

# Spotlight on State: Vermont

*This is part of a [series of summaries](#) that highlight notable legislation and initiatives in health policy and reform of all 50 states. Check back on The Source as we roll out additional states each week.*

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Vermont has been active in cost containment and transparency through a number of state planning initiatives, rate and premium control, and the [VHCURES](#) all-payer claims database. Most notably, Vermont attempted to be the first state to operate a single-payer healthcare system, Green Mountain Care, in 2011; however, the state gave up on the plan in 2014 due to lack of viable financing system to fund the system. Following that effort, the state began implementing an [all-payer ACO model](#) in 2016, designed to encourage the state's largest payers – Medicare, Medicaid, and Blue Cross and Blue Shield of Vermont – to move quickly from fee-for-service to risk-based contracting by using a common payment methodology. Regulated by the Green Mountain Care Board, which was created along with the single payer system to improve the quality of health care and reduce the growth in health care costs for Vermont residents, the alternative payment model has resulted in a [total savings of \\$97 million](#) across the first three implementation years. The state also proposed a publicly funded public option for health care coverage that would be available to all Vermont residents and employers.

Besides an all-payer claims database mandated since 1991, now administered by the Green Mountain care Board, Vermont law also provides surprise and balance billing protections by requiring a hold harmless provision and no liability notice requirement for both emergency and non-emergency healthcare services. Additional price transparency initiatives prohibit gag clauses in managed care organization contracts with health

care providers, requiring that the terms cannot prohibit the health care provider from disclosing to members information about the contract or the members' enrollment plan. Vermont's ACPD statute is also the subject of the far-reaching Supreme Court decision regarding ERISA preemption of state laws. Decided in 2016, [\*Gobeille v. Liberty Mut. Ins.\*](#) determined that Vermont's law requiring health insurers to report payments and other information relating to health care claims and services for compilation in its APCD is preempted as applied to ERISA plans.

In the healthcare provider market, the state mandates notice of all nonprofit healthcare transactions to the attorney general and allows for review and approval by the Green Mountain Care Board, and either the AG or the court. Additionally, the state requires a certificate of need for the construction, development, purchase, renovation, or other establishment of certain health care facilities and ambulatory surgical centers, which is granted based on criteria of cost, affordability, and access. The state also prohibits most-favored nation clauses in provider contracts to curb anticompetitive practices.

To encourage use of telemedicine, Vermont requires health insurance plans to provide parity for coverage, reimbursement, and cost-sharing of telehealth services to the same extent that the plan would cover the services if they were provided through in-person consultation.

In recent terms, Vermont tackled prescription drug costs with legislation to allow the wholesale purchase of prescription drugs from Canada. Also, to promote drug price transparency, Vermont law requires state officials to identify 15 drugs whose wholesale acquisition costs rose by 50 percent or more over the last five years, and 15 medicines that rose 15 percent or more over a 12-month period. The drugs' makers must justify the price increases to the state's attorney general and the information is made public.