermine  
7 the financial sustainability of our critical access hospitals and that comply with  
8 federal law.

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

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

14 (2) Post prominently on its website and in outpatient departments of the  
15 hospital a disclosure about the federal requirement that Medicare beneficiaries  
16 must pay 20 percent of the charge for outpatient services at critical access  
17 hospitals, that Medicare beneficiaries may be able to receive care with reduced  
18 out-of-pocket costs from other providers, and how to contact the hospital's  
19 patient financial assistance department for more information. The hospital  
20 shall file its proposed disclosure materials with the Green Mountain Care  
21 Board for the Board's approval prior to posting.

