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February 12, 2026

Representative Alyssa Black, Chairwoman of the
House Committee on Health Care
115 State Street
Room 42
Montpelier, VT 05633

RE: AHIP Comments on H.583, An Act Relating to Health Care Financial Transactions and Clinical Decision Making (AMENDED DRAFT) -- OPPOSE

To Chairwoman Black and Members of the House Committee on Health Care,

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments on the draft amended version of H.583, which places restrictions on health care facility ownership and clinical decision-making, along with establishing transparency and reporting requirements for health care entities.

We believe patients should be able to receive the health care they need in their communities at costs they can afford. Unfortunately, growing consolidation among health care providers and acquisitions by private equity firms threaten the availability of quality, local, affordable health care.

This bill's ownership and contracting restrictions, however, are overly broad, unnecessarily burdensome and will have numerous unintended consequences that may include massive disruptions in coverage and access to care with increased costs for the Vermont consumers and employers our members serve. For these reasons, AHIP opposes this draft amended version of H.583.

Health Care Facility Ownership

AHIP is committed to supporting market-based solutions that make health care better and coverage more affordable for everyone. We share the Committee's concern with the rising consolidation of health care providers and increased acquisitions by private equity firms motivated by the extraction of short-term profits.

Decades of hospital and health system consolidation have shifted market dynamics. A 2020 report from Medicare Payment Advisory Commission found that 90% of hospital markets would be deemed highly concentrated by Federal Trade Commission standards, and in most markets, a single hospital system had more than a 50% market share of discharges.[1] Further, as of January 2024, nearly four out of five physicians were employed by hospitals or other corporate entities rather than in independent practice.[2]

AHIP opposes the addition of health insurers and pharmacy benefit managers (PBMs) to the definition of "Health care entity" under Subchapter 1. Together with Subchapter 2(a)(2), H.583 would prohibit ownership of health plans and PBMs by for-profit entities, with limited exceptions for professional corporations or limited liability companies as permitted under law.

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[1] Medicare Payment Advisory Commission. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC, March 2020.
[2] Avalere Health. "Updated Report: Hospital and Corporate Acquisition of Physician Practices and Physician Employment 2019-2023." Physicians Advocacy Institute. April 2024.

It was our understanding that the original intent of H.583 was to limit and provide greater transparency into the role of private equity in the purchase and control of health care facilities, for example through real estate invest trust ownership or sale-leaseback structures.

The expansion in scope beyond that original intent, however, under the current language of Subchapter 2(a)(2) may have several immediate and future unintended consequences for Vermont consumers and patients. This could unwind existing health plan and PBM ownership structures, even with the included exemptions, leading to health coverage interruptions or even loss of coverage for Vermonters. Furthermore, it may prevent future partnerships between health plans and/or PBMs with for-profit entities to create innovative programs that could make health care better and more affordable for everyone.

As a result, we urge the committee to remove health insurers and PBMs from the definition of "Health care entity".

Corporate Practice of Medicine

AHIP is also concerned with the operational unintended consequences of Subchapter 3 and would appreciate clarification of its intended purposes. One area of concern relates to Subchapter 3 that would prevent health plans from owning medical practices. AHIP is concerned this would significantly reduce provider capacity in Vermont, reducing competition, raising consumer costs and diminishing patient access -- and potentially jeopardizing health plans' ability to meet network adequacy requirements on behalf of their members. Together, this language would disrupt existing care for vulnerable Vermonters, including seniors and people with complex chronic diseases.

Health insurers and other stakeholders should be able to respond to their clients' demands for capabilities to help defray health care costs, stretch benefit dollars, and improve patient experiences and outcomes. Leveraging these vital resources under a "single roof" can achieve those objectives and reflect a competition-based approach to addressing these client and member needs, enhancing responses to the dynamics of a complex, evolving market.

We thus urge the Committee to explicitly exempt health insurers from the prohibitions and requirements under Subchapter 3.

Transparency

Subchapter 4 outlines transparency and reporting requirements for health care entities operating in Vermont, which includes, among other things, an organizational chart detailing all affiliates, subsidiaries, and parent organizations, information on affiliated health care providers, and comprehensive financial reports to the Attorney General and Green Mountain Care Board every two years.

We support transparency requirements in instances where providers are either owned by or are significantly staked by private equity. When private equity and other investment firms make health care about extracting short-term profit, everyone loses. Private equity hospital investments should be transparently disclosed, so patients and regulators can scrutinize changes in quality.

We thus urge the Committee to refine these measures to:

- Enforce and publicly disclose existing hospital cost reporting requirements on private equity investment and real estate holding companies.
- Require hospitals to disclose staffing arrangements with private equity-backed provider groups, including the compensation structure and any incentives.
- Urge CMS to fix the No Surprises Act's Independent Dispute Resolution process to stop private equity-backed groups from flooding the system with ineligible claims.
- Require more stringent oversight of arbitrators, including greater transparency, audits, and penalties for non-compliance.

We recognize that sometimes outside investment can be a force for good in health care by reducing unnecessary costs and encouraging higher quality. Too often, when private equity gets involved, these investments prioritize short-term returns at the expense of patient care. Transparency and oversight are needed to ensure that private equity investment in the health care sector improves quality at a lower cost.

Private Right of Action

AHIP is concerned with the private right of action provisions in Subchapter 5 if applicable to health plans. Allowing private lawsuits may greatly increase frivolous lawsuits, to the detriment of consumers. Lawyers with a financial stake in the outcome of the case could push for litigation where it is not warranted. This incentivizing of frivolous litigation also may undermine attempts by health plans to provide quick resolution to consumer complaints. We believe that the result will be worse outcomes and increased costs, which will be borne by consumers.

Recommendation: AHIP urges the Committee not to pass this draft amended version of H.583. Key areas in which we believe the Committee should consider amending this legislation to protect Vermonters from unintended negative consequences include:

1) Removing “pharmacy benefit managers” and “health care plans” from the definition of “Health care entities” under Subchapter 1;
2) Explicitly exempting health plans from Subchapter 3; and
3) Recalibrating the transparency requirements to focus on private equity’s role in improving health care quality at lower costs.

Thank you for your consideration of these comments. AHIP stands ready and willing to work with policymakers in Vermont and we look forward to more opportunities to provide input in this area. If you have any questions or concerns regarding our comments and would like to discuss these matters further, please contact Sarah Lynn Geiger at slgeiger@ahip.org or by phone (609) 605-0748.

Sincerely,

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cc: Members, House Committee on Health Care
Jonathan Wolff, AHIP Retained Counsel