

S.190: GMCB Testimony Notes

An Act Relating to the Green Mountain Care Board, Reference-Based Pricing, and Hospital Outsourcing of Clinical Care
Senate Health and Welfare Committee Testimony | February 20, 2026 – 10:00 AM

Sec. 1 – Hospital Reference Based Pricing (RBP)

GMCB supports the language in Section 1 of the bill as introduced but has offered for your consideration language that would replace 18 V.S.A. § 9376(e)(3)(F) - (G) (page 3, line 17, through page 4, line 3). This language was provided via email on 02/19/2026 and would address the following.

- **Require hospitals to target any GMCB-ordered commercial rate reductions to their high-priced services.** While GMCB arguably has authority to do this under current law, the Legislature should pass GMCB's proposed language which will improve access to essential services, improve affordability, *and* avoid expensive and wasteful potential litigation were a hospital to argue that application of reduced prices to specific high-priced services (expressed as a percentage of Medicare prices) constitutes rate setting or reference-based pricing (RBP). Directing GMCB-ordered commercial rate reductions to high-priced services (or explicitly authorizing GMCB to do this) would also ensure that hospitals are preparing for the shift to a RBP methodology in FY28, while still allowing a glide path to the reductions in commercial revenue necessary to achieve greater affordability in health care.
- **Establish a hospital reference-based price ceiling for qualified health plans (QHPs).** This would offer immediate relief to many regular Vermonters and small employers who currently pay some of the highest premiums in the nation (or, increasingly, go without insurance). Providing ceilings that target Vermont's high-priced hospitals that are focused *only* on a small segment of the commercial insurance market would protect hospital finances and stability as compared to a full implementation of RBP that applies caps across the entire commercial sector at one time. Early estimates suggest that capping hospital rates at 250% of the Medicare adjusted base rate in these markets would likely improve affordability for Vermonters by over \$50M. We will work to refine this estimate with actuaries and carriers.

Sec. 2, 3, 4, 5 – Outsourcing

- **GMCB supports the language as written.** To ensure that we can continue to make progress addressing the commercial affordability crisis, it is imperative to keep all hospital services within the same regulatory framework (Hospital Reference-Based Pricing and Hospital Net Patient Revenue Caps). Absent this, we risk creating perverse incentives for hospitals to increase outsourcing of services, and potentially cost shifting onto patients and payers, with no tools for curbing cost growth.

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- Moreover, many outsourcing firms are owned by Private Equity firms which creates risks that some of Vermont’s scarce healthcare dollars will be siphoned off into profits. Having “non-profit” hospitals outsource services so that those services are provided on a for-profit basis risk not only profiteering and decreased affordability, but avoids the provider tax which is an important mechanism Vermont uses to maximize federal dollars for Medicaid and important Medicaid-funded health services. It is critical to ensure outsourced hospital care is included in hospital budgets so that Vermont ensures it is maximizing federal dollars and supporting access to services.

Sec. 6, 7, 8 – Bargaining

GMCB provided replacement language for Sec. 8 of the bill on 02/19/2026.

- **Exclude GMCB activities and functions from the provider bargaining group statute.** State law currently authorizes provider bargaining groups to negotiate with GMCB regarding a variety of matters, including matters of provider regulation and provider reimbursement, and to proceed to non-binding arbitration if agreement is not reached. GMCB has an extensive provider and stakeholder collaboration process and a law allowing negotiations and non-binding arbitration adds additional costs to our system, unnecessary bureaucracy and complexity, administrative waste, and duplication. This provision of law has never been utilized with respect to GMCB and would be overly cumbersome as it would require (1) GMCB’s 5 member board to vote on an issue, (2) retention of lawyers, staff time, and retention of arbitrators, (3) drafting and submission of arbitration positions, (4) arbitration hearings, (5) arbitration decisions, and, then, (6) another full GMCB process for the 5 member board to review the arbitrators’ decision to determine whether it even wants to accept the non-binding recommendation. Moreover, this provision hurts provider interests in having a right to meaningful appeals as it would significantly delay their day in court and, again, add additional bureaucratic costs.

Sec. 9 – Appeals

- **GMCB supports the language as written.** The language clarifies that an aggrieved party subject to a final GMCB action or order may appeal directly to the Vermont Supreme Court, without having to exhaust an administrative appeal procedure that does not exist. This would improve affordability by reducing administrative and regulatory costs and waste and would expedite hospitals’ rights to appeal. The language reflects the reality that there is no higher authority within the GMCB that can hear an appeal from a final GMCB action or order.

Sec. 10 – Audits

- **GMCB supports the language as written.** In response to estimates provided by DFR indicating the high cost of examinations (\$300K), comparing a full examination of an insurance company to a financial audit of a hospital is inapt. Analogous authority at the GMCB would not require the same level of

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investment; the kinds of audits that GMCB would conduct with hospitals would be more targeted to ensuring data submission accuracy and compliance with Board orders; this is also distinct from audits that hospitals already do on their own to demonstrate adherence to accounting standards.

- GMCB has recent experience where a hospital's financials are plainly entirely inaccurate and not reliable, and forcing GMCB to make decisions on bad data is extremely risky, harmful to patients, bad for the hospital, risks loss of services and even potential hospital closure, and is bad for affordability.

Sec. 11, 12 – Data/Performance Transparency

- GMCB continues to support the language as written and provided during earlier testimony a language change request in Sec. 11 (b)(1) provided to SHW in Jan. for your consideration.

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