

1 TO THE HOUSE OF REPRESENTATIVES:

2 The Committee on Health Care to which was referred Senate Bill No. 190
3 entitled “An act relating to the Green Mountain Care Board, reference-based
4 pricing, and studying the creation of a Public Employee Health Benefit
5 Authority” respectfully reports that it has considered the same and
6 recommends that the House propose to the Senate that the bill be amended by
7 striking out all after the enacting clause and inserting in lieu thereof the
8 following:

9 * * * Reference-Based Pricing * * *

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

11 (e) Reference-based pricing.

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

1 ways to achieve all-payer alignment on the design and implementation of
2 reference-based pricing.

3 (B) The Board shall utilize reference-based pricing to reduce hospital
4 prices incrementally until they are equal to national median prices by hospital
5 type by calendar year 2030. The Board shall use the highest quality,
6 nonpartisan data demonstrating hospital prices as a percentage of Medicare to
7 evaluate progress toward reducing hospital prices in Vermont to the national
8 median.

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

13 * * *

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

1 (B) The Board, in collaboration with the Department of Financial
2 Regulation, shall monitor the implementation of reference-based pricing to
3 ensure that any decreases in amounts paid to hospitals also result in decreases
4 in health insurance premiums. The Board shall post its findings regarding the
5 alignment between price decreases and premium decreases annually on its
6 website.

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

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

17 (iii) For purposes of subdivisions (i) and (ii) of this subdivision
18 (3)(C), a hospital may express rates as a percentage of Medicare based on the
19 actual reimbursement amounts the hospital receives from Medicare for items
20 provided and services delivered to Medicare beneficiaries until such time as
21 the Green Mountain Care Board adopts a rule establishing the methodology for

1 determining Medicare rates for use as a benchmark in establishing reference-
2 based prices pursuant to this subsection (e).

3 (D)(i) Each hospital shall apply for, obtain, and use a unique National
4 Provider Identifier (NPI) on all claims filed after October 1, 2027, for
5 reimbursement or payment of items provided and services delivered at an off-
6 campus department of the hospital that is distinct from the NPI used for
7 services delivered at the main hospital campus or at any other off-campus
8 hospital department.

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

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

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

13 * * *

14 Sec. 2. 18 V.S.A. chapter 221, subchapter 7 is amended to read:

15 Subchapter 7. Hospital Budgets and Budget Review

16 § 9451. DEFINITIONS

17 As used in this subchapter:

18 * * *

19 (4)(A) “Medicare adjusted base rate” means the standardized Medicare
20 payment amount for a hospital inpatient, outpatient, or professional service as
21 determined under the Medicare program, calculated prior to the application of

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

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

10 * * *

11 § 9459. LIMITATIONS ON HOSPITAL REIMBURSEMENTS FOR
12 QUALIFIED HEALTH BENEFIT PLANS AND PLANS
13 COVERING SCHOOL EMPLOYEES

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) “Hospital” means a general hospital licensed under chapter 43 of this
18 title that is not:

19 (A) a critical access hospital;

20 (B) classified as a Medicare-dependent hospital under 42 C.F.R.
21 § 412.108; or

1 (C) participating in the Rural Community Hospital Demonstration
2 program through the Centers for Medicare and Medicaid Services.

3 (3) “Qualified health benefit plan” has the same meaning as in
4 33 V.S.A. § 1802.

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

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

7 (b)(1) In establishing fiscal year 2027 hospital budgets, the Board may
8 direct an amount equal to 3.5 percent of the hospitals’ combined commercial
9 net patient revenue based on approved fiscal year 2026 hospital budgets toward
10 reducing commercial reimbursement rates for qualified health benefit plans
11 and for health benefit plans offered to school employees by a health benefit
12 association pursuant to 24 V.S.A. § 4947 based on a percentage of the
13 Medicare adjusted base rate determined by the Board for each item provided
14 and service delivered in Vermont to enrollees in these plans.

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

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

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

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

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

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

1 (e) To the extent that a hospital is required by the Board’s budget order to
2 reduce its commercial reimbursement rates by amounts greater than the
3 reductions achieved pursuant to subsection (b) of this section, the hospital shall
4 reduce its commercial reimbursement rates that exceed 500 percent of the
5 Medicare adjusted base rate or, if the hospital does not have any commercial
6 reimbursement rates that exceed 500 percent of the Medicare adjusted base
7 rate, by reducing its commercial reimbursement rates that are the highest in
8 relation to the Medicare adjusted base rate.

9 (f) Except as provided in subsections (b), (c), and (e) of this section, a
10 hospital may increase the commercial reimbursement rates for one or more of
11 its service lines, such as primary care, provided that in doing so the hospital
12 remains compliant with the total budget ordered for the hospital by the Board
13 pursuant to section 9456 of this subchapter.

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

18 (2) In its review of premium rates in accordance with 8 V.S.A. § 4026
19 and 24 V.S.A. chapter 121, subchapter 6, the Department of Financial
20 Regulation shall ensure that the limitations on reimbursements established in

1 this section are appropriately reflected in the premium rates for health benefit
2 plans offered to school employees by a health benefit association.

3 * * * Hospital Outsourcing * * *

4 Sec. 3. HOSPITAL OUTSOURCING; HOSPITAL BUDGETS;
5 PROVIDER TAXES; REPORT

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

9 (b) On or before January 15, 2027, the Green Mountain Care Board, after
10 consulting with hospitals and their contracted independent providers and
11 assessing the impact of outsourcing on access to and the quality and
12 availability of care, shall provide findings and recommendations regarding
13 hospital outsourcing to the House Committees on Health Care and on Ways
14 and Means and the Senate Committees on Health and Welfare and on Finance.
15 In addition, the Board, in collaboration with the Agency of Human Services,
16 shall report on the extent to which hospital outsourcing affects provider tax
17 revenue and recommend any necessary modifications to 33 V.S.A. chapter 19,
18 subchapter 2 to appropriately reflect expenditures for patient care at Vermont
19 hospitals.

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. 5. 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 * * *

* * * Data Infrastructure * * *

1
2 Sec. **6**. 18 V.S.A. § 9411 is amended to read:

3 § 9411. INTERACTIVE PRICE TRANSPARENCY DASHBOARD AND
4 HEALTH SYSTEM PERFORMANCE TOOL

5 (a)(1) The Green Mountain Care Board shall develop and maintain a
6 public, interactive, ~~Internet-based~~ internet-based price transparency dashboard
7 that allows consumers to compare health care prices for certain health care
8 services across the State. Using data from the Vermont Healthcare Claims
9 Uniform Reporting and Evaluation System (VHCURES) established pursuant
10 to section 9410 of this title, the dashboard shall provide the range of actual
11 allowed amounts for selected health care services, showing both the amount
12 paid by the health insurer or other payer and the amount of the member's
13 responsibility, and shall allow the consumer to sort the information by
14 geographic location, by health care provider, by payer type, and by the specific
15 health care procedure or health care service. The Board shall provide a link on
16 the dashboard to the statewide comparative hospital quality report published by
17 the Commissioner of Health pursuant to section 9405b of this title.

18 ~~(b)~~(2) The Board shall update the information in the interactive price
19 transparency dashboard at least annually.

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. **7**. 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. **8**. 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 ~~begin to~~
4 ~~provide some relief for~~ **provide information** to Vermont’s seniors and other
5 Medicare beneficiaries ~~from the consequences of~~ **about** the federal
6 requirement ~~promptly~~ while a working group of interested stakeholders
7 endeavors to develop appropriate and enduring solutions that do not undermine
8 the financial sustainability of our critical access hospitals **and that comply**
9 **with federal law.**

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

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

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

1 **disclosure materials with the Green Mountain Care Board for the Board’s**
2 **approval prior to posting.**

3 (c) To the extent that the Green Mountain Care Board engages in efforts to
4 address the Medicare outpatient cost-sharing issue in hospital fiscal year 2027,
5 the Board shall consider any proposals from the critical access hospitals and
6 other interested stakeholders and shall ensure that its actions are consistent
7 with ongoing hospital transformation efforts and the principles for health care
8 reform expressed in 18 V.S.A. § 9371.

9 * * * Effective Date * * *

10 Sec. 9. EFFECTIVE DATE

11 This act shall take effect on passage.

12 **and that after passage the title of the bill be amended to read: “An act relating**
13 **to reference-based pricing and the Green Mountain Care Board”**

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18 (Committee vote: _____)

19

20

Representative _____

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FOR THE COMMITTEE