2025 Health Care Affordability State Policy Snapshot

VERMONT

ADDRESS CONSOLIDATION AND PROMOTE COMPETITION	**Consolidation Oversight**	**Facility Fee Limits**	**Anti-Competitive Contract Provisions**		
MEDICAL DEBT PREVENTION	**Balance Billing and Short-Term Insurance**	**Charity Care and Community Benefit**	**Reducing Financial Consequences**		
CURB EXCESS COSTS IN THE SYSTEM	**Premium Rate Review**	**Hospital Price Regulation**	**Affordable Coverage**	**Prescription Drug Pricing**	**Medicaid Costs**
MEDICAID SERVICES AND IMMIGRANT COVERAGE	**Medicaid Administration**	**Medicaid Covered Services**	**Medicaid Eligibility**	**Immigrant Coverage**	
IMPROVE OVERSIGHT, ACCOUNTABILITY AND TRANSPARENCY	**Health Care Spending Oversight**	**Prescription Drug Affordability Board**	**All-Payer Claims Database**	**Price Transparency**	
REDUCE COST-SHARING FOR PATIENTS	**Prescription Drugs**	**Behavioral Health**	**Preventive Care**	**Maternal and Reproductive Health Care**	**Cancer Screening and Testing Services**

HEALTHCARE VALUE HUB

State Has Active Legislation

State Does Not Have Active Legislation

The Health Care Value Hub ("the Hub") is proud to launch the 2025 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties 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 impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of June 1, 2025. Sources for this information can be found in the downloadable **Data and Source Document available on the Dashboard page. Definitions and descriptions for each policy category can be found in the Glossary.**

The Hub offers online and hands-on support with staff dedicated to understanding health care policy and connecting advocates and other interested parties together to help build 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.

Address Consolidation and Promote Competition

Consolidation Oversight

Policy	Status as of June 2025	Summary
Transaction Notification Required	● Requires health systems or providers to notify the state of consolidation transactions	Vermont requires the Attorney General be notified of any hospital acquisition or transaction. The Green Mountain Care Board must also be notified of nonprofit hospital conversion of assets to for-profit entities. Additionally, the state Certificate of Need program must be notified of purchases of certain health facilities based on type and dollar value.
Authority to Modify or Reject Consolidation Transactions	● Has authority to approve, set conditions, or disapprove consolidation transactions	The Attorney General and the Green Mountain Care Board have authority to approve or disapprove nonprofit hospital conversions to for-profit entities. The Certificate of Need programs also has the power to approve or disapprove transactions.
Affordability Criteria included in Transaction Review	● Includes consumer affordability or price growth in review criteria, approval conditions, or both	The Vermont Green Mountain Care Board and Certificate of Need review criteria include assessment of potential undue increases in costs of medical care or impact on affordability resulting from the transaction.

● 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

Facility Fees

Policy	Status as of June 2025	Summary
Prohibits Facility Fees	⊗ State does not prohibit providers from charging any facility fees	
Facility Fee Transparency Laws	⊗ State does not require providers to disclose facility fees to consumers, requires off-campus outpatient departments to identify the physical location where care was provided on claims forms, or both	
Limits Cost-Sharing for Facility Fees	⊗ The state has no laws that limit the amount a patient may be billed out-of-pocket for facility fees	

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Address Consolidation and Promote Competition

Anti-Competitive Contract Provisions

Policy	Status as of June 2025	Summary
Restricts All-or-Nothing Contract Provisions	⊗ No law restricting All-or-Nothing contract provisions	
Restricts Anti-Tiering and Anti-Steering Contract Provisions	⊗ No law restricting Anti-Tiering or Anti-Steering contract provisions	
Restricts Physician Noncompete Clauses	⊗ No statutes limiting physician non-competes	
Restricts Most-Favored Nation Contract Provisions	● Law restricts Most Favored Nation contract provisions	Vermont bans Most Favored Nation clauses in contracts with providers, hospitals, and pharmacies, prohibiting guaranteed best rates as well as contracts that require providers to disclose their reimbursement rates.

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Medical Debt Prevention

Balance Billing and Short-Term Insurance

Policy	Status as of June 2025	Summary
Prohibits Balance Billing for Ground Ambulance Services	● Prohibits balance billing for out-of-network ground ambulance services	Vermont has established balance bill protections that extend to both public and private ground ambulance services but do not cover non-emergency transport.
Prohibits Short-Term, Limited Duration Health Plans	● State law has eliminated short-term, limited duration health plans	STLD health plans aren't explicitly banned in the state, but strict regulations have effectively removed them from the market.

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Medical Debt Prevention

Charity Care and Community Benefit

Policy	Status as of June 2025	Summary
Mandated Hospital Charity Care	State law requires hospitals to provide free or discounted care to low-income patients and sets standards for eligibility (see notes)	Hospitals in Vermont must provide free care to those earning up to 250% of the federal poverty level (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.
Hospital Charity Care Screening Requirements	State does not require health care providers to screen patients for Medicaid, Marketplace, or charity care eligibility before collecting payment	
Hospital Charity Care Notification Requirement	State law requires health care providers to notify patients of charity care options before collecting payment	Large health care facilities in Vermont are required to publicize their financial assistance policies, provide paper copies on request, offer translations, and inform patients about financial assistance through notices and billing statements. It also requires direct notification to patients during their first visit and on billing statements.
Hospital Community Benefit Reporting Requirement	State law requires hospitals to annually report the amount of charity care provided	Hospitals are required to file annual reports to the Green Mountain Care Board that must include information on bad debt, charity care, or both.

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Medical Debt Prevention

Reducing Financial Consequences

Policy	Status as of June 2025	Summary
Mandates Waiting Prior to Collections	State law prohibits sending medical debts to collections for a prescribed period (see note)	Large health care facilities in Vermont are prohibited from selling medical debt to collections agencies.
Limits on Liens or Foreclosures due to Medical Debt	State law does not prohibit initiating a lien or foreclosure to collect medical debt	
Limits Wage Garnishment due to Medical Debt	State law exceeds federal wage garnishment protections for residents with medical debt	Vermont law prohibits wage garnishment for residents who received assistance from the Vermont Department for Children and Families or the Department of Vermont Health Access within two months before a judicial hearing.
Limits on the Amount of Interest Charged to Medical Debt	State law limits interest rates on medical debt	Vermont law bars hospitals and medical debt collectors from charging interest, late fees, or prepayment penalties on medical debt owed by a patient who qualifies for discounted or free charity care.

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Curb Excess Costs in the System

Premium Rate Review

Policy	Status as of June 2025	Summary
Effective Rate Review per Centers for Medicare and Medicaid Services (CMS)	Has an effective rate review process	
Authority to Modify or Reject Premium Rate Increases	Has the authority to modify or reject premium rate increases	Vermont's Green Mountain Care Board (GMCB) has the authority to approve, modify, or disapprove rate requests in the individual, small group, and large group market.
Affordability Criteria Included in Premium Rate Review	Incorporates affordability criteria into premium rate review	The Green Mountain Care Board evaluates proposed rates against a series of affordability criteria, including whether a rate is affordable, promotes quality care, and promotes access to health care, among other factors. Plans are considered unaffordable based on whether premiums, cost sharing, and deductibles are above a certain percentage of household income.

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Curb Excess Costs in the System

Hospital Price Regulation

Policy	Status as of June 2025	Summary
Medicare Reference-Based Pricing	⊗ State does not use reference-based pricing tied to Medicare rates to regulate hospital pricing	Vermont passed legislation (S 126) in 2025 requiring the Green Mountain Care Board to develop a plan to establish Medicare reference-based pricing by 2030.
Hospital Global Budgets	● State has implemented hospital global budgets	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. In 2024, Vermont was selected to participate in the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, a state total cost of care (TCOC) model. Additionally, in 2025, Vermont passed a bill (S 126) in requiring the Green Mountain Care Board to develop a plan to implement global hospital budgets by 2030.

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Curb Excess Costs in the System

Affordable Coverage

Policy	Status as of June 2025	Summary
Public Option	⊗ State does not offer an active public option insurance plan	
Public Option Includes Provider Participation Mandate	⊗ State does not does not offer a public option, with or without a participation mandate	
Basic Health Plan	⊗ State does not operate a Basic Health Plan	
State-Based Premium Subsidies	● Supplementary state-funded premium subsidies are available to eligible residents	Vermont offers premium subsidies and cost-sharing reductions for enrollees with incomes up to 300% FPL. The program remains in place for 2025 and 2026.

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Biologic Substitution Laws: Prescriber Permission Requirements	State does not require express authorization for biologic substitution	Pharmacists in Vermont are encouraged to substitute prescriptions for the lowest priced interchangeable listed in the Orange Book, unless otherwise instructed by the prescriber, patient, or health insurance carrier.
Biologic Substitution Laws: Prescriber Notification Requirements	Pharmacists are required to notify prescribers of biologic substitution	Pharmacists in Vermont are required to notify the prescribing physician of a substitution within five business days.
Drug Purchasing Consortium	State participates in a drug purchasing consortium (see note)	Vermont is a member of the Sovereign States Drug Consortium.
Drug Coupon Prohibitions	State does not prohibit the use of drug manufacturer coupons*	
MCO Carve Out	State Medicaid does not carve out any drug classes from their MCO benefits*	
FFS Policies to Promote Generic Utilization: Mandatory Generics	Medicaid Fee-for-Service (FFS) programs and pharmacists are required to substitute a generic version of a drug	Vermont has policies or tools to promote mandatory generics.

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Curb Excess Costs in the System

Prescription Drug Pricing

Policy	Status as of June 2025	Summary
Supplemental Rebate Programs	Medicaid Pharmacy Supplemental Rebate Agreement (SRA) in place	
Drug Rebate Transparency and Reporting Requirements	Pharmacy benefit managers are not required to report rebate data to the state	
Spread Pricing Restrictions	State prohibits pharmacy benefit managers from engaging in spread pricing	
Pharmacy Reimbursement and Clawbacks	State does not prohibit PBMs from retroactively reducing reimbursement to pharmacies (“clawbacks”)	
Cost-Disclosure and Gag Clause Restrictions	State law prohibits gag clauses in pharmacy contracts	
Prohibits Copay Accumulator Programs	State prohibits copay accumulator programs	

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Curb Excess Costs in the System

Medicaid Costs

Policy	Status as of June 2025	Summary
Medical Loss Ratio Remittances for Medicaid Managed Care Population	⊗ State does not require MLR remittances for its Medicaid managed care population	Vermont does not use Medicaid MCOs.
Medicaid Site Neutral Payments	⊗ State has not enacted Medicaid site neutral payment legislation*	

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Medicaid Services and Immigrant Coverage

Medicaid Administration

Policy	Status as of June 2025	Summary
Medicaid Managed Care	⊗ State does not partner with MCOs to operate their Medicaid program	
Medicaid Vendor — Eligibility and Enrollment	● State contracts with a vendor for Medicaid enrollment or eligibility	
Integrated Medicaid-Medicare	⊗ State does not integrate Medicare-Medicaid to coordinate care for the dually eligible population	

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Medicaid Services and Immigrant Coverage

Medicaid Covered Services

Policy	Status as of June 2025	Summary
Medicaid Coverage for Fertility Services	⊗ State Medicaid program does not cover infertility treatments or fertility preservation services	
Medicaid Coverage for Doula Services	◉ The state has received approval to reimburse doula services under Medicaid but is still implementing the program	Vermont's Governor signed Act 50 (SB 53) in June 2025, requiring Medicaid reimbursement of doula services. The Department must seek their State Plan Amendment by July 1, 2026.
Medicaid Coverage for Abortion Care	● State Medicaid program utilizes state-based funds to cover abortion care	
Medicaid Coverage for Transition-Related Care	● State Medicaid program explicitly covers any transition-related care for adults	
Medicaid Coverage for Hearing Aids	● State Medicaid program covers hearing aids for all adults	
Medicaid Coverage for Eye Exams and Glasses	◉ State Medicaid program covers only eye exams or eyeglasses but not both, or biannually or less frequently, or restricts coverage based on age or health condition (see notes)	Exam coverage only.
Medicaid Coverage for Dental Services	◉ State Medicaid program covers some dental services for adults (see notes)	Vermont Medicaid does not cover dentures.

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Medicaid Services and Immigrant Coverage

Medicaid Eligibility

Policy	Status as of June 2025	Summary
Medicaid Expansion	State has expanded Medicaid eligibility to 138% FPL	
Retroactive Medicaid	State retroactively extends Medicaid benefits 90 days prior to application date for all adult enrollees	
Adult Medicaid Continuous Eligibility	State has not authorized 12-month continuous eligibility for non-pregnant adult Medicaid enrollees*	
12-Month Postpartum Coverage	State has authorized 12-month postpartum Medicaid coverage	
Medicaid Available to People who are Incarcerated	State has not authorized Medicaid coverage for justice-involved individuals while they are in a correctional setting*	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 with coverage slated to start January 2026.
Medicaid ABD Asset Limits	State has not expanded the asset limit for Medicaid for the Elderly and Disabled eligibility beyond $2,000 for an individual applicant and $3,000 for joint applicants	
Medicaid ABD Life Insurance Exemption	Life insurance exemption limits do not exceed $1,500	
Medicaid ABD Retirement Account Exemptions	State exempts both applicants' and spouses' retirement savings from Medicaid eligibility determinations	Applicant and/or spouse's retirement account must be in payout status (i.e. generating monthly income) in order to be exempt.

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Medicaid Services and Immigrant Coverage

Immigrant Coverage

Policy	Status as of June 2025	Summary
From Conception to End of Pregnancy (FCEP)	Covers pregnancy-related services through the CHIP From-Conception-to-End-of-Pregnancy (FCEP) Option and post-partum coverage	Vermont has not adopted the From Conception to End of Pregnancy option, but provides state-funded coverage to income-eligible pregnant people regardless of immigration status including 12 months postpartum coverage,
Immigrant Children without a Five-Year Bar	State offers coverage for lawfully residing immigrant children without a five-year bar	
Pregnant Immigrants without a Five-Year Bar	Offers coverage for lawfully residing pregnant immigrants without a five-year bar	
State-Funded Coverage for Children Regardless of Citizenship Status	Offers coverage for children regardless of immigration status	
State-Funded Coverage for Adults Regardless of Citizenship Status	Does not offer coverage for adults regardless of immigration status	

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Improve Oversight, Accountability, and Transparency

All-Payer Claims Database

Policy	Status as of June 2025	Summary
Established an All-Payer Claims Database (APCD)	State has a(n) all-payer or multi-payer claims database	
All-Payer Claims Database (APCD) Operated by the State	APCD is operated by the state	

Prescription Drug Affordability Board

Policy	Status as of June 2025	Summary
Established Prescription Drug Affordability Board (PDAB)	The state has not established or passed legislation to establish a prescription drug affordability board	
Prescription Drug Upper Payment Limits	The state has not established Upper Payment Limits for prescription drugs	

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Improve Oversight, Accountability, and Transparency

Price Transparency

Policy	Status as of June 2025	Summary
Service Cost Price Transparency Tool	State has a public-facing price transparency tool that reports negotiated rates	
Prescription Drug Price Reporting Requirement	Organizations are required to report prescription drug price information to a state entity	Drug manufacturers must 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.

Health Care Spending Oversight

Policy	Status as of June 2025	Summary
Health Care Spending Benchmark	State has not established a health care spending benchmark for providers, insurance carriers, or both	
Authority to Enforce Health Care Spending Benchmark	State has not established a health care spending benchmark, with or without enforcement mechanisms	
Hospital or Primary Care Spending Oversight Entity	State monitors and reports hospital spending, primary care spending, or both	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.

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Reduce Cost-Sharing for Patients

Reduce Cost-Sharing: Prescription Drugs

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Diabetes Medications	State has enacted legislation to limit cost-sharing for insulin, diabetes related equipment, or both	Vermont 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.
Waives or Reduces Cost-Sharing for Asthma Inhalers	State has not enacted legislation limiting cost-sharing for asthma inhalers	
Waives or Reduces Cost-Sharing for Epinephrine Auto-Injectors	State has not enacted legislation to limit cost-sharing for prescription epinephrine autoinjector(s)	
Waives or Reduces Cost-Sharing for Specialty Drugs	State has not enacted legislation to limit cost-sharing for specialty drugs	

Reduced Cost-Sharing: Behavioral Health

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for an Annual Behavioral Health Office Visit	State does not require private insurers to cover at least one annual mental health wellness exam without cost-sharing	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Preventive Care

Policy	Status as of June 2025	Summary
Waives Cost-Sharing for Preventive Services Recommended by the U.S. Preventive Services Task Force (USPSTF)	State mandates private insurers cover USPSTF recommended preventive services without cost-sharing	

Reduced Cost-Sharing: Maternal and Reproductive Health Care

Policy	Status as of June 2025	Summary
Individual and Small Group Health Plans Required to Cover Fertility Treatment	The state does not require individual and small group health plans to offer coverage for in-vitro fertilization or fertility preservation services	
Individual and Small Group Health Plans Required to Cover Doula Services	State does not require private health insurers to cover doula services for enrollees	
Individual and Small Group Health Plans Required to Cover Abortion Services	The state requires individual and small group health plans to cover abortion services	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Colorectal Cancer Screenings	State law requires insurers to cover colorectal cancer screening tests with no cost-sharing	
Waives or Reduces Cost-Sharing for Follow-Up Colorectal Cancer Screening Exams	State law requires insurers to cover follow-up colorectal cancer screening tests with no cost-sharing	
Waives or Reduces Cost-Sharing for Lung Cancer Screenings	State law does not require coverage or waive cost-sharing for lung cancer screening exams*	

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Cervical Cancer Screenings	⊗ State law does not require coverage or waive cost-sharing for cervical cancer screening exams*	
Waives or Reduces Cost-Sharing for Breast Cancer Screenings	● State law requires insurers to cover breast cancer screening with no cost-sharing	
Waives or Reduces Cost-Sharing for Supplementary Breast Cancer Screenings	● State law requires insurers to cover supplementary breast cancer screening with no cost-sharing	Insurers in Vermont are required to cover screening mammography and screening ultrasounds for a patient for whom the results of a screening mammogram were inconclusive or who has dense breast tissue, or both, without cost-sharing. Beginning January 1, 2025, insurers will be required to cover all medically necessary breast imaging services recommended by a provider, with no copayments, deductibles, or coinsurance (except where needed to preserve HSA eligibility under federal law).

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Reduce Cost-Sharing for Patients

Reduced Cost-Sharing: Cancer Screening and Testing Services

Policy	Status as of June 2025	Summary
Waives or Reduces Cost-Sharing for Prostate Cancer Screenings	State law requires insurers to cover prostate cancer screening but allows cost-sharing	
Waives or Reduces Cost-Sharing for Ovarian Cancer Screening	State law does not require coverage or waive cost-sharing for ovarian cancer screening exams*	
Waives or Reduces Cost-Sharing for Biomarker Testing for Cancer	State does not require coverage or waive cost-sharing for biomarker testing	

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