SECTION BY SECTION RATIONALE FOR VERMONT SENATE BILL S.190

An Act Relating to the Green Mountain Care Board, Reference-Based Pricing, and Hospital Outsourcing of Clinical Care, and other technical changes and updates.

REFERENCE-BASED PRICING (Sec. 1)

Sec. 1: Purpose

Act 68 of 2025 directs the GMCB to begin implementing hospital reference-based pricing (RBP) by hospital fiscal year 2027. Due to State contracting requirements and statutory conditions on the GMCB's rate setting authority that require consideration of multiple factors (e.g. payer mix, population health, demographics etc.), stakeholder engagement, and a subsequent rule-making process, the earliest RBP can be effectuated is for hospital fiscal year 2028. While staff are proposing to leverage GMCB's FY2027 hospital budget process as a transition year, there is no legal mechanism for GMCB to establish prices or absolute price caps within the existing hospital budget review rule. GMCB's 2026 legislative proposal for hospital RBP is a way to ensure we collectively meet the 2027 requirement of Act 68.

Sec. 1(C): Medicare-Referenced Contracting

- Requires hospitals and insurers to express rates as percentages of Medicare (or another GMCB-approved benchmark) for contracts entered after October 1, 2026.
- Creates foundational infrastructure for Vermont's reference-based pricing program by establishing Medicare as transparent, publicly available benchmark.
- Current contracts use various methodologies (billed charges, case rates, per diems), lacking standardization.

Sec. 1(D): Site-of-Service Identification via Unique NPIs

- Requires unique NPIs for off-campus hospital departments (>250 yards from main campus).
- Allows tracking of potential pricing differentials where hospitals may be extending higher hospital-campus pricing to off-campus outpatient services.
- Without discrete NPIs, regulators cannot track when unwarranted prices are charged in outpatient settings.
- Similar requirements being discussed at the federal level, as part of the Consolidated Appropriations Act, 2026, SEC. 6225.
- Minimal administrative burden—NPI registration is straightforward and free.

Sec. 1(E): Enhanced Price Transparency Reporting

- Requires hospitals to include in machine-readable files (per 45 C.F.R. Part 180) pricing as percentages of Medicare plus actual dollars and cents, disaggregated by payer and plan.
- Goes beyond federal transparency rules by mandating Medicare-referenced reporting for direct comparability.

- Transforms raw data into actionable information for identifying market inefficiencies and pricing disparities.
- Provides GMCB data infrastructure to monitor compliance with RBP and budget caps.
- Empowers employers for informed network decisions and creates market pressure toward reasonable pricing.

Sec. 1(F): New Service Rate Caps

- Directs GMCB to establish default percentage of Medicare cap for newly established CPT codes.
- Prevents excessive pricing during initial adoption when hospitals can charge inflated rates.
- Creates price protection for consumers during early adoption and prevents windfall profits.
- GMCB's original proposal included a cap for new services at 250% of the "Medicare adjusted base rate", based on precedent set in other states, capping prices at 200% using similar methodologies. This is meant to provide pricing predictability while GMCB is working to establish RBP methodologies in rule, which would replace this provision.

Sec. 1(G): Consumer Price Protection Ceiling

- Directs GMCB to establish default maximum percentage of Medicare for any individual inpatient or outpatient service.
- GMCB original proposal included a cap of 500% of the "Medicare adjusted base rate" for any individual service. This was meant to bring down outlier prices in the transition year before GMCB is able to establish a rate setting rule.
- Vermont data shows some services priced at 600-1000% of Medicare—extreme outliers in specialized procedures, implants, or high-cost medications. For example, the Sage Transparency dashboard estimates CT/MRI prices at some Vermont hospitals upwards of 700% and 800% (https://dashboard.sagetransparency.org/).
- Patients with serious conditions (cancer, cardiac disease) face enormous out-of-pocket costs, which can lead to delaying or avoiding care, increasing acuity or medical debt.
- Provides immediate consumer protection against excessive billing while GMCB is working to establish RBP methodologies in rule, which would replace this provision.
- Creates clear, enforceable protection while comprehensive RBP program is designed and implemented.
- Enforced through hospital budget review process.
- During our January 28th Board meeting, GMCB heard from several experts on Medicare pricing methods and reference-based pricing, which continues to inform our thinking about the anticipated rate setting rule and legislative language to support the transition year (hospital fiscal year 2027).
    - Distinguished scholar and former executive director at Maryland Hospital Rate Agency, Robert Murray recommended Vermont consider setting a cap on out of network prices as a transition year to incentivize downward pressure on price through payer-provider negotiations.

- RAND estimated 11% VT savings (or $135 million/year) in commercial prices with OON price cap set at 200% of what Medicare would have paid for the same or similar service.
- Creates a "leveraging" effect, conferring more negotiating leverage to payers to negotiate lower rate increases.
- New Mexico, Oregon, and Washington all include OON caps as part of their RBP approach, generally 15 to 20 percentage points lower than in-network (which, themselves, are generally established at 200% of what Medicare would have paid for the same or similar service).

- Brown researchers Chris Whaley and Ros Murray modeled expected savings at various aggregate levels of Medicare. Savings range from $9.6 million at 400% of Medicare to $445 million at 200% of Medicare rates, with no saving at 500% of Medicare. These estimates were based on aggregate prices, not at the service level, as recommended to GMCB from Mike Smith, liaison to UVM Health. Hospital generated estimates would be required to understand immediate impact of establishing service-level caps.

HOSPITAL OUTSOURCING PROVISIONS (Secs. 2-5)

Secs. 2-5: Purpose

When hospitals outsource clinical services (emergency medicine, anesthesiology, radiology, etc.) and billing is conducted by non-regulated entities, revenue from such services are excluded from GMCB oversight. Outsourced revenue may circumvent hospital budget and price caps (RBP), undermining transparency, accountability, and potentially leading to additional unnecessary market distortions. As a result, patients may face network adequacy issues, surprise bills that are not addressed by the federal "No Surprises Act", and inconsistent financial assistance. These sections establish legislative intent to track outsourced services, bring hospital-affiliated revenue within GMCB purview, ensuring hospital budget review, RBP, or any other relevant GMCB regulation applies to outsourced services.

Sec. 3(a): Definition of Outsourcing and Outsourced Services

- Provides a clear definition of "outsourcing" that distinguishes clinical from administrative services, aligning with patient protection rationale.
- Captures economic reality—services delivered under hospital license, in hospital facilities—regardless of employment structure.

Sec. 3(b): Regulatory Oversight and Accountability

- Closes regulatory gaps preventing hospitals from maintaining or expanding revenue at full-service levels while eliminating costs through outsourcing.
- Ensures comprehensive and consistent accountability regardless of service delivery structure.

Sec. 3(c) & Sec. 4: Consumer Protections

- Requiring that hospitals bill insurance claims for all outsourced services delivered by contracted providers who would otherwise be out-of-network ensures continuity of coverage and prevents surprise bills.
- Clearly articulates comprehensive protection for patients who may require hospital financial assistance, extending such policies to outsourced services; this addresses information asymmetry—patients cannot determine which services are employed versus contracted and consistently protects low-income Vermonters regardless of hospital delivery model.

Sec. 5: Provider Tax Definition

- Explicitly includes outsourced services in "net patient revenues" for provider tax assessment, aligning tax treatment with regulatory treatment for comprehensive accountability thus eliminating the opportunity for hospitals to shift services to outsourced models to reduce tax obligations.

ADDITIONAL PROVISIONS (Secs. 6-12)

Secs. 6-8: Repeal of Health Care Provider Bargaining Groups

- Provider bargaining groups were first authorized to allow health care providers to negotiate with the Health Care Authority regarding a unified health care budget without the threat of a challenge under the antitrust laws.
- Mechanism has not been utilized, at least with respect to GMCB. Only one provider bargaining group exists and GMCB has not engaged in negotiations.
- Vermont is moving to RBP (rates set through regulatory process vs. collective bargaining). If GMCB had to negotiate re RBP, it could substantially delay implementation. Consultation requirements that the GMCB must comply with prior to implementing RBP are sufficient to ensure provider feedback is considered.
- Eliminates unused statutory authority, simplifies code, removes potential confusion.
- Does not affect hospitals' ability to negotiate contracts individually or participate in ACOs and payment reform models.

Sec. 9: Appeals Process Clarification

- Ensures aggrieved parties have clear and immediate path to Supreme Court review of final decisions made by GMCB.
- Clarifies existing practice – no appeal of final decisions made by GMCB other than to the Supreme Court – and is consistent with PUC, which was a model for GMCB.

Sec. 10: Hospital Audits and Examinations

- Aligns GMCB authority over providers and delivery system with DFR authority over insurers to conduct investigations, examinations, and audits of regulated entities.
- Addresses concerns related to GMCB's ability to verify hospital financial information and detect noncompliance.

- As regulatory requirements evolve (RBP, outsourcing oversight, budget caps), rigorous verification becomes essential to ensure Vermont's regulatory ROI.

Secs. 11-12: Health System Performance Tool

- Directs GMCB to develop public, interactive tools displaying health system performance.
- Allowing more real time insights into health system costs, quality, and access, supports future improvement and accountability efforts.
- GMCB proposes slight amendment to existing language to ensure timing is operationally feasible and purpose of tool is clear and robust to policy evolution over time.