

1 S.190

2 Representative Black of Essex moves that the report of the Committee on  
3 Health Care be amended as follows:

4 First: By striking out Sec. 2, 18 V.S.A. chapter 221, subchapter 7, in its  
5 entirety and inserting in lieu thereof a new Sec. 2 to read as follows:

6 Sec. 2. LIMITATIONS ON HOSPITAL REIMBURSEMENTS FOR  
7 QUALIFIED HEALTH BENEFIT PLANS AND PLANS  
8 COVERING SCHOOL EMPLOYEES **FOR HOSPITAL FISCAL**  
9 **YEAR 2027**

10 (a) As used in this section:

11 (1) “Health benefit association” has the same meaning as in 24 V.S.A.  
12 § 4947.

13 ~~(2) “Hospital” means a general hospital licensed under chapter 43 of this~~  
14 ~~title that is not:~~

15 ~~(A) a critical access hospital;~~

16 ~~(B) classified as a Medicare dependent hospital under 42 C.F.R.~~  
17 ~~§ 412.108; or~~

18 ~~(C) participating in the Rural Community Hospital Demonstration~~  
19 ~~program through the Centers for Medicare and Medicaid Services.~~

20 (2)(A) “Medicare adjusted base rate” means the standardized Medicare  
21 payment amount for a hospital inpatient, outpatient, or professional service as

1 determined under the Medicare program, calculated prior to the application of  
2 any hospital-specific, patient-specific, or policy-based payment adjustments  
3 and reflecting only the core payment methodology used by the Centers for  
4 Medicare and Medicaid Services to establish baseline payment levels, which  
5 include adjustments for geographic factors such as wages.

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

11 (3) “Qualified health benefit plan” has the same meaning as in  
12 33 V.S.A. § 1802.

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

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

15 (b)(1) ~~In establishing~~ **Notwithstanding any provision of 18 V.S.A.**  
16 **§ 9375(b)(1)(A) to the contrary, for hospital** fiscal year 2027 ~~hospital~~  
17 ~~budgets,~~ the Board may ~~direct an amount equal to 3.5 percent of the hospitals’~~  
18 ~~combined commercial net patient revenue based on approved fiscal year 2026~~  
19 ~~hospital budgets toward reducing~~ **order hospitals to reduce their** commercial  
20 reimbursement rates for qualified health benefit plans and for health benefit  
21 plans offered to school employees by a health benefit association pursuant to

1 24 V.S.A. § 4947 based on a percentage of the Medicare adjusted base rate  
2 determined by the Board for each item provided and service delivered in  
3 Vermont to enrollees in these plans.

4 ~~(2) In establishing fiscal year 2028 and 2029 hospital budgets, the Board~~  
5 ~~may limit commercial reimbursement rates for qualified health benefit plans~~  
6 ~~and for health benefit plans offered to school employees by a health benefit~~  
7 ~~association pursuant to 24 V.S.A. § 4947 to not more than the following~~  
8 ~~percentages of the Medicare adjusted base rate for each item provided and~~  
9 ~~service delivered in Vermont to enrollees in these plans:~~

10 ~~(A) for hospital fiscal year 2028, not more than 300 percent of the~~  
11 ~~Medicare adjusted base rate; and~~

12 ~~(B) for hospital fiscal year 2029, not more than 250 percent of the~~  
13 ~~Medicare adjusted base rate.~~

14 (c)(1) A registered carrier or health benefit association shall not reimburse  
15 or agree to reimburse a hospital more than the percentage of the Medicare  
16 adjusted base rate specified by the Green Mountain Care Board pursuant to  
17 subsection (b) of this section, if any, for the applicable hospital fiscal year for  
18 any item provided or service delivered in Vermont to an enrollee in a qualified  
19 health benefit plan or a health benefit plan offered to school employees by a  
20 health benefit association.

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

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

10          (e) To the extent that a hospital is required by the Board’s budget order to  
11          reduce its commercial reimbursement rates by amounts greater than the  
12          reductions achieved pursuant to subsection (b) of this section, the hospital shall  
13          reduce its commercial reimbursement rates that exceed 500 percent of the  
14          Medicare adjusted base rate or, if the hospital does not have any commercial  
15          reimbursement rates that exceed 500 percent of the Medicare adjusted base  
16          rate, by reducing its commercial reimbursement rates that are the highest in  
17          relation to the Medicare adjusted base rate.

18          (f) Except as provided in subsections (b), (c), and (e) of this section, a  
19          hospital may increase the commercial reimbursement rates for one or more of  
20          its service lines, such as primary care, provided that in doing so the hospital

1 remains compliant with the total budget ordered for the hospital by the Board  
2 pursuant to section 9456 of this subchapter.

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 Second: By striking out Sec. 3, 18 V.S.A. § 9407, in its entirety and  
13 inserting in lieu thereof a new Sec. 3 to read as follows:

14 Sec. 3. [Deleted.]

15 Third: By striking out Sec. 10, effective dates, and its reader assistance  
16 heading in their entirety and inserting in lieu thereof a new Sec. 10 and reader  
17 assistance heading to read as follows:

18 \* \* \* Effective Date \* \* \*

19 Sec. 10. EFFECTIVE DATE

20 This act shall take effect on passage.