HCA Positions on VAHHS Recommended Edits to H. 482

VAHHS Recommendation	HCA Position	HCA Explanation
Sunset entire bill in March of 2026, similar to emergency powers under COVID	Oppose	Given the uncertainty at the national level with federal funding for Medicaid and excessive hospital prices that must be reduced to ensure system sustainability, it is prudent for the state to establish and retain this emergency authority.
Replace rate adjustment with loan or lump-sum settlement - Payment will not be considered violation of budget	Oppose	Given the consensus that commercial prices at some Vermont hospitals are excessive and the primary driver of our health care financing crisis, it is both inefficient and ineffective to prevent the Board from addressing the root cause directly. Cost reductions to hospitals via rate cuts also have precedent from regulation in Massachusetts.
Require that action does not breach financial covenants	Partial Support *Support is conditioned on "financial covenants" being clearly defined and all covenants are provided to the GMCB and the HCA to verify their terms	HCA recognizes and appreciates the importance of bond covenants to VT hospitals. Suggestion – Require hospitals to provide covenant documents to the GMCB and require Board to consider covenants.
Meet instead of exceed 200%/company action RBC—exceed is vague	Oppose	RBC is only officially determined for the Annual Report. Any intermediary RBC estimates are just that, estimates, and they cannot trigger a change in RBC status (i.e. regulatory control or lower). This would essentially mean that

		the Board could only exercise these powers once a year (when the Annual Report comes out). DFR continued monitoring of solvency does not, therefore, rely on official RBC. Currently, BCBSVT's RBC is at the authorized control level and just above the regulatory level. Under VAHHS language, the Board could only act if it falls further as demonstrated by the 2026 Annual Report. The Board could do nothing between now and then.
A limit to amount given to domestic insurer to ensure that hospitals can continue to operate	Oppose	What constitutes "continue to operate" is not defined, overly broad, and could be used to block needed rate reductions to ensure health insurer solvency.
Eliminate consolidated network level for 135 days' cash on hand—could impact hospital with 0 days' cash on hand.	Oppose	DCOH is too volatile of a metric to use. Based on 2025 Q1 hospital actuals, only 3 hospitals currently have this amount of DCOH to be eligible. UVM is not one of them. Recommend using metrics based on net worth (unrestricted net assets) which are less volatile to ensure rate reductions are derived from hospitals and hospital networks that can sustain reductions. See HCA Letter

Include due process from current hospital budget enforcement section, which recognizes emergent nature	Oppose	Hospitals retain due process through hospital budget review and budget adjustment request process.
Eliminate ability for GMCB to change budget based on the previous fiscal year—this is done through the budget enforcement process	Oppose	The GMCB must be given the authority to act quickly and decisively to correct deviations.
Eliminate the ability for the board to adjust commercial rates any time in the hospital's fiscal year—this is done through the budget enforcement process	Oppose	The GMCB must be given the authority to act quickly and decisively to correct deviations.
For hospital observer—eliminate the noncompliant with budget piece—this is what the hospital budget process is for and adds expense to hospitals	Oppose	The current hospital budget process does not contemplate or involve a hospital observer, so this comparison is not valid.