Written Testimony to the Vermont House Health Care Committee on S.285
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Good morning. For the record, my name is Mark Hage and I'm the Director of Benefit Programs at the Vermont-National Education Association. I am also a long-time Trust Administrator with the Vermont Education Health Initiative (VEHI), which is the self-insured risk pool that provides health insurance benefit plans to approximately 35,000 school employees, active and retired, and their dependents.

To be clear, I am testifying as a union advocate with Vermont-NEA, not on behalf of VEHI.

Vermont-NEA endorses the broad reform direction in S.285, including global budgeting for Vermont hospitals. Vermont will benefit from an empirically sound and rigorously regulated system of global budgeting that allocates fixed annual payments to hospitals to cover their verifiable operating costs and ensures funding for the delivery of all vital health services.

Global budgeting so conceived and implemented is foundational to the long-term financial sustainability of our hospitals and to the medical and economic well-being of Vermonters and their employers.

Global budgeting can also substantially reduce excessive administrative expenses. And it can confer on hospitals the latitude to be creative and flexible in helping patients in ways that are now either not possible or made unnecessarily complicated by current funding mechanisms.

The savings from reduced administration and better health care outcomes should be invested in programs that expand access to community-based medical services like primary care, nursing, mental health, home health care and hospice. The latter are fundamental to a high-functioning, cost-effective, patient-centered health care system.

More specifically, I recommend to this committee that it incorporate language into S.285 that mandates the development of models of reference-based pricing (RBP) indexed to Medicare rates for consideration prior to determining global budgets for hospitals.

For more than a year, I've been investigating the potential or promise of reference-based pricing for hospitals and other care centers after discovering the success Montana achieved by implementing referenced-based pricing for its state employees in recent years. *I was driven to this research, in part, by the fact that better than 50% of every VEHI premium dollar is devoted to inpatient and outpatient hospital services, and by the profound impact of medical inflation on our premium rates.*

Montana's achievement is remarkable. It fused political will and fair negotiations by the state with extensive data and analysis on actual hospital costs and expenses. What I learned from extensive reading and speaking directly with the key individual who spearheaded the project is that reference-based pricing can dramatically lower costs without endangering the fiscal solvency of hospitals or reducing essential services. Achieving both objectives is critically important. Global budgeting must be fair in equal measure to hospitals and patients; the former must be adequately staffed and financed, and the latter need health care to be more affordable, accessible, and equitable, consistent with the principles in Act 48.

Currently, we pay different prices to different medical providers for the exact same service. This is called "price variation." One of the most extreme examples of price variation is the difference in prices for an echocardiogram. According to findings by the Vermont State Auditor's office, based on data provided by

BCBSVT, the highest-priced Vermont provider is paid **9.3 times** more for this procedure than the lowest priced. Reference-based pricing would correct for this, so that the price of a given procedure is the same or substantially the same regardless of the payer or the provider. It levels the playing field and savings are realized in the process. Those savings, again, can be invested in improved care and workforce development in hospitals and community care centers.

What did the State of Montana achieve for its 31,000 state employees and their family members? In brief:

- It set inpatient hospital prices at acute care centers at between **220% to 225%** of Medicare rates and between **230% to 250%** of Medicare rates for outpatient services.
- There have been **no premium rate increases** for state employees for 6 consecutive years (2017 - 2022).
- Montana saw an **actual reduction** in its health insurance costs by nearly **$48 million** from 2017 – 19 alone.
- The state restored **the financial reserves** of its state health insurance pool, which had been in steep decline, and it substantially lowered its OPEB liabilities for its state pension system.

After researching the Montana initiative, State Auditor Doug Hoffer and his team released a well-documented report last November that examined the benefits of reference-based pricing benchmarked to Medicare to health care costs for Vermont's state employees. The report found that if reference-based pricing was implemented for Vermont state employees alone for all services, total savings could reach **$16.3 million annually**.

I urge you, therefore, to broaden the scope of S.285 to include a mandate to investigate and design models of reference-based pricing benchmarked to Medicare rates that would be fair to hospitals, fair to Vermonters and their employers, and sustainable.

Below I provided recommended language to be inserted into S. 285.

Lastly, the National Academy of State Health Policy (NASHP) has resources and expertise to assist GMCB and the pertinent state agencies in developing reference-based pricing and hospital global budgets at no charge.

Thank you for your time today, and for your work.

Recommended additional language for S.285:

Develop options for the design and implementation of reference-based pricing based on a multiple of Medicare rates for inpatient and outpatient hospital services as an integral part of hospital global payments.

Determine how best to secure comprehensive data and analytical services from hospital financial analysts to evaluate hospitals' pricing, revenue sources, and financial and operating reporting and metrics to effectively model reference-based pricing alternatives based on a multiple of Medicare rates.