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Good morning, I am Judi Fox, President and CEO of Rutland Regional Medical Center.

Thank you for allowing me time to offer comments on H.482.

While Rutland agrees that the current situation with Blue Cross is concerning, we do not believe that the current language in H.482 is effective or in the best interest of the Vermont Healthcare system.

I offer the following comments referring to GMCB's ability to adjust a hospital's reimbursement rates.

Pertaining to the 135 days of cash threshold, Rutland recently faced a breach of its financial covenants (stemming from our 2022 operating loss) which required a covenant suspension agreement with our lender. As part of the agreement Rutland was required to maintain a minimum of 150 days of cash on hand, or risk having our outstanding debt called or a financial facilitator in place for Rutland. As proposed, H.482 would set days cash at a level below the breach requirement and would therefore present risk should a financial issue arise again. Continued financial risks are a real possibility given the uncertain times in healthcare and the volatility in the financial markets.

Hospitals are currently in turbulent economic times given the impact of tariffs, the reduction in government grant funding, and unknown program changes with the Federal Medicaid program. Attempting to resolve Blue Cross solvency issues by drawing on hospital capital places the solvency and sustainability of Vermont hospitals at significant risk. For instance, in one week's time (last week) RRMC lost 18 days of cash on hand due to the volatility in the financial markets. The strength of our Balance Sheet is critical in allowing us to weather these types of financial situations. It allows us to mitigate the risk of breaching covenants that result from heightened inflation and decreased reimbursement that drive market volatility.

If predictions hold true and we see wide sweeping increases in goods and services, it is highly likely that hospitals could face significant cost pressures that have not been anticipated through our budget process. Depending on the severity of these pressures, the impact could result in increased spending and again a decline in our days cash on hand. Now is not the time to destabilize hospital's sustainability.

While we oppose a claw back of reimbursement as outlined in H.482, we do feel that we have a duty to be responsive to the concerns of healthcare affordability.

To the end, RRMC has proactively implemented significant cost-saving initiatives to maintain financial stability amidst a challenging healthcare environment. Unfortunately, the proposed hospital rate adjustment mechanism penalizes hospitals that have exercised fiscal responsibility by targeting them for rate reductions. This approach could create a disincentive for prudent

financial management and inadvertently destabilize institutions that have worked diligently to remain solvent.

In particular, as reported by the GMCB, RRMC has the lowest compounded annual cost growth rate, which was driven by a commitment to lower costs by nearly $10 million over the last three years. This cost saving served to reduce commercial rate requests by nearly 6%. This is the work we should be focused on.

Likewise, for this bill to make a difference where it matters, we must be assured that any Blue Cross insolvency responses will directly and measurably improve our Vermont Blue Cross plan, not out-of-state plans. Of the current Blue Cross volume at Rutland, excluding our own self-insured plan, Vermont Blue Cross revenue accounts for only 53% of total Blue Cross revenue.

Based on the rate setting procedures set by the Green Mountain Care Board and utilized to take back commercial rates in Rutland last year, a mandatory hospital rate reduction of this contemplated nature would have the effect of Vermont Hospital's subsidizing out-of-state plans, offering diminished return to Vermont's own residents but placing local hospitals at increased financial risk. Any proposed legislation should prioritize savings to Vermonters, H.482 does not achieve this.

Additionally, I offer the following comments referring to GMCB's ability to require an independent observer.

To begin, hospitals rely on financial lenders and bond markets to secure the necessary capital for infrastructure improvements, technology investments, and long-term sustainability. Hospitals operate under strict financial covenants that govern their fiscal management. These covenants are set by bondholders and financial institutions to ensure hospitals maintain adequate reserves, operational performance, and financial stability.

A critical component of these agreements is that if a hospital falls out of compliance with its bond covenants, bondholders have the contractual right to appoint a financial facilitator to assess the hospital's financial position and recommend corrective actions. The opportunity for the GMCB to mandate an independent observer would be redundant and could present conflicts of interest if there are differences of opinion.

Further, as described in H.482, the primary role of the observer is to provide the GMCB with information pertinent to their oversight of hospitals. RRMC has a long history of providing the GMCB with all required information as part of the budget process. RRMC takes pride in the data we provide and works to transparently respond to all requests. In fact, last year RRMC spent more than 600 hours providing initially required and subsequently requested data to the GMCB, which occurred over several months.

Additionally, hospitals are required to submit monthly data to the GMCB that discloses and explains variance between approved budgets and monthly hospital performance. The GMCB already has the opportunity each month to review the submission and ask for clarification or additional information. To be clear, we haven't denied GMCB of their request for more information and don't see the value of an observer.

Given the existing reporting requirements, an independent observer would serve to triangulate the relationship and further challenge the GMCB and hospital's ability to build collaborative relationships. Today's healthcare and affordability challenges require that we work more closely together, again H.482 does not achieve this.

The State of Vermont has adopted core health care reform principles under 18 V.S.A. § 9371(4), including that the system must be "sustainable." A key element of sustainability is ensuring hospitals remain financially viable and creditworthy.

Although RRMC is currently above its lenders' required days of cash on hand, the appointment of a monitor or the imposition of unilateral rate changes could be perceived by financial institutions as a ***material adverse event***, triggering external oversight and/or a formal credit downgrading and special assets oversight, a place where no one wants to be with their lenders.

Over time, this kind of regulatory uncertainty with this bill may discourage lenders from extending capital to Vermont hospitals—undermining the very sustainability the law seeks to protect. Financial institutions want predictability and certainty to the borrowers they lend to. Vermont hospitals have already experienced the loss of interested lenders within the State, this proposal would likely create additional issues in access to credit.

To conclude, rather than implementing a mandatory rate reduction, Rutland urges the GMCB and the Legislature to pursue targeted, collaborative solutions. One such approach could be a reference-based pricing pilot limited to Blue Cross of Vermont, offering aligned savings without putting undue financial pressure on local hospitals.

This approach is contemplated in the Senate Health Bill S.126 and could serve to begin to align strategies and opportunities. RRMC stands ready to partner with the State, GMCB, and insurers to explore this model—we should be focused on creating relief designed for Vermonters, not exported outside of our state. As these types of payment models are explored it is important that the financial position of hospitals is strong enough to weather unintended consequences or losses over and above projected levels. H.482 risks the ability for hospitals to explore creative payment models.

Finally, RRMC would prefer, and is committed to continuing to work directly with the Green Mountain Care Board and the Office of the Health Care Advocate, as we already do.

Moreover, we feel that this bill runs contrary to the goal that we are working toward, to reduce hospital costs. Rather it will require substantial investment of Vermont healthcare dollars to have a hospital observer assigned if this bill passes and certain criteria are met. These dollars could be spent elsewhere to directly impact access to care for Vermonters.

Given the uncertainty in health care—both in Vermont and at the federal level—now is the time for health care leaders to collaborate directly, not to introduce additional layers that risk fracturing important working relationships rather than imposing a broad and potentially arbitrary independent observer mechanism.

We urge the legislature to consider a more structured and more collaborative path forward that emphasizes existing reporting mechanisms rather than duplicating oversight efforts and increasing

administrative costs. We urge our lawmakers to develop a clear, evidence-based process for financial concerns before escalating to an independent observer.

Hospitals are willing partners in ensuring financial stability and cost accountability. However, this provision, as drafted, risks eroding trust, creates uncertainty, and penalizes financially responsible hospitals rather than addressing the core cost drivers in Vermont's healthcare system.

Thank you for allowing these comments.