Vermont S.190 – GMCB Testimony

An Act Relating to the Green Mountain Care Board, Reference-Based Pricing, and Studying the Creation of a Public Employee Health Benefit Authority

As Passed by the Senate (2026) | Testimony April 28, 2026, Alena Berube, Director of Policy, GMCB

Section	Section Summary	GMCB Position
Sec. 1 Price Transparency	Mandates that hospitals and insurers express rates as a percentage of Medicare by Oct 1, 2026, and that hospitals include this information in their price transparency files. Allows hospitals to use actual Medicare reimbursement amounts until GMCB adopts a rule establishing a method for determining the Medicare referent. Mandates that hospitals use unique NPIs for off-campus hospital departments by Oct 1, 2027.	**Support with three adjustments for clarity**. 1. Clarify that mandate applies to all new and existing contracts between hospitals and insurers, even "evergreen" contracts that do not expire and thus may not need to be amended or renewed (page 2, line 1). 2. Clarify the scope of the "collaborative process" (page 2, line 5), or remove; we expect the contracting and transparency reporting provisions to apply to all items and services for which there is a Medicare price. 3. Clarify "actual paid amount" for CAHs (page 2, line 13) is their interim Medicare payment, not the reconciled payment at year end, which would cause delay and make this operationally infeasible.
Sec. 2 & 3 Reference Based Pricing FY2027	Creates an interim statutory cap – registered carriers may not reimburse hospitals more than 250% of the Medicare adjusted base rate for services provided to qualified health benefit plan (QHP) members in Vermont—and requires GMCB to ensure this cap is reflected in QHP premiums. Prohibits hospitals from billing patients beyond their authorized cost-sharing. Adds a definition of 'Medicare adjusted base rate' to the hospital budget chapter. Directs hospitals to implement any GMCB-ordered commercial rate reductions first through the 250% cap in Sec. 2, and then by targeting rates above 500% of Medicare. Allows hospitals to shift rates within service lines if they remain within their total budget.	**Support with minor adjustment for clarity**. **While GMCB's approach to hospital RBP is to set limits on what hospitals can charge for the full commercial market, why is targeting the QHP market the right "first step" to implementing this program?** 1. Directs initial savings to most vulnerable market and **ensures dollar-for-dollar savings are returned to Vermonters (not the case for a broad service-level cap)**. The QHP market is the market of last resort, with those who exit largely becoming uninsured. GMCB regulates the QHP market and can ensure savings go back to Vermonters through premium reductions. If a reduction applies to all markets is not guaranteed that the price reductions will result in lower premiums and other unregulated markets (insurers can keep the savings). 2. Take a meaningful first step to build a comprehensive program that can be implemented on both the provider and the insurer side, working out any operational challenges before scaling to the broader commercial market. This balances hospital sustainability, by applying the cap to a commercial portion of the market, maximizing the Vermont benefit, and

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		allowing hospitals a glide path to reference based pricing. GMCB's RBP program anticipates phasing in other insurers over several years beginning in FY28 to allow for this glide path. This provision establishes a hard ceiling on hospital reimbursements to drive down insurer costs and, in turn, lower premiums in our most vulnerable market. People on QHP plans would likely become uninsured without access to these plans. Estimated impact to hospital budgets in FY2027 is **~$85M**. The impact on each hospital is different and reduces total revenue between a low of 0.5% to a high of 3%. This translates to an estimated reduction in QHP premiums of about **14%** for individuals and small employers (businesses, municipalities and nonprofits). This also reduces out of pocket costs for families with high-deductible plans. Based on NASHP's Hospital Cost Tool (which is derived from hospital-submitted cost reports), the median commercial breakeven for Vermont hospitals is 112%. That is, a hospital at 112% breakeven needs commercial payers to pay 12% above Medicare rates, on average, to finish the year at zero; this is well below the legislation's cap of 250%. Minor Adjustments (pages 3-5): Clarify that the Act 55 outpatient drug cap remains at 120% of ASP and is excluded from this separate 250% cap. Clarify that 250% cap applies starting January 1, 2027, the beginning of plan year 2027 for QHPs and one quarter into hospital fiscal year 2027.
Sec. 4 Reference-Based Pricing for Public Employees; Report	Tasks the GMCB, in consultation with DFR, DHR, and VEHI, with analyzing claims data for State employees and teachers to assess opportunities for applying reference-based pricing to those plans. Requires a report to legislative committees by January 15, 2027.	**Neutral**. This is an update to a study published in 2024, required per Act 113 of 2024. We have already included VEHI and state employees in the next release of our price transparency dashboard. If specific insights are desired, additional resources may be necessary (pages 6-7).
Sec. 5 Hospital Outsourcing; Report	Requires hospitals to report outsourcing information to the GMCB as part of FY2027 budget submissions. GMCB must report findings and recommendations on outsourcing's impact on care access, quality, and provider tax	**Prefer Original Language**. Prior versions of this bill included language that explicitly includes outsourced revenue in hospital budget caps and hospital reference-based pricing to ensure incentives are consistent across hospital settings. Savings to hospitals through outsourcing could mean higher prices for Vermonters if not subject to

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	revenue to the legislature by January 15, 2027.	the same rules as hospital operated service lines (pages 7-8). If committee goes forward with reporting-only, the report should include an assessment of impact on (1) reference-based pricing, (2) consumer affordability, including financial assistance and systemwide costs, and (3) access and quality.
Sec. 6 Provider Bargaining	Amends the health care provider bargaining groups statute to explicitly exclude reference-based pricing from topics that the GMCB is required to negotiate or arbitrate with provider bargaining groups.	**Neutral.** We prefer the original broader language that excludes provider bargaining from GMCB regulatory decisions, but we understand that VMS advocated for this narrower carve out for RBP. Ensures the GMCB retains unilateral authority to set reference-based prices without being subject to delay or challenge through the provider bargaining process (pages 8-9).
Sec. 7 Appeals Process	Clarifies that aggrieved parties may appeal final GMCB actions and orders directly to the Vermont Supreme Court.	**Support**. Strengthens and clarifies the legal pathway for challenging GMCB decisions (direct appeal to Supreme Court), recognizing that there is no appellate process within GMCB for final GMCB decisions (page 10).
Sec. 8 & 9 **Health System Performance**	Updates the price transparency dashboard statute to also require GMCB to develop and maintain a public interactive health system performance tool displaying quality, access, and affordability information. Updates the dashboard annually and the performance tool regularly. Limits the GMCB's obligation to build the new health system performance tool (Sec. 8) to situations where sufficient federal or other non-State funding is available.	**Support**. Expands public accountability tools beyond price transparency to include broader health system performance metrics, supporting consumer and policymaker decision-making. Federal funding has been appropriated and work has already begun. Completion of this work is contingent on continued federal funding for the duration of the RHTP (pages 10-12).
Sec. 10 Public Employee Health Benefit Authority Study Committee	Creates a time-limited study committee led by the State Treasurer to evaluate establishing a centralized Public Employee Health Benefit Authority (PEHBA) for all Vermont public employees. Includes broad membership (unions, school boards, municipalities, universities, DHR). Committee must hold public hearings, access insurer/vendor data under NDAs, and report to the legislature and Governor by February 15, 2027. Sunsets March 1, 2027.	**Neutral**. Studies the feasibility of consolidating health benefits for all Vermont public employees into a single authority to achieve cost savings, standardized coverage, and greater bargaining leverage. No members receive per diem compensation (pages 12-17).
Sec. 11 Critical Access	Directs the GMCB to convene a working group to develop recommendations for mitigating the	**Do Not Support**. We are already convening a workgroup so do not require any additional legislative direction (pages 17-18). Our next

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Hospitals; Medicare Outpatient Cost Sharing Working Group	impact of the federal rule requiring Medicare beneficiaries to pay 20% cost-sharing for outpatient services at critical access hospitals (CAHs). Report due January 15, 2027. Explicitly prohibits GMCB from using its hospital budget authority to address this issue in FY2027.	meeting is May 13th. We are developing solutions transparently alongside our partners and soliciting feedback to the extent our partners are willing to be forthcoming and work in good faith. We are exploring solutions that do not necessarily mean hospitals will lose revenue, but this legislation risks forestalling this good work and delaying much needed cost relief for rural Vermonters who are unnecessarily paying more than their urban counterparts.
Sec. 12 Effective Date	This act takes effect on passage.	**Support**.
Sec. X Audit Authority	Previous version of S.190 included language that provides explicit audit authority, and the ability to bill back a specific hospital instead of the industry or state bear some of the cost.	**Consider adding back this section**.

Additional comments for consideration based on the committee discussion:

1. Clarify legislative intent by establishing a system-wide vision for specific RBP goals over the next 3-5 years, following the QHP cap in FY2027.
2. The GMCB supports proposals made on April 28th to study other opportunities to bring health insurance premiums more in line with what Vermonters can afford and would be willing to participate in such efforts.

Other Requested Follow-up

1. The reductions to QHP premiums as a result of this hospital price cap, would translate to a reduction in the federal subsidy payments made to insurers for qualifying individuals. The precise magnitude of foregone subsidy depends on the distribution of full and partial subsidies, and interactions with silver loading.
2. The federal subsidies are high because premiums are high in Vermont. Lower prices result in lower subsidies, but families purchasing health plans are not impacted, rather there is a reduction in the federal subsidies paid to insurers. Lowering prices will also significantly lower the out-of-pocket costs through deductibles and cost-sharing requirements.
3. There are a number of changes to the federal advanced premium tax credit subsidies that are reducing the benefits available to Vermonters that are unrelated to this proposal, such as the elimination of the enhanced subsidies and limits on Silver loading.
4. Many individuals and families left the market in 2026 due to the loss of the enhanced premium tax credit. A reduction in the premiums associated with this price cap would offer uninsured individuals an option to reenter the market at a more affordable (estimated at 14% less) price point.
5. The GMCB's $85 million savings estimate for the 250% of Medicare hospital price cap reflects the assumption that hospitals can recalibrate services currently reimbursed below 250% (which are typically services such as Primary Care, Mental Health, Obstetrics and Gynecology and other historically under-reimbursed services). The BCBS/DFR estimate of $113 million does not account for this dynamic; it implicitly assumes that no service currently priced below the cap will increase, a restriction that does not

appear in the bill's current language. The GMCB estimate was developed with actuarial consultation and grounded in the Vermont All-Payer Claims Database and hospital budget data, the most comprehensive claims data available in the state. The Board was not made aware of the BCBS/DFR estimate until the April 28th hearing, despite having proactively requested carrier estimates and shared our own methodology in advance. Based solely on the joint testimony presented that day, our understanding is that the BCBS/DFR figure was derived from BCBS claims data alone and extrapolated to the broader market, a significantly narrower data foundation than the All-Payer Claims Database, and one that raises questions about representativeness across all commercial payers. The Committee should weigh these methodological differences when evaluating the two estimates.