THE UNION OF VERMONT EDUCATORS

To: Vermont Legislature, House Health Care Committee

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

RE: Reference-based Pricing Benchmarked to Medicare Rates

Date: February 5, 2025

Good afternoon. My name is Mark Hage, and I'm the Director of Benefit Programs for the Vermont-National Education Association. I am also the longest serving trust administrator for the **Vermont Education Health Initiative (VEHI)** – a self-insured, public-sector risk pool with roughly 35,000 covered lives, active and retired school employees and their eligible dependents. I am testifying exclusively in my capacity as a Vermont-NEA labor advocate, but I will draw on VEHI data in the public record.

Vermont-NEA strongly endorses implementation of a **reference-based pricing methodology** benchmarked to Medicare rates (**RBP,** for short) to determine fair and sustainable reimbursements for inpatient and outpatient hospital services and to substantially reduce hospital costs and commercial insurance premiums.

There is ample evidence in research and from the experiences of other states that RBP is fair, empirically grounded, and can dramatically lower costs without compromising access to hospital care.

What is RBP Benchmarked to Medicare rates?

To demystify RBP, it is a methodology for determining an **objective value** for hospital services and products using Medicare prices as a **reference point**. With RBP, an insurance carrier or a self-insured entity like VEHI, for example, would pay participating providers an **established rate of reimbursement** that represents a **multiple of the value** that Medicare sets for hospital services.

In this context, think of RBP as a **Medicare-Plus** system of reimbursement.

Why benchmark hospital reimbursements to Medicare?

Medicare is a national system and the largest health care payer in the world.

We know how Medicare's reimbursements are calculated, they are intended to be fair, and they are adjusted for a host of factors outside of hospital control: wage rates, case-mix severity, outlier and transfer cases, teaching intensity, interest expense, etc.

The **Medicare Payment Advisory Commission** – MedPac – is an invaluable source of data and information and a good steward of public monies. MedPac research shows that **efficient hospitals** can breakeven or even make money on Medicare rates.[1]

Medicare Cost Reports (MCRs) provide hospital-level data and are the only national, public source of hospital costs.

Where has RBP been implemented?

RBP, in one form or other, is in force in several states, including Montana, Oregon, Colorado, Washington, North Carolina, South Dakota, and Oklahoma. It will be implemented in 2026 in Nevada.

It is being studied in other states. The reason for the move to RBP is simple: **hospital prices** are the main driver of premium costs and the affordability crisis in health care.

VEHI: It's the Hospital Prices

Hospital costs account for **55%** of VEHI's total spend.

The recent **GMCB RBP analysis** shows that VEHI, whose costs impact every school district and taxpayer, paid hospital costs that, on average, were:

- **301** percent of Medicare rates from 2018 through the first three quarters of 2023;
- **316** percent for 2022; and
- **326** percent over the first three quarters of 2023.

For the last four years, **2020 through 2023**, VEHI was paying on average **at or above 300 percent** of Medicare rates.

[1] MedPAC March 2023 Report to the Congress: Medicare Payment Policy

If VEHI had been reimbursing hospitals **double** the Medicare rates – at 200 percent – the savings in 2022 and 2023 (assuming the savings for the missing fourth quarter were consistent with the first three) would have been nearly **$100 million.** Over the entire period of the GMCB analysis, beginning in 2018, the savings for VEHI alone added up to **$230 million**. Again, that is based on paying **double** what Medicare paid for the same services during this period.

Where cost studies of RBP have been issued, the results are very impressive. Montana and Oregon stand out at present in this context.

1. **Montana:** An independent study on Montana's reference pricing program concluded that this initiative saved the **state employee plan** (with 31,000 covered lives) nearly **$48 million** from state fiscal year (SFY) 2017 through SFY 2019, following its 2016 implementation. It was tremendously successful and became a model for the nation. There were **no premium rate increases** for state employees from 2017 through 2024, and the state's health care reserves rebounded greatly and became a source of revenue for other state programs.

   Inpatient Reimbursement Range: 220 to 225 percent of Medicare rates.

   Outpatient Reimbursement Range: 230 to 250 percent of Medicare rates.

2. **Oregon:** This program covers **300,000 public-sector workers and their families** – state, public school and municipal employees.

   - It was mandated by statute in 2017 and went into effect in 2019 and affects **24 hospitals** out of **62**.

   - **In-network** hospitals: reimbursed at **200%** of Medicare rates; **Out-of-network** hospitals: reimbursed at **185%** of Medicare rates

   - The initiative generated **$59 million** in savings in 2020 and **$113 million** in 2021 according to an independent actuarial analysis.

   - In plan year **2022,** the actuarial firm Mercer concluded that the RBP "capped" hospitals in Oregon were paying on average roughly **165%** of Medicare's rates for inpatient services and roughly **190%** for outpatient services. Ten of the affected hospitals were **at or above 300 percent of**

Medicare rates for outpatient services in 2017; 5 were **between 272-285%.** Clearly, they have learned to operate with greater efficiencies since 2017.

- **No evidence has emerged that the RBP-capped hospitals raised prices for other commercial beneficiaries to compensate for lower reimbursements from the public sector**. The same is true for Montana.

- Nor did Oregon did experience **any hospital departures** from the insurance network or **hospital closures**. The same is true for Montana and other states.

3. **South Dakota & Oklahoma:** There have been no external cost evaluations of RBP in these states, but according to a recent article in the journal "Health Affairs," both states report that their RBP strategy has **generated significant savings** for public-sector plans, their members, and state taxpayers.

   - The article goes on to say that savings do not appear to have affected access to care, and there is broad provider participation in the medical networks.

     - In **Oklahoma**, 99.3 percent of hospitals and 80.0 percent of physicians participate in the public-sector network.

     - **South Carolina's** plan has 100 percent hospital participation and more than 99 percent of physicians (although they do not directly contract with behavioral health providers).

   - **South Carolina** officials noted that providers like working with the public sector because it is a "prompt payer" and provides generous coverage.

   - Officials have observed that because teachers and other public servants are covered by the RBP arrangements, providers in their states have been **generally sympathetic** about the need for lower rates for these employees and their families.

4. **Washington:** This year, Washington's Office of the Insurance Commissioner recommended provider-based reference pricing for that state's public-sector plans following the initiatives in Oregon and Montana.

    - RBP is in force in this state's exchange programs at **160 percent** of Medicare.

    - According to a report in Health Affairs, Washington's insurance office has projected that if the state implemented a reference price of **160 percent** of the Medicare rate for the **entire commercial market**, it would reduce medical spending **between 3 and 19 percent.**

I hope my testimony is helpful and makes clear why Vermont-NEA believes RBP is essential to reducing unjustifiably high hospital and commercial insurance costs for public schools, the State of Vermont and our municipalities.

Indeed, it is essential for the **entire commercial insurance market**.

There is no compelling reason why Vermont cannot adopt this pricing methodology and set our state on the road to achieving more affordable health care and commercial health insurance rates.

Finally, and respectfully, I would urge the committee to invite and take testimony from experts on RBP, including from knowledgeable sources in Montana and Oregon, and from national analysts. I would be happy to assist you in facilitating introductions to these individuals if that would be helpful.