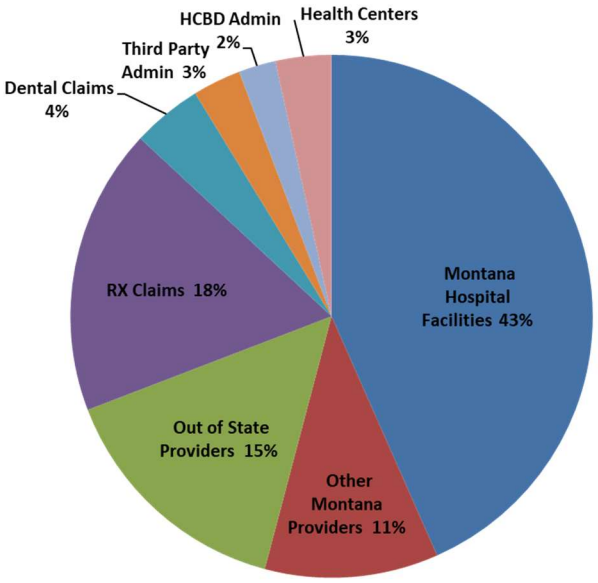
TESTIMONY of Marilyn Bartlett
Vermont State Legislature House Healthcare Committee
February 18, 2025

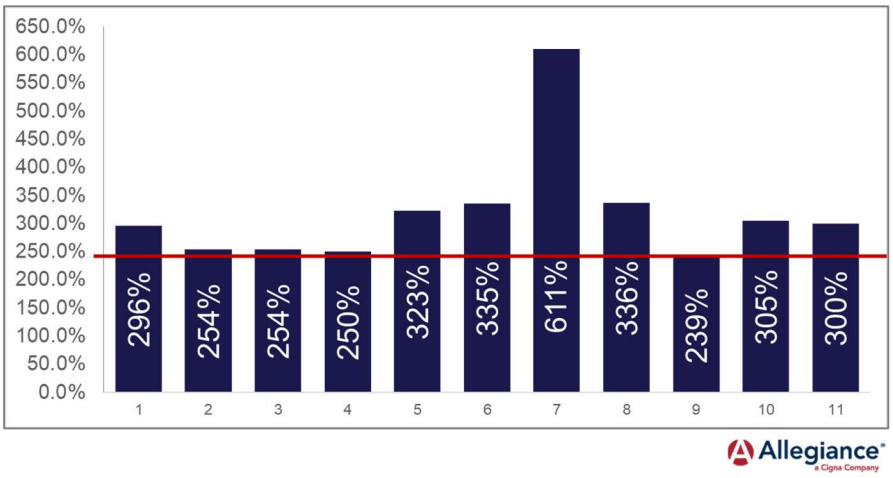
The Montana State Employee Group Health Plan (Plan) covers 31,000 employees, retirees, and dependents throughout the state. In 2015, the Plan faced a financial tipping point. The Plan had a history of raising premiums, state contributions, and/or reducing benefits to address rising costs. Actuarial projections showed Plan reserves would be -$9 million in just two years, and this strategy would not work anymore.

Montana Hospital spend was 43% of the Plan spending, with 11 larger hospital facilities comprising 87% of those expenses.

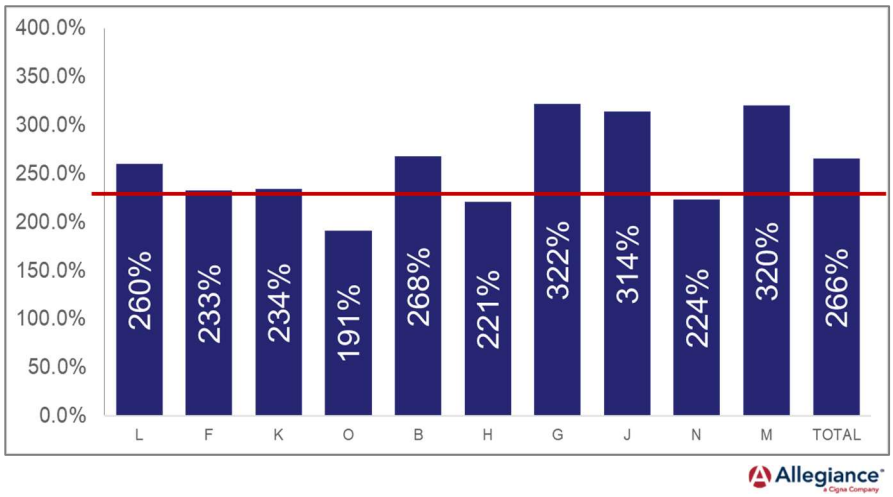


An independent analytics firm repriced a year of health claims to the Medicare reimbursement rates.

- Outpatient ranged 239% to 611% multiple of Medicare by facility for the 11 larger hospitals:



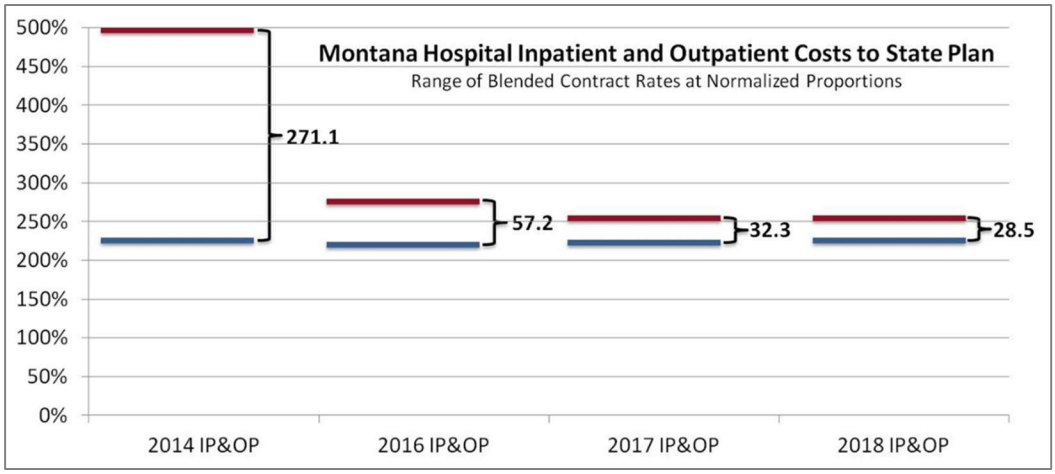
- Inpatient ranged 191% to 322% multiple of Medicare by facility for the 11 larger hospitals:



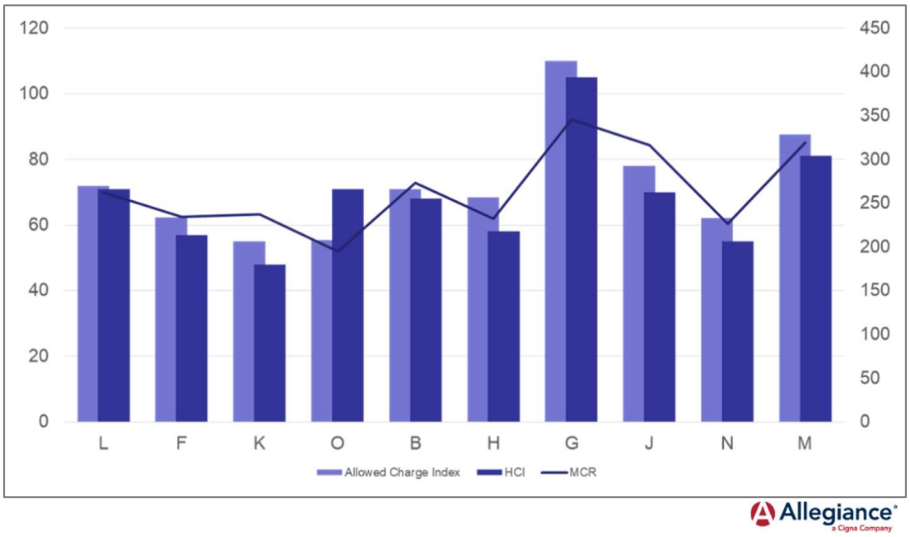
The Plan made the decision to change the reimbursement method for Montana hospitals, moving completely away from the traditional discount off chargemaster rates, where there is no transparency or control over Plan price trends.

- Reference would be Medicare rates:
  - Rates are hospital specific
  - Adjusted for case mix, wage index, geography, etc.
  - Calculation methods and rates are publicly available
  - DRG and APC "bundled" pricing
  - Common reference overcoming variation in chargemasters and billing practices
- Apply to **all** hospital services (inpatient, outpatient, and physician), to prevent cost shifting
- Travel benefits for Plan members if no contract was agreed to
- Independent third-party Medicare claims repricer
- Contracts required to eliminate member "balance-billing"

Strategy was to bring the higher cost hospitals more in line with the lower cost facilities.



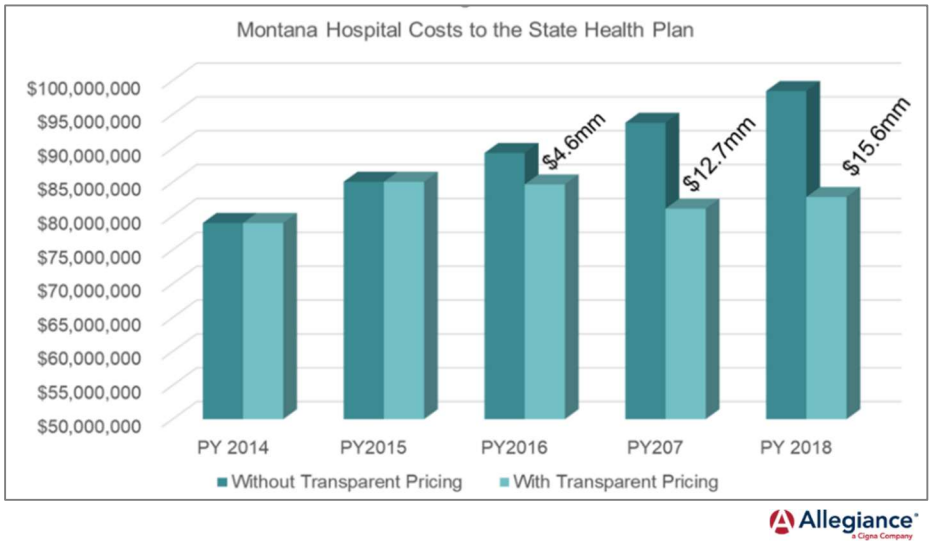
Hospital negotiations were data driven and transparent, openly sharing data with each hospital. The Montana Hospital Association requested Cleaverly and Associates review the data, and our results were confirmed with Cleaverly and Associates' determination of Hospital Cost Index (HCI):



Montana Hospital Association stated large hospitals are reimbursed only 65% of Medicare costs and 40% of Medicaid costs. To verify, we obtained Medicare Cost Report information from three large acute care hospitals cited by the association. Cost recovery ranged from 87% to 103% for Medicare and 92% to 107% for Medicaid. And our plan was to pay a **multiple** of the Medicare rate.

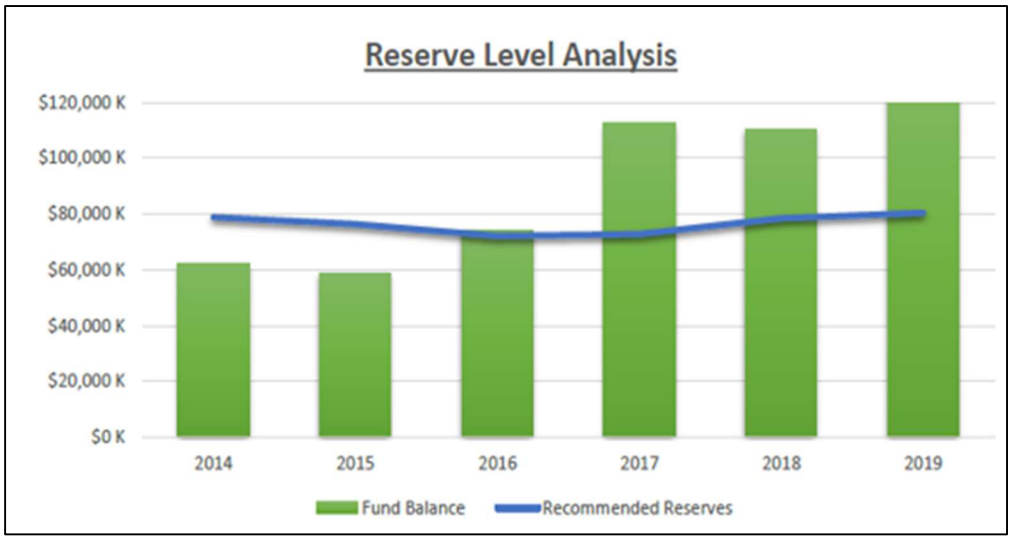
Reference based pricing (RBP) was implemented on July 1, 2016. The contracts provided a "glide path" to the higher cost hospitals to reach the desired range in 3 years. All 11 large facilities and 3 critical access hospitals (owned by health systems) received revenue reductions.

Initial projections showed $32.9 million savings through 2018, without increasing premiums or state contributions.



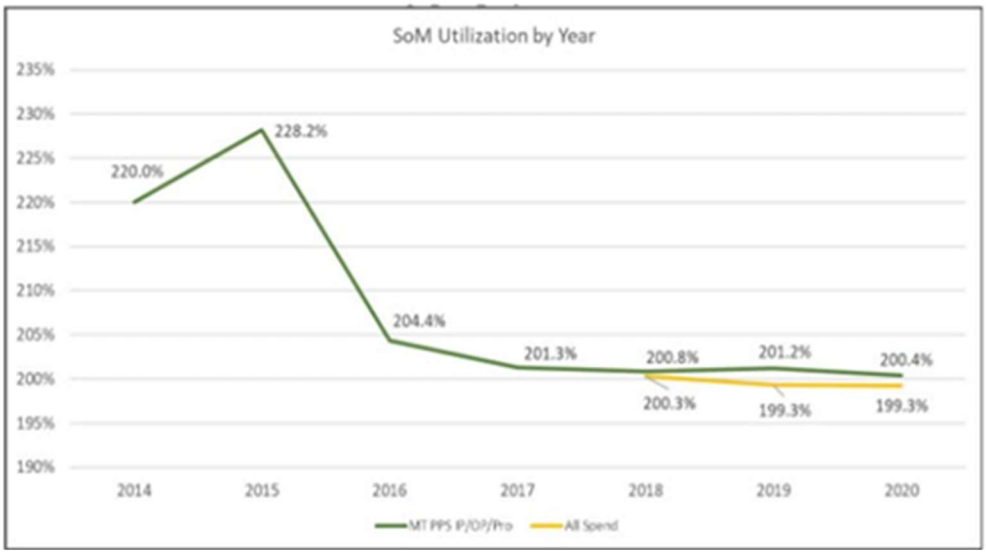
An independent consultant calculated an estimate of $47.8 million savings realized through 2019 compared to the traditional discount off chargemaster rates. Independent Analysis Montana RBP - NASHP

Actuarial analysis confirmed Plan reserves were well above required levels in 2017 at $112 million, compared to the 2015 projections of -$9 million. Reserve levels continued to grow, as Plan costs were lower, and premiums and state contributions remained flat. In 2018, and again in 2021, the Plan was determined to be "over-reserved", and the Montana Legislature passed bills to allow two premium holidays for the State, effectively lowering Plan reserves and increasing State budgets by $52 million.

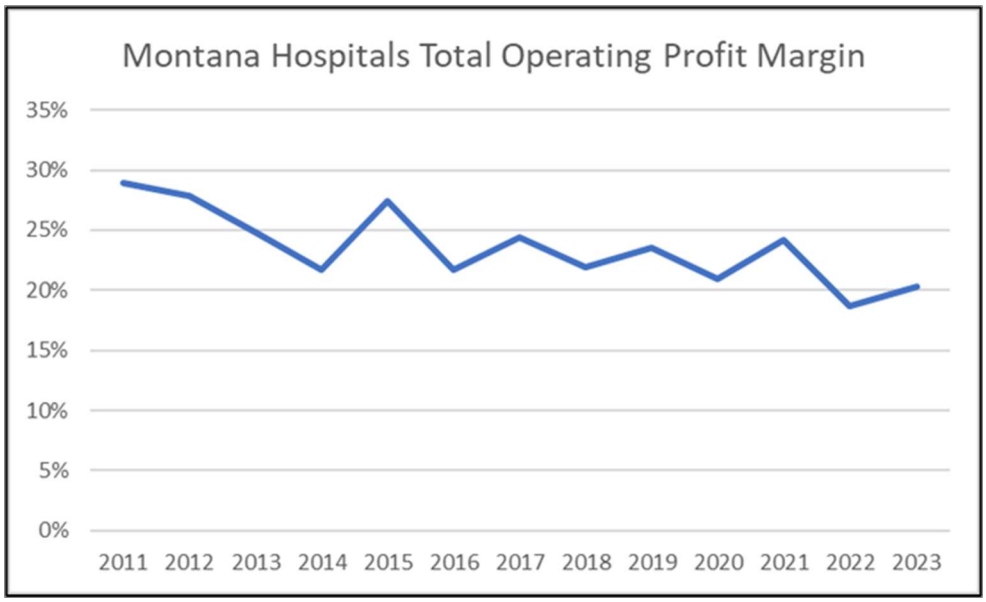


Source: ANW Actuary report

The Plan was able to maintain a reimbursement level of 200% Medicare rate for all Montana hospitals and providers.



Montana's RBP initiative (spanning the years 2016-2022) both saved and strengthened the financial foundations of the Plan without compromising access to affordable, quality care and without undermining the fiscal stability of the affected hospitals. The Montana hospitals maintained health Operating margins ranging between 20% and 25%, with no evidence of "cost shifting" to other commercial of group health plans.



NASHP Hospital Cost Tool | Overview

On January 1, 2023, the Plan reprocured TPA services, terminating the RBP contracts and moving to a standard carrier PPO network. When the Administrative Services contract was issued in 2022, the State issued a news release, projecting savings of $28 million over the next three years (2023-2026). BlueCross BlueShield of Montana Will Be State Plan's Medical TPA Vendor in 2023.

The projected savings, however, were not achieved after the Plan terminated the RBP contracts, and consequently, in 2025, the Plan is compelled to increase contributions. A bill (HB 13) is moving through the 2025 Montana Legislature to increase the State contribution, which had not happened in 10 years. The following provision is included in HB 13, with an estimated annual budget impact of $4 million in 2026 and $8 million in 2027, over current funding levels.

> (2) (a) Except as provided in subsection (2)(b), for employees defined in 2-18-701 and for members of the legislature, the employer contribution for group benefits is ~~$1,054~~ $1,080 a month beginning January 2026 and $1,107 a month beginning January 2027.