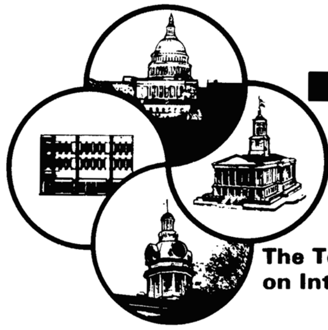

The Tennessee Advisory Commission on Intergovernmental Relations

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MEMORANDUM

TO: Commission Members

FROM: Cliff Lippard
Executive Director

DATE: 16 December 2022

SUBJECT: Senate Bill 2330 and House Bill 2456 (Reference-Based Pricing)—Draft for Review and Comment

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The attached draft Commission report is submitted for your review and comment. It was prepared in response to Senate Bill 2330 by Senator Hensley and House Bill 2456 by Representative Sparks, introduced in 2022, which directed the Commission to study the effects of reference-based pricing on health insurance prices. The final report is to be presented to the General Assembly no later than January 31, 2023.

The cost of healthcare and health insurance poses a significant burden for many individuals and their families. In 2010, between premiums and out-of-pocket expenses, Tennessee households on average might have had to spend the equivalent of about 10% of the median income before they could even begin to derive benefits from their insurance; by 2019, that had risen to 15%. On top of this, physicians and hospitals can charge amounts for the same services that differ by orders of magnitude.

Reference-based pricing is one method that has been proposed to help try to control rising healthcare costs by indexing those costs to a reference point like Medicare's payment rates for given procedures. California, Montana, North Carolina, and Oregon each use reference-based pricing for their state employee health plans, while the state of Washington has applied it to what it calls public option plans, or standardized plans designed by the state but offered by commercial insurers through the individual insurance marketplace. Colorado may also implement reference-based pricing for its public option plans if certain premium reduction targets are not achieved. The experiences of these other states demonstrate some of the effects that reference-based

pricing can be expected to yield, as well as some of the challenges that may arise to its implementation.

Reference-based pricing can be implemented in two main ways. In one method, the reference price is the amount the provider is willing to accept as payment in full for the service—for example, 160% of Medicare rates. However, in another method, the insurer will pay up to the reference price amount, but the provider may make patients liable for paying any remainder of a bill that exceeds the reference price, which is known as balance billing.

Reference-based pricing is likely to deliver cost reductions for insurers, including employers and state health plans. California's state health plan saw savings of between 13% and 27% on particular medical procedures after implementing reference-based pricing. Montana saw overall savings of 22%, and Oregon, by the third year of its program, achieved savings of 33%.

Reference-based pricing could produce savings for patients, though this depends on how it is structured and whether balance billing occurs. Montana's state employee health plan, for example, has seen no premium increases since 2016, and state employees were able to negotiate for pay increases on two separate occasions when the state legislature offered employees premium holidays. Representatives for Oregon's state employee health plan credit reference-based pricing with limiting cost growth, while Washington's reference priced public option plans are expected to see premium increases of 2% in the next year versus 8% to 10% for other individual insurance plans.

Reference-based pricing could possibly spur healthcare providers to lower their prices and operate more efficiently, but this is not guaranteed. While it is often claimed that lower payments from one group of patients might lead healthcare providers to raise prices for others—what is known as cost-shifting—research suggests it is limited. In fact, past analysis suggests that lower payments to healthcare providers could incentivize them to reduce costs and function more efficiently.

Hospitals in other states have nonetheless been strongly opposed to reference-based pricing and resisted its implementation, and Tennessee's Benefits Administration has raised concerns that hospitals could leave the health plan's networks. Both Oregon and Washington had to adjust some of the rules behind their programs in response to hospital opposition. In North Carolina, the state employee health plan was able to convince 28,000 smaller healthcare providers to participate, most of whom are primary care physicians, but no major hospital has agreed to participate in the reference-based pricing program.