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To: Members of the House Health Care Committee

RE: S.126 An act relating to payment and delivery system reform

On the whole, Blue Cross and Blue Shield of Vermont is supportive of the majority of the proposals in S.126 relating to payment and delivery system reform. We are offering the following suggestions to helps clarify some of the sections, express concern with some provisions, and oppose specific proposals.

Our health care dollars are a scarce resource, and we need to balance our investment in planning and health care reform efforts and money that goes to direct patient care. We are a small, rural state is inefficient in our scale. Because of this, we must prioritize and be strategic with our investments.

Reference based pricing

Reference-based pricing may be useful as a rate setting tool for the Green Mountain Care Board in the hospital budget approval process. Blue Cross VT supports less restrictive statutory language and allowing the GMCB to develop and implement RBP on certain hospitals and services with broad guardrails. Please consider these suggested changes:

Section 3 § 9376.(e) page 6

(e)(1) Consider reversing the language to reflect that the bill is setting hospital prices:

“reference-based prices that represent the amounts that health insurers in this State shall pay to hospitals for items provided and services delivered in Vermont”

“reference-based prices that represent the prices that hospitals in this State shall charge health insurers (commercial payers?) for items provided and services delivered in Vermont”

“site neutral pricing structure” the way the term site-neutral here is confusing and then contradicted later. Site neutral pricing can mean the same across all sites of care – hospitals, urgent care, office visits. The bill establishes RBP set by the GMCB only for hospitals. While RBP may be implemented in a site-neutral manner, the Medicare structure is not currently “site neutral.” The second sentence allowing the Board to differentiate prices based on a number of factors then appears to contradict the first.

Finally, both “hospital service area” and “acuity” may be components of the Medicare pricing system and payments should not again be adjusted for these factors.

(e)(2)(A) Recommend that the definition be expanded to “Medicare reimbursement rate **and methodologies** for the same or similar” because some of the value in moving to a RBP model is how Medicare pays for services. For example, Medicare has a methodology for grouping codes for outpatient services and paying for them in combination.

The language further adds “the Board may opt to update the prices in the future based on . . “ is not how reference based pricing works – in a RBP system, the percentage is changed, not the price. The GMCB considers all of these factors when setting the hospital budget and the commercial price increase cap. While these are all considerations available to the Board this should be permissive language allowing the Board to set the reference-based prices based on the established hospital budget guidance.

(e)(3)(C) requires the GMCB and DFR to ensure that any decrease in prices for hospitals result in lower premiums for consumers” is too limited for every situation and does not allow the GMCB to shift payments to non-hospital based services such as for independent primary care or mental health services; nor does this allow for the provisions of H.482 which you passed earlier that lowers prices in the event of health insurance plan solvency concerns.

(e)(5) **Blue Cross VT opposes allowing another separate entity (AHS) with no direct oversight over health insurers to set the prices for services not delivered in a hospital setting.** The current bifurcated system with DFR responsible for health insurer solvency and rates for some types of health insurance plans while the GMCB approves health insurance rates for the ACA/Exchange plans and large group fully insured is already convoluted and leads to a lack of regulatory coordination.

Hospital Budgets

Section 5 § 9456. (b)(7) page 11

Blue Cross VT opposes excluding revenue derived from primary care, mental health care and substance use disorder treatment services from a hospital’s net patient revenue and total cost of care targets.

- These services are part of our system of care and the costs of these services increase net patient revenue and health insurance premiums. Artificially

excluding these services from a hospital budget will not actually lower health care costs.

- Typically the prices for these services are higher when delivered in a hospital setting than from a non-hospital affiliated provider. These differences shouldn't be hidden from view.
- If Vermont joins a federal model such as global hospital budgets with AHEAD, it is unlikely that CMS will approve excluding these services.
- Reference-based pricing has not been used for services outside of a hospital setting in any other state. Blue Cross VT would prefer that RBP for hospital services is successful before implementing it across the health care system.

(d)(1)(A) Blue Cross VT questions whether global hospital budgets are as effective and worth the investment of time and resources without Medicare's participation through AHEAD or another federal model.

Health Care Contracts

Sec. 7. 18 V.S.A. § 9418c (e) page 17

Blue Cross VT opposes removing the language allowing for reasonable confidentiality agreements in health care contracts. We would prefer to carve out an exception if the contracts are shared with our regulators such as the Department of Financial Regulation and the GMCB. DFR already has regulatory authority and oversight over health insurance contracts. We want confidentiality to be maintained in the event that we share these contracts with our regulators.

Statewide Health Care Delivery Plan and Advisory Committee

Sec. 9. 18 V.S.A. § 9403a page 22

(1) Establishing affordability benchmarks for commercial health insurance is duplicative of the GMCB's authority. Just last week, the GMCB adopted Affordability Guidance for health insurance rate review.

The Advisory Committee should include more membership from consumers and payers. Of the 14 members, 10 are from providers, while the remaining 4 are AHS, GMCB, HCA and a commercial insurer.

Data Integration

Sec. 10. 18 V.S.A. § 9353 page 24

Blue Cross VT opposes integrating commercial health care claims data with clinical records. This is an example of where we need to prioritize our resources and scale our ambitions. This additionally requires duplicate submissions of claims data – to the GMCB for VHCURES and to AHS for this integrated database. A few of our concerns include:

- There are too many issues with the data for it to be used to improve the quality of care, be useful for real-time care delivery, or improve provider decisions in the clinical setting.
- Medicare prohibits access to personally identifiable Medicare claims information in VHCURES, according to the GMCB. As a result, at least a third of the records would be excluded.
- Many self-funded employers have elected to withhold their data, further diminishing the dataset.
- Mental health and substance use disorder data are treated differently in each data set and we are concerned about data on abortions and gender affirming care that is also sensitive and treated inconsistently in privacy policies.
- The multiple and serious data limitations render the entire project of minimal value for health care reform initiatives, providers, payers, or government entities.
- If necessary, first integrate the Medicaid claims and clinical records to determine whether the data add enough value to justify the resources required for this enormous project.
- This is a tremendous cost for research purposes when there are so many other dire needs in the healthcare system.

Thank you for considering these suggestions and concerns. Blue Cross VT supports the Legislative efforts to address the serious issues impact affordability, access and the quality of care for all Vermonters.