TO THE HOUSE OF REPRESENTATIVES:

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

* * * Reference-Based Pricing * * *

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

(e) Reference-based pricing.

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

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

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

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

* * *

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

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

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

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

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

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

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

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

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

(II) "Off-campus" means a facility located more than 250 yards from the main hospital campus.

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

Subchapter 7. Hospital Budgets and Budget Review

§ 9451. DEFINITIONS

As used in this subchapter:

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

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

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

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

(a) As used in this section:

(1) "Health benefit association" has the same meaning as in 24 V.S.A. § 4947.

(2) "Hospital" means a general hospital licensed under chapter 43 of this title that is not:

(A) a critical access hospital;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 3. 18 V.S.A. § 9407 is amended to read:

§ 9407. OUTPATIENT PRESCRIPTION DRUGS; LIMITATIONS ON HOSPITAL CHARGES

(a)(1) A hospital shall not submit a claim to a health insurer for reimbursement of a prescription drug administered in an outpatient or office setting in an amount that exceeds ~~120~~ **130** percent of the average sales price (ASP), as calculated by the Centers for Medicare and Medicaid Services, for any drug for which the hospital charged any health insurer more than ~~120~~ **130** percent of the ASP in effect as of April 1, 2025.

(2) For any prescription drug administered in an outpatient or office setting for which a hospital charged a health insurer ~~120~~ **130** percent or less of the ASP in effect as of April 1, 2025, the hospital shall not charge the health insurer a greater percentage of the ASP, as calculated by the Centers for Medicare and Medicaid, for that drug than the percentage of the ASP that the hospital charged the health insurer as of April 1, 2025.

(3) A hospital shall update the ASP for each drug annually on January 1 and July 1 based on the Centers for Medicare and Medicaid Services' ASP calculations for the most recent calendar quarter.

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* * * Hospital Outsourcing * * *

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

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

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

* * * Excluding Reference-Based Pricing from Scope of Health Care Professional Bargaining * * *

Sec. 5. 18 V.S.A. § 9409 is amended to read:

§ 9409. HEALTH CARE PROVIDER BARGAINING GROUPS

(a) The Green Mountain Care Board may approve the creation of one or more health care provider bargaining groups, consisting of health care providers who choose to participate. A bargaining group is authorized to negotiate on behalf of all participating providers with the Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the Commissioner of Labor with respect to any matter in this chapter; chapter 13, 219, 220, or 222 of this title; 21 V.S.A. chapter 9; and 33 V.S.A. chapters 18 and 19 with respect to provider regulation, provider reimbursement, administrative simplification, information technology, workforce planning, or quality of health care.

(b) The Green Mountain Care Board shall adopt by rule criteria for forming and approving bargaining groups and criteria and procedures for negotiations authorized by this section.

(c) The rules relating to negotiations shall include a nonbinding arbitration process to assist in the resolution of disputes. Nothing in this section shall be construed to limit the authority of the Secretary of Administration, the Secretary of Human Services, the Green Mountain Care Board, or the

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

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

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

Sec. 6. 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.

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* * * Data Infrastructure * * *

Sec. 7. 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 services across the State. Using data from the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES) established pursuant to section 9410 of this title, the dashboard shall provide the range of actual allowed amounts for selected health care services, showing both the amount paid by the health insurer or other payer and the amount of the member's responsibility, and shall allow the consumer to sort the information by geographic location, by health care provider, by payer type, and by the specific health care procedure or health care service. The Board shall provide a link on the dashboard to the statewide comparative hospital quality report published by the Commissioner of Health pursuant to section 9405b of this title.

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

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

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

Sec. 8. IMPLEMENTATION OF HEALTH SYSTEM PERFORMANCE TOOL

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

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

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

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

impact on Medicare beneficiaries in the State's most rural communities and that Vermont's critical access hospitals are some of the State's most financially vulnerable health care facilities. It is the intent of this section to ~~begin to provide some relief for~~ **provide information to** Vermont's seniors and other Medicare beneficiaries ~~from the consequences of~~ **about** the federal requirement ~~promptly~~ while a working group of interested stakeholders endeavors to develop appropriate and enduring solutions that do not undermine the financial sustainability of our critical access hospitals **and that comply with federal law**.

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

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

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

with the Green Mountain Care Board for the Board's approval prior to posting.

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

* * * Effective Dates * * *

Sec. 10. EFFECTIVE DATES

This act shall take effect on passage**, except that Sec. 3 (18 V.S.A. § 9407) shall take effect on July 1, 2026**.

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

(Committee vote: _____)

_____

Representative _____

FOR THE COMMITTEE