BlueCross BlueShield of Vermont

An Independent Licensee of the Blue Cross and Blue Shield Association.

Chair Black and Members of the Committee,

Thank you for the opportunity to testify on S.190. We appreciate the Committee's focus on affordability and the recognition that Vermont must act more directly on the underlying cost of care.

At a high level, we agree with the central premise of this bill. Price matters. Hospital pricing is the most significant driver of cost in Vermont's health care system, and policies that lower unit cost can and should translate into lower premiums and greater affordability for Vermonters.

Our concern is not with the goal. Our concern is whether the current structure of the bill is broad enough, certain enough, and operationally clear enough to deliver the impact ALL Vermonters need.

Section 1: Reference-Based Pricing Implementation

We support the focus on connecting hospital price reductions to premium reductions. That is essential. If the system is going to reduce reimbursement, Vermonters should see the benefit.

However, implementation matters. The bill requires hospital and insurer contracts entered, amended, or renewed after October 1, 2026, to express rates as a percentage of Medicare or another benchmark. It also allows hospitals to use actual Medicare reimbursement amounts until the Board adopts a rule establishing the Medicare benchmark methodology.

That creates a significant operational challenge, particularly for hospitals. In practical terms, insurers and hospitals would need to translate current contracts, fee schedules, claims systems, and transparency files into a new Medicare-percentage framework while the underlying methodology may still be evolving.

The policy direction is clear. The mechanics are not yet clear enough.

And in health care pricing, the mechanics matter.

We do strongly support the National Provider Identifier provisions in Section 1. Requiring unique NPIs for off-campus hospital departments after October 1, 2027, is an important step toward site-of-service transparency and future site-neutral billing. That data infrastructure is critical if Vermont wants to understand where services are delivered, how they are billed, and where there may be opportunities to reduce unnecessary price variation.

Section 2: QHP Reimbursement Cap

Section 2 establishes a reimbursement cap of 250 percent of the Medicare adjusted base rate for hospital services delivered to enrollees in qualified health benefit plans.

We understand the intent. A cap tied to Medicare can directly reduce QHP premiums if implemented effectively and reflected in rate review. But we have two major concerns.

The first is scope. The QHP market represents a very limited portion of Vermonters. Roughly 10%. Even under optimistic assumptions that lower premiums could increase enrollment, the large majority of Vermonters (nearly 600,000) would remain outside the reach of these savings. In fact, **18 V.S.A. § 9371**, **Principles for health care reform** mandates that The General Assembly adopts the following principles as a framework for reforming health care in Vermont:

(1) The State of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. ***All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.***

The second is certainty. We have not yet seen a fully modeled, Vermont-specific financial analysis that demonstrates the total savings, premium impact, hospital revenue impact, potential provider response, or likelihood of cost shifting into other markets from the Green Mountain Care Board. For a change of this magnitude, we are surprised that we haven't seen this level of detail yet. As we sit here today, we have no idea as to the certainty of the impact of the proposed legislation on price, premiums, or subsidies in the QHP. Our initial estimates indicate that the total financial impact of the current bill would be more than $125M and produce premium reductions of 13-15% in the QHP alone. This is if we ensure a price cap on all services, to ensure Vermonters don't end up paying more under this legislation. We have no data on subsidies, market shifts, or hospital revenue impact.

That is not a small issue. It is central to whether this policy works.

Without that level of analysis, it is difficult to fully understand the impact of this approach.

We believe Vermont has an opportunity to take a more comprehensive and disciplined approach. One that combines immediate action with data-driven structural reform.

We are proposing a phased, multi-year pathway that:

- Starts with the highest-cost services in the system (over 500% of Medicare)
- Uses existing tools:
    - GMCB budget guidance
    - Contracting and Negotiations
    - Reference Based Pricing

This approach is designed to deliver immediate cost savings for ALL Vermonters while simultaneously creating immediate downward pressure on premiums for all Vermonters in all markets.

At the same time, we strongly support continuing work to improve the QHP market, but believe it should be grounded in a comprehensive, Vermont-specific study by an agreed upon independent contractor who has completed the same scope of work for other states.

That work would be designed to:

- Evaluate the full set of interconnected factors that drive QHP affordability, including:
    - Age rating structure
    - Silver loading
    - Prescription drug cost-sharing
    - Plan design and actuarial value
    - Reinsurance options
    - Vermont's regulatory framework compared to peer states
- Model the impact of potential changes:
    - Individually
    - And in combination
- Incorporate Vermont-specific realities:
    - Demographics
    - Workforce trends
    - Economic conditions

This study would be conducted in 2026 for recommendations to HROC in December 2026, that would then inform legislative action in 2027, enabling implementation beginning in Plan Year 2028. In fact, it would combine many previously discussed studies, all in one place. The QHP market is highly complex and interconnected. Without a full-system analysis, there is real risk of:

- Unintended cost shifts
- Market instability
- Missed opportunities for broader affordability gains

If the goal is affordability for Vermonters, we should be asking how many Vermonters benefit, how quickly they benefit, and whether savings in one market are offset by pressure elsewhere.

We believe a combined approach of immediate system-wide action paired with thoughtful, data-driven QHP reform, offers the strongest path forward to achieving over $200M in total savings for Vermonters across the next several years, while redesigning the QHP to better reflect the needs of future generations.

Section 3: Targeted Commercial Reimbursement Rate Reductions

Section 3 is, in our view, one of the most important sections of the bill because it begins to move toward a broader system-wide affordability strategy.

We strongly support the concept of targeting the highest-cost services first.

In fact, we believe this should be the foundation of the bill's affordability strategy. Instead of beginning with a QHP-only reimbursement cap, Vermont should first target services across the system that are above 500 percent of Medicare and bring those down to 500 percent, or as close as possible within the hospital budget process, and contract negotiations.

As many of you know, Blue Cross Vermont has been championing this type of effort for quite some time now. In fact, we delivered data and analysis to GMCB in October of 2025, and to the entire legislature in December of 2025, specifically regarding the savings of unit cost reductions in Lab and Radiology services. While typical reimbursement rates for Lab services sit at roughly 90% of Medicare, we routinely see hospitals charging nearly 10x that. In Radiology, services that we would expect to be charged at roughly 250% of Medicare, we see Vermonters being charged over 1200% of Medicare in multiple instances. The reductions we have previously recommended to GMCB, DFR, the legislature, all hospitals, and the Health Care Advocate would produce roughly $100M in savings from Blue Cross VT alone, if targeted to just Labs/Radiology.

An approach to target these high-cost services would immediately produce broader savings, reach more Vermonters, and reduce the risk of limiting meaningful relief to a small market segment while having significant downward pressure on premiums.

We believe a phased, system-wide approach could produce more than $200 million in savings.

Section 4: Public Employee Health Plan RBP Analysis

Section 4 requires an analysis of reference-based pricing opportunities for state employees, retirees, teachers, school employees, and dependents. This type of work has already been done.

We do not support the requirement of a state study that has already been conducted, and can be produced, for the State, in relatively short order using existing materials.

A 500% price cap on all services at all hospitals would likely produce savings of over $25M for VEHI, and nearly $20M for the State of Vermont. Additionally, a study already conducted by GMCB, reported that VSEA would have saved $89M in 2022 with a 200% price cap.

Section 5: Hospital Outsourcing

We support studying this issue carefully.

Outsourcing can raise legitimate questions about cost, accountability, quality, access, and tax policy. But it can also be a necessary strategy to preserve access when hospitals face workforce shortages, financial instability, or limited-service capacity.

The key is not to assume outsourcing is inherently good or bad. The key is to understand where it supports access and where it creates risk.

We believe that several hospitals are successfully outsourcing services now, or with plans to do so in the future, and that outsourcing, in many cases, has resulted in Vermonters receiving the care they need, when they need it, and where they need it.

Section 6: Excluding RBP from Provider Bargaining

We understand the rationale. If reference-based pricing is going to be implemented, the Board needs clear authority to act.

But this also increases the importance of getting the methodology right. If providers have limited bargaining rights in this process, the rate-setting framework must be transparent, technically sound, and operationally workable.

Section 7: Appeals of GMCB Orders

We support having a clear appeals process. As the Board's authority expands into complex reimbursement and pricing decisions, it will be important that regulated entities have a clear and efficient path for review.

We would encourage the Committee to ensure that the administrative process is detailed enough to handle disputes involving benchmarking methodology, compliance, and implementation timelines.

Sections 8 and 9: Data Infrastructure and Health System Performance Tool

We support better public-facing information on price, quality, access, and affordability.

Vermont collects significant health care data. The opportunity is to use it not only for oversight, but for strategy. Consumers, policymakers, regulators, and system partners all benefit from clearer information.

That said, the funding contingency matters. If this tool is important to the success of broader health reform, the State should be clear about how it will be funded and maintained.

Section 10: Public Employee Health Benefit Authority Study Committee

Section 10 creates a study committee led by the Office of the Treasurer (but not requested by that office) to evaluate the potential creation of a Public Employee Health Benefit Authority.

This is a significant undertaking that could cost hundreds of thousands of dollars. It could affect benefit design, vendor relationships, public-sector labor structures, data sharing, fiduciary risk, and long-term cost accountability.

We would encourage the Committee to consider three points.

First, insurers and third-party administrators should be meaningfully included in the process, not only required to provide data and contracts.

Second, the data-sharing provisions must include strong confidentiality, data security, and use protections.

Third, this work should be aligned with the broader system-wide affordability strategy. Vermont should avoid multiple disconnected studies that look at overlapping populations, plans, and cost drivers in isolation.

Lastly, while we are happy to partner with many of the named groups in this section, and indeed already do, we would anticipate that meaningful price reductions at hospitals through reference-based pricing, along with budget guidance, and negotiations with insurers, and other existing legislation, would significantly reduce the possibility of meaningful savings from this type of committee.

Through existing reporting, legislation, and regulatory frameworks, this section seems redundant, and very expensive, with no guarantee of any outcomes.

Section 11: Critical Access Hospital Medicare Outpatient Cost Sharing

We support this work. It identifies a real affordability issue for Medicare beneficiaries and Medicare supplement premiums.

We also appreciate that the bill prevents the GMCB from attempting to address this issue through FY2027 hospital budget review authority. That is appropriate. A federal Medicare cost-sharing problem should be studied and addressed directly, not indirectly through a hospital budget mechanism that may create unintended consequences for Vermonters.

Our Recommendations

We believe S.190 is asking the right question, how do we reduce the cost of care in Vermont?

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But we believe the strongest answer requires a broader and more sequenced approach.

First, Vermont should act immediately on known high-cost drivers. That means targeting services across the system that exceed 500 percent of Medicare and bringing them down to 500 percent, or as close as possible through reference-based pricing, hospital budget guidance and contract negotiations. That work is well underway and ensuring that this legislation delivers meaningful cost savings for 100% of Vermonters is critical to addressing and achieving affordability.

Second, Vermont should pursue a comprehensive QHP market study before making near-term changes to the QHP. That study should examine age rating, silver loading, plan design, prescription drug cost-sharing, reinsurance, federal subsidies, risk adjustment, and Vermont's regulatory framework compared to other states. The QHP market is complex, and changes in one area can create unintended consequences in another.

This approach allows Vermont to do two things at once.

It allows us to lower costs now across the system. And it allows us to redesign the QHP market with real Vermont data, not assumptions.

We appreciate the Committee's work on S.190 and share the goal of making health care more affordable.

The question is not whether to act. The question is how to act in a way that reaches the greatest number of Vermonters, creates real savings, and protects system stability.

If the problem is system-wide, the solution should be too.

Thank you,

Courtney Harrness

Director of Legislative and Government Relations