2024 Health Care Affordability State Policy Snapshot

VERMONT

CURB EXCESS PRICES IN THE SYSTEM	**PREMIUM RATE REVIEW**	**HEALTH CARE SPENDING BENCHMARKS**	**HOSPITAL PRICE REGULATION**	**PUBLIC OPTION**
IMPROVE OVERSIGHT, ACCOUNTABILITY AND TRANSPARENCY	**HEALTH SPENDING OVERSIGHT ENTITIES**	**ALL-PAYER OR MULTI-PAYER CLAIMS DATABASE**	**PRICE TRANSPARENCY**	**MEDICAL DEBT COLLECTION REGULATIONS**
ADDRESS CONSOLIDATION AND PROMOTE COMPETITION	**CONSOLIDATION ASSESSMENT AND AUTHORIZATION**	**BALANCE BILL PROTECTIONS**	**FACILITY FEE LIMITS**	**ANTI-COMPETITIVE CONTRACT PROVISIONS**
MAKE OUT-OF-POCKET COSTS AFFORDABLE	**REDUCED COST-SHARING: PRESCRIPTION DRUGS**	**REDUCED COST-SHARING: HIGH VALUE SERVICES**	**MEDICAL DEBT PREVENTION**	**EXPANDED COVERAGE**

State Has Active Legislation

State Does Not Have Active Legislation

HEALTHCARE VALUE HUB

The Health Care Value Hub ("the Hub") is proud to launch the 2024 Health Care Affordability Policy Snapshot ("Affordability Snapshot") which replaces the annual Healthcare Affordability Scorecard ("Scorecard"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other stakeholders a tool to compare their state's health policies across other states.

The categories examined in this resource explore a variety of policy options that have previously appeared in the Scorecard, as well additional policies that impact health care affordability. Policies were selected based on whether they have the potential to impact health care affordability or access to health care at the state level, whether a reputable source was available for review, and whether evidence was current within the past ten years.

Policies were examined for whether they were active, implemented to a limited degree, or not active as of July 1, 2024. Sources for this information can be found in the downloadable Data and Source Document available on the **Dashboard** page.

The Hub offers both online and hands-on support, with a staff dedicated to monitoring, translating, and disseminating evidence and connecting advocates, researchers, and policymakers to build communities and galvanize action around creating a patient-centered, high-value healthcare system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Curb Excess Prices in the System

Premium Rate Review

States can control excessive health insurance premium increases through premium rate review, where state insurance regulators scrutinize proposed rate hikes for the upcoming year to ensure that the increases are based on accurate data and realistic projections of health care costs and utilization. The Affordable Care Act (ACA) set standards for these efforts, and states meeting these standards are recognized by the Centers for Medicare and Medicaid Services (CMS) as having an effective rate review process. States may also establish the authority to approve or deny rate increases and incorporate affordability criteria into their evaluations. This section examines whether a state has an effective rate review program, as defined by CMS, the power to approve or deny rate increases, and if affordability criteria are integrated into the rate review process.

Health Care Spending Benchmarks

Health spending benchmarks aim to limit annual health care spending growth by establishing a maximum limit, or "benchmark." Benchmarks may examine overall spending or spending for specific hospitals or insurers. If the benchmark is surpassed, the overseeing state entity will often collaborate with providers to curtail spending, and some states authorize the entity to mandate performance improvement plans or impose penalties. This section examines whether a state has established a benchmark, and if so, whether the state has statutory authority to enforce the benchmark.

Hospital Price Regulation

This section assesses state efforts to reduce hospital service costs through reference-based pricing, global budgets, or a comparable program that regulates hospital pricing. Unlike reference-based benefits, which set a maximum allowed benefit for specified drugs or services, reference-based pricing establishes set service costs based on a predetermined reference rate. As of publication, each state that has implemented this model has set reimbursement as a multiple of the Medicare reimbursement rate.

Similarly, global budgeting involves setting a fixed prospective payment for a specified range of services over a defined period, rather than being paid for each service. By establishing a limit on annual spending, this model shifts the financial responsibility to providers and payers and encourages managing service delivery within the set budget. Some states have established state-specific insurance models which mirror select aspects of these strategies, which are also highlighted under "alternative hospital price regulation strategies."

Public Option

A Public Option is a state-managed health insurance model designed to enhance competition and control costs through negotiated rates. States possess a degree of flexibility in designing these coverage options, resulting in variations in cost-containment measures and provisions related to network adequacy and reimbursement. This section highlights states that have an active Public Option and those with provider participation mandates to ensure consistent access to in-network providers.

Policy	Status as of July 1, 2024	Summary
Premium Rate Review	● Has an effective rate review process. ● Has the authority to modify or reject premium rate increases. ● Incorporates affordability criteria into premium rate review.	Vermont has the authority to approve or deny proposed premium rate increases in the individual and small group markets, with authority to hold public hearings to solicit stakeholder engagement in the process. In the large group market, the state has the authority to approve or deny proposed premium rate increases for HMOs and Blue Cross Blue Shield plans only. The state also incorporates affordability criteria into their rate review. The Green Mountain Care Board must determine whether a proposed premium rate is affordable and promotes quality care and access to health care.
Health Care Spending Benchmarks	● Has health care spending benchmark for providers and/or insurers. ⊗ Does not have enforcement mechanism for healthcare spending benchmark.	As part of its All-payer Accountable Care Organization model authorized by the federal government, Vermont is required to limit healthcare spending growth to 3.5% per year. However, this does not constitute a statewide effort and is limited to insurers that report data through the Vermont Healthcare Uniform Reporting and Evaluation System claims database including Medicare, Medicaid, all commercially insured, Medicare Advantage and self-insured reporting. The Vermont Green Mountain Care Board is considering avenues to expand the benchmark to other entities.
Hospital Price Regulation	⊗ Has not implemented hospital reference-based pricing or rate-setting. ⊗ Has not implemented hospital global budgets. ● Has implemented alternative hospital price regulation strategies.	The Vermont All-Payer Accountable Care Organization (ACO) Model is a voluntary payment system that reimburses all providers the same amount for a given service or procedure. The Green Mountain Care Board annually sets provider rates and approves hospital and ACO budgets. Similarly, Vermont was recently selected to join the "States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Innovation Model" by CMS. As part of the first cohort, Vermont will undergo an 18-month pre-implementation period, expected to run from July 2024 to December 2025.
Public Option	⊗ Does not have an active Public Option. ⊗ Does not offer a state-wide Public Option, with or without a provider participation mandate.	

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Improve Oversight, Accountability, and Transparency

Health Spending Oversight Entities

Health Spending Oversight Entities monitor and track health care spending systematically, offering data and research support to ensure efficient resource use. While many states set population health priorities, few have established oversight entities with enforcement powers. This section examines whether a state has a health spending oversight entity reviewing primary care, hospital, or prescription drug spending, and if upper payment limits for prescription drugs have been implemented.

All-Payer or Multi-Payer Claims Database

All-payer claims databases (APCDs) compile diverse health care data, that may include health, dental, and pharmacy claims from private insurers, state employee health programs, Medicare, and Medicaid. In instances where a database includes only some of these payers, it is referred to as a multi-payer claims database. Typically created through legislation, APCDs are often subject to state oversight and regulation. However, some claims databases have been voluntarily developed by independent entities, limiting oversight.

This section examines whether a state has an active all-payer or multi-payer claims database, if the database is facilitated and managed by the state or by third-party entities, if the data is free and accessible without institutional review board approval, and if the database is required to capture race and ethnicity demographic information.

Price Transparency

This section evaluates state efforts to provide access to health care price data through a publicly available and easily accessible tool. To be credited, the tool must show negotiated prices for various services and be accessible without fees, IRB approval, or legislative restrictions. Additionally, this section reviews whether a state requires prescription drug price data to be reported to a state entity and if a state has another form of price transparency regulation.

Medical Debt Collection Regulations

This section examines how a state regulates providers' ability to collect medical debt once it has been incurred. It reviews whether a state: prohibits providers from sending debts to collections while a patient is actively pursuing efforts to address the bill (e.g., appealing to insurance, applying for financial assistance, negotiating the bill, in a payment plan); prohibits spouses or other persons from being held liable for another adult's debt; limits collections' ability to garnish wages; prohibits collections from initiating home foreclosure; prohibits collections from initiating actions that would lead to an individual's arrest due to medical debt; prohibits collections from seizing a bank account.

Policy	Status as of July 1, 2024	Summary
Health Spending Oversight Entity	⊗ Does not have a Prescription Drug Affordability Board reporting on prescription drug prices. ⊗ Does not have a Prescription Drug Affordability Board, with or without Upper Payment Limits. ● Monitors and reports on hospital spending. ● Monitors and reports on primary care spending.	Vermont's Green Mountain Board, established in 2011, monitors hospital and primary care spending. The board may hold public meetings and with stakeholders to enforce further guidelines for hospitals. In 2020, the Green Mountain Board established the Prescription Drug Technical Advisory Group to review solutions for prescription drug affordability. In 2024, the state passed Senate Bill 98-- requiring the Green Mountain Board to draft a plan to regulate prescription drug cost.
All-Payer or Multi-Payer Claims Database	● Has an all-payer or multi-payer claims database. ● Database is operated by the state. ● Database does not include access restrictions. ● Database is required to capture demographic information.	Vermont's APCD covers 60% of commercially insured population and 100% of the Medicaid and Medicare population. Age, sex, and zipcode are demographics that are included in the APCD.
Price Transparency	● Has a price transparency tool showing negotiated rates. ● Has a Prescription Drug price transparency reporting requirement. ⊗ Does not have any other price transparency regulation.*	Vermont's Reimbursement Variation Report shares the amount providers were reimbursed for over 30 medical services and procedures. Drug manufacturers must also report cost information to the Office of the Attorney General for the top 15 drugs on which the greatest amount of money was spent across all payers during the previous calendar year.
Medical Debt Collection Regulations	● Prohibits providers from sending debts to collections while patient is actively pursuing means to pay the bill. ● Prohibits other persons being held liable for another adult's medical debt. ⊗ Does not prohibit collections from initiating home lien or foreclosure due to medical debt. ● Exceeds federal wage garnishment protections. ⊗ Does not prohibit actions that would lead to an individual's arrest due to medical debt.* ⊗ Does not prohibit collections from initiating bank account seizure due to medical debt.	In Vermont, wages cannot be garnished for individuals who received assistance from the Vermont Department for Children and Families or the Department of Vermont Health Access within the two months prior to the hearing. Eligibility for this exemption must be demonstrated at the time of the hearing.

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Address Consolidation and Promote Competition

Consolidation Assessment and Authorization

This section examines whether relevant parties are required by law or statute to notify the state of hospital consolidation transactions beyond the federal requirements, and whether the state has the authority to review these transactions; to approve, reject, or modify conditions of the transaction; and if consumer affordability or price growth are included in the review criteria

Balance Bill Protections

The federal No Surprises Act (NSA) protects patients from balance bills, which are unexpected costs from out-of-network providers. Under the federal legislation, patients receiving emergency care or who are unknowingly treated by out-of-network providers during an in-network procedure are only required to pay the in-network cost-sharing amount for services provided. Effective January 1, 2022, the No Surprises Act applies to most health plans but not all care sites and services. States can legislate additional protections for balance bills not covered under the NSA, such as for ground ambulances, or services provided at urgent care locations, hospice facilities, and birthing centers.

Facility Fee Limits

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees increase the out-of-pocket costs for care and are becoming increasingly more common as the rate of health system consolidation has accelerated. This section explores whether a state prohibits facility fees under certain circumstances, if they have imposed regulations to protect consumers against out-of-pocket costs from facility fees, and if they require hospitals to report facility fee data.

Anti-Competitive Contract Provisions

Anti-competitive contracting is a pattern of contracting between health care providers and insurers where one party gains unfair advantages over potential competitors. States can enact regulations that limit dominant health systems from abusing their market power in ways that increase prices. This section evaluates whether states prohibit four types of anti-competitive contracting practices in the health system:

- Most Favored Nation Clauses: Health systems agree not to offer lower prices to competing insurers, preventing them from offering the same service at a lower price. These provisions may allow insurers and providers to collude to raise prices.
- All-or-Nothing Clauses: Health systems require plans to contract with all providers in their system or none of them, even if those providers are low-value or high-cost.
- Non-Compete Clauses: Doctors are prohibited from working at competing hospitals within a certain distance for a certain period of time.
- Anti-Tiering or Anti-Steering Clauses: Insurers must place favored providers in higher tiers regardless of cost or quality (anti-tiering) and restrict directing patients to higher value care from competitors (anti-steering).

Policy	Status as of July 1, 2024	Summary
Consolidation Assessment & Authorization	● Requires certain healthcare providers to notify the state of consolidation transactions. ● Has authority to approve, set conditions, or disapprove consolidation transactions. ● Includes consumer affordability and/or price growth in review criteria or approval conditions.	Vermont requires both the Attorney General and Green Mountain Care Board be notified of nonprofit hospital conversions (transfer of some or all of its assets or control over those assets to a for-profit entity), and has the power to approve or disapprove transactions. The Green Mountain Care Board's review criteria include assessment of potential undue increases in costs of medical care or impact on affordability resulting from the transaction. Vermont also requires the state Certificate of Need program be notified of purchased of health facilities values at more than $3 million dollars, and has authority to approve or disapprove transactions, with criteria including undue increase in costs of medical care or impact on affordability.
Balance Bill Protections	● Prohibits balance billing for out-of-network ground ambulance services. ⊗ Does not prohibit balance billing for out-of-network services at specific facilities not included in the NSA.	Vermont has established balance bill protections that extend to both public and private ground ambulance services.
Facility Fee Limits	⊗ Does not prohibit facility fees for specified procedures and/or care settings.* ⊗ Does not have codified protections against out-of-pocket costs from facility fees.* ⊗ Does not require hospitals to report facility fee data.*	
Anti-Competitive Contract Provisions	● Law restricts Most Favored Nation contract provisions. ⊗ No law restricting all-or-nothing contract provisions. ⊗ No law restricting anti-tiering or anti-steering contract provisions. ⊗ No statutes limiting physician non-compete contract provisions.	Vermont prohibits Most Favored Nation clauses in any contracts involving health care providers, hospitals, pharmacists, or pharmacies. The law bars provisions that (a) guarantee one insurer the most favorable rates and (b) require providers to disclose their reimbursement rates to another entity.

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Make Out-of-Pocket Costs Affordable

Reduced Cost Sharing: Prescription Drugs

This section examines whether states have passed legislation reduce the amount a consumer pays out-of-pocket for select prescriptions drugs including insulin, epinephrine, oral oncology medications and asthma inhalers. This section also examines state-level legislation prohibiting copay accumulator programs, which are payer strategies that limit the impact of manufacturer cost-sharing assistance programs on consumer out-of-pocket costs.

Reduced Cost-Sharing: High Value Services

This section provides an overview of state efforts aimed at reducing consumer cost burdens for high-value services. Specifically, it identifies states which have enacted legislation mandating coverage without cost-sharing for: primary care services recommended by the United States Preventive Services Task Force (USPSTF); various cancer screening and diagnostic services; and annual mental health exams. It also evaluates state efforts to expand access to affordable maternal and reproductive health care by highlighting the states that mandate private insurers cover in-vitro fertilization, fertility preservation, doula services and abortion care. The section concludes with a review of whether a state has incorporated equity-focused initiatives in their state-regulated insurance design.

Medical Debt Prevention

This section reviews state laws aimed at preventing medical debt, including mandates for hospitals and health care providers to offer financial assistance policies, screen patients for insurance and charity care eligibility, and inform patients of charity care policies before collecting payment. It also assesses whether states have extended Medicaid benefits retroactively for 90 days; expanded general presumptive eligibility for Medicaid to all adults; prohibited short-term, limited duration health plans; and if the state has established annual reporting requirements on community benefit spending.

Expanded Coverage

This section evaluates policies aimed at expanding access to and improving the affordability of health insurance, including whether a state has expanded Medicaid eligibility to adults with incomes up to 138% of the federal poverty level (FPL); authorized 12-month continuous Medicaid eligibility for all adults; extended postpartum Medicaid coverage to 12 months following delivery; established a Basic Health Plan; initiated a program providing state-funded premium subsidies for residents ineligible for Medicaid; explicitly authorizes coverage for gender-affirming care under Medicaid; has authorized the provision of Medicaid coverage to individuals transitioning from incarceration; and if the state has extended Medicaid coverage to include dental, hearing, and vision benefits, including eye exams and glasses, beyond what is deemed medically necessary following injury or surgery. Beyond these policy options, this section also reviews state efforts to extend coverage to children, pregnant residents, and non-pregnant adults regardless of immigration status. This includes waiving the five-year required waiting period for immigrant children and legally residing pregnant residents (the "five-year bar"); offering alternative coverage options regardless of citizenship status; and opting into the From-Conception-to-End-of-Pregnancy (FCEP) option under the Children's Health Insurance Program (CHIP), previously known as the CHIP Unborn Child option.

Policy	Status as of July 1, 2024	Summary
Reduced Cost-Sharing: Prescription Drugs	● Prohibits copay accumulator programs. ● Caps the price of insulin or diabetes supplies. ⊗ Does not cap the price of other prescription drugs or medical devices.	As of July 1, 2024, insurers in Vermont must count any amounts paid by or on behalf of an enrollee for a prescription drug toward their out-of-pocket costs when there is no generic available, or when a generic is available but the enrollee obtains access to the brand-name drug through step therapy, prior authorization, or the pharmacy benefit manager's or health benefit plan's exceptions and appeals process. Vermont also caps the out-of-pocket cost for a 30-day supply of insulin at $100.00, regardless of the amount, type, or number of insulin medications prescribed.
Reduced Cost-Sharing: High Value Services	● Mandates private insurers cover USPSTF recommended preventive services without cost-sharing. ⊗ Does not waive or reduce cost-sharing for an annual mental health wellness exam in private health plans. ● Provides coverage and/or waives or reduces cost-sharing for select maternal and reproductive health services. ● Mandates coverage for some cancer screening services without cost-sharing. ⊗ Insurance design does not include cost-saving measures to mitigate health disparities.*	Vermont requires all individual and group health plans cover abortion services with no cost-sharing. Insurers in Vermont are also required to cover colorectal cancer screenings, including lab fees and anesthesia, as well as breast cancer screening and mammography without cost-sharing. Starting January 1, 2026, coverage for supplemental breast exams will also be required without cost-sharing when medically necessary.
Medical Debt Prevention	● Mandates hospitals and other health care providers provide free or discounted care with set eligibility criteria for low-income patients (see notes). ● Mandates health care providers screen patients for insurance eligibility or charity care. ● Mandates health care providers notify patients of charity care options before collecting payment. ● Retroactively extends Medicaid benefits ninety days prior to application date for all enrollees. ⊗ Has not authorized all qualified entities to provide presumptive eligibility for all adults in Medicaid. ● Has prohibited or effectively eliminated short-term, limited duration health plans. ● Requires transparency in spending for community benefit programs.	Hospitals and other health care facilities in Vermont are required to provide free care for those earning up to 250% FPL, discounted care for those earning between 251% and 400% FPL, and catastrophic assistance for those earning up to 600% FPL if their medical bills exceed 20% of their household income. STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found

Policy	Status as of July 1, 2024	Summary
Expanded Coverage—Medicaid and Other Options	● Expanded Medicaid income eligibility to 138% FPL. ⊗ Does not offer a basic health plan or other affordable coverage option for residents with incomes below 200% FPL.* ⊗ Has not authorized 12-month continuous eligibility for adult Medicaid enrollees. ● Includes 12 months of postpartum care in Medicaid benefits. ⊗ Does not provide select Medicaid services to justice-involved people up to 90 days before release. ● Medicaid policy explicitly includes coverage for gender-affirming services. ◉ Offers some, but not an extensive amount of dental, vision, or hearing coverage in Medicaid benefits (see notes). ● Offers state-based premium subsidies.	Vermont Medicaid covers eye exams, but not eyeglasses, for adults; covers hearing aids and other hearing devices for adults; and offers some dental coverage for extraction, root canals, restorative, preventive, and diagnostic services, but does not cover dentures. Vermont's 1115 waiver extending Medicaid coverage to incarcerated individuals 90 days before release was approved in July 2024 and the state is in process of implementation. Vermont also offers state-based premium subsidies and cost-sharing reductions for enrollees with incomes up to 300% FPL. Additionally, Vermont has incorporated statutory language into state law ensuring that the state Medicaid program includes gender-affirming care in the benefits package.
Expanded Coverage—Immigrant Coverage	● Offers coverage for lawfully residing immigrant children or pregnant people without a five-year bar. ⊗ Does not cover pregnancy-related services through the CHIP "From-Conception-to-End-of-Pregnancy" (FCEP) Option. ● Offers an affordable coverage option for undocumented immigrant children. ◉ Offers an affordable coverage option for some, but not all, undocumented immigrant adults (see notes).	Vermont offers limited Medicaid-like benefits (excludes long-term care) for pregnant people and children under 19 regardless of immigration status.

● State Has Active Policy or Program ◉ Policy or Program Partially Implemented ⊗ State Does Not Have an Active Policy or Program ✱ No Source, or Limited Information Found