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THE UNION OF VERMONT EDUCATORS

TO: Senate Committee on Health and Welfare

FROM: Mark Hage, Director of Benefit Programs, Vermont-NEA

DATE: March 10, 2020

SUBJECT: Testimony on S.290, Section 12, Subsection (a)

Good morning. My name is Mark Hage, and I am the Director of Benefit Programs at Vermont-NEA.

Some of you may know I am also a trust administrator for the Vermont Education Health Initiative – VEHI. I've been in that role since 2001; but I am not testifying on behalf of VEHI. My testimony is exclusively on behalf of Vermont-NEA.

My testimony will be limited to **Section 12, subsection (a), of S.290**, which calls for a report to be generated under the auspices of the Agency of Human Services, with participation by representatives of Vermont-NEA and VSEA, on the potential impact of future attribution of public school employees and state employees to OneCare Vermont.

Laura Soares, a fellow member of VEHI's management team, has provided this committee with a statement by the VEHI Board of Directors on the trust's decision to defer attributing lives to OneCare Vermont in 2020. Contrary to a report in Vermont Digger, I must clarify that the unanimous vote in support of that statement came from the **VEHI** Board of Directors – **not** the Vermont-NEA Board of Directors.

Vermont-NEA has yet to adopt a formal position on the attribution of school employee lives to the ACO and the All Payer Model. It may do so in the future.

But, at present, the union believes looking to VEHI for guidance and direction in 2020 is the most appropriate course to determine if, and when, and under what terms, active public school employees should be attributed to OneCare Vermont.

Respectfully, we believe the public school community will be better served by allowing VEHI to continue undertaking its own analysis of OneCare Vermont, which its Board of Directors has authorized, than the generation of a separate report as called for in S.290.

Why do we feel this way?

a. First, if school employees were attributed to the ACO next year – or not – they would continue to have access to the same health care plans, the same Rx formulary and

pharmacies, and to the same doctors and other health professionals in the BCBSVT medical network.

So, when it comes to school employees' access to care, their experience as patients, and their evaluation of the "relative value" of their health benefits, *three areas of inquiry cited in Section 12*, none hinge definitively at present on the question of ACO attribution, because, again, they are linked to VEHI's benefit plans and BCBSVT's medical network. In fact, I suspect that most patients today have no idea they are attributed to the ACO.

It's true that a good care coordination experience facilitated by a team of doctors associated with OneCare would enhance the medical experience of patients and, potentially, increase the value of health insurance in their minds. The same would be true if good care coordination happened outside an ACO model. In either scenario, we wouldn't need an outside study to conclude that excellent care coordination is a worthy end.

b. When it comes to **health outcomes**, I don't see how an AHS-facilitated report, one to be released in mid-October of this year, could predict or assess how health outcomes in the future, for better or worse, would be affected by the attribution of school employee lives to the ACO.

   Based on the timing of the Green Mountain Care Board's annual quality review of the ACO, it is my understanding that the 2019 quality results will not be in the public domain until October, when the proposed report in S.290 must be completed.

   This means those producing the report would be limited, as we are now, to the most recent history of the ACO's quality results.

c. Studying the work of the ACO and health outcomes, also referenced in S.290, is admittedly, complicated. An excellent analysis posted on GMCB's website by independent consultant Julie Wasserman raised or deepened questions I have. For example:

   - Why did OneCare's 2018 Medicaid Quality Performance scores show a decline from 2017 in 7 of 10 measures, including in two high-cost areas: Diabetes Mellitus and Hypertension?
   - Why did its 2018 Medicare score of 82.4% decline from 87.9% in 2017, which was a dramatic drop from 2016's score of 96.88%?
   - With its commercial population, however, OneCare's 2018 quality score of 86.12% was a significant improvement over the prior year's 73.07%. However, OneCare had declines from 2017 with that group in two critical "population health" measures: diabetes and hypertension; plus, in its hospital readmission rate (All-Cause Hospital Readmissions). Why were there declines in these areas?

I also learned in a letter last December from Mike Fisher at the Office of the Health Care Advocate, to Kevin Mullin, Chair of the Green Mountain Care Board, that only 2 percent of OCV attributed patients in BCBSVT's commercial population who are deemed to be high- or very high-risk are receiving care management. Why are these percentages so low, especially given that commercial lives have been attributed to OCV since 2014?

Over the course of 2020, as VEHI grapples with the question of attribution, costs and quality, I have committed myself, on behalf of Vermont-NEA, school employees, and school boards, and in my capacity as a trust administrator for VEHI, to investigate thoroughly and pursue answers to these questions and more.

Putting my and Vermont-NEA's energies into this endeavor, which involves drawing data from multiple sources, and engaging in conversations with the ACO, BCBSVT and others about how the attribution of lives and risk sharing will improve access to and the quality of care for school employees would be more productive and targeted than putting those efforts toward the production of an outside report.

Rising Health Care Prices: The Elephant in the Room

I want to caution us, as we move forward with our discussion about OneCare Vermont, to not confuse the process of ACO attribution and how we pay doctors with systemic reforms that are needed to address the root causes of the worsening affordability crisis in health care.

Such reforms include budgeting rationally for what we pay for health care treatments and pharmaceutical products, and lowering what we are charged in the process, to name a few.

The ACO aspires to lower the rate of rising medical inflation, to keep it at no more than 3.5 percent annually.

If it succeeds, it will mean that a health care system that is unaffordable now will be, minimally, 3.5 percent more unaffordable next year and in future years.

I would also be remiss if I did not say something about the dire situation we are facing with the cost of **prescription medications**. They are killing us, and everyone else, as recent comments by BCBSVT CEO Don George underscore.

The average price per month of specialty medications today for Vermont's school employees and their families is $5,100. The monthly average for generics: $23.

Specialty medications are low-volume, high-cost drugs, often administered intravenously or by injection, that treat serious chronic conditions like Hepatitis C, rheumatoid arthritis, cancer, MS, HIV, and more.

These drugs account for more than 50 percent of VEHI's spending on prescriptions, but only 2 percent of our subscribers take them. This trend is unfolding nationally as well. Without regulatory protection, these drugs will very soon account for 60 percent of our drug spend, with no end in sight.

This is a big reason why Vermont-NEA supports **S.246** to establish a state-based, prescription drug affordability board under the direction of the Green Mountain Care Board, which Maryland did last year. Maine followed suit with a similar model.

School boards and school employees – and all Vermonters, all employers, public and private – need extensive regulatory relief from the predatory business practices and greed of Big Pharma. S.246 is an important step in that direction.

Everything we can do as a state to lower health care prices for school boards and school employees, and for all employers and their workers in the public and private sector, must be done.

One day soon, I hope, the federal government will join us and do its part.

Returning to the bill before you, respectfully, Section 12, subsection (a), of S.290, Vermont-NEA does not support an AHS report about OneCare Vermont and attribution of school employee lives to the ACO.

Thank you.