

**STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD**

In re: 2024 Essential Health Benefits)
 Benchmark Plan)
_____)

**REVISED ORDER APPROVING ESSENTIAL HEALTH BENEFITS
BENCHMARK PLAN FOR PLAN YEAR 2024**

The Green Mountain Care Board is responsible for reviewing and approving, with recommendations from the Department of Vermont Health Access (DVHA), the benefit package or packages for qualified health benefit plans and reflective silver plans.¹ 18 V.S.A. § 9375(b)(9). On March 2, 2022, the Board voted to approve an essential health benefits (EHB)-benchmark plan beginning in plan year 2024 that includes all the existing benefits within the current benchmark plan and adds coverage for up to one hearing aid per ear² every three years and an annual exam, as recommended by DVHA on February 16, 2022.

The Affordable Care Act requires individual and small group plans to cover 10 categories of EHB:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

42 U.S.C. § 18022(b), 45 C.F.R. § 156.110. Vermont has codified the federal requirements into state law. 33 V.S.A. § 1806(b)(1)(A) (plans in Vermont’s individual and small group markets must provide the “essential benefits package required by . . . the Affordable Care Act”).

¹ Reflective silver plans are defined in 33 V.S.A. § 1802(10) and § 1813 as plans that are similar to, but contain at least one variation from, the silver-level qualified health plans offered through Vermont Health Connect that include funding to offset the loss of federal cost-sharing reduction payments.

² This order was first issued on March 7, 2022 and incorrectly described the benefit as providing coverage for up to one hearing aid per “year” every three years, as opposed to one hearing aid per “ear” every three years. This revised order, issued March 8, 2022, corrects that typo.

The parameters of each EHB category are defined in state specific EHB-benchmark plans. *See* 45 C.F.R. § 156.100, et seq. Benefits in addition to those chosen through the EHB-benchmark plan must be paid for by the state. *See* 45 C.F.R. § 155.170 (requiring states to defray the cost of benefits required by state action taking place on or after January 1, 2012 other than to comply with federal requirements). Vermont's current EHB-benchmark plan is The Vermont Health Plan's 2014 CDHP-HMO plan,³ which was recommended by DVHA and approved by the Board in 2015. *See* In re: 2016 Essential Health Benefits Benchmark Plan for Vermont Benefits Exchange, Order Approving Essential Health Benefits Benchmark Plan (Jul. 16, 2015).

In 2018, the federal government provided states with new flexibility to update their EHB-benchmark plans. 83 Fed. Reg. 16930 (Apr. 17, 2018). Under this flexibility, states could, for plan years beginning on or after January 1, 2020:

- 1) select a benchmark plan used by another state during the 2017 plan year;
- 2) replace one or more categories of EHB with the same category or categories of EHB used in another state's benchmark plan for the 2017 plan year; or
- 3) select a set of benefits to constitute the State's benchmark plan.

45 C.F.R. § 156.111. States that update their EHB-benchmark plan pursuant to this new flexibility will not be subject to defrayal requirements. CMS, Frequently Asked Questions on Defrayal of State Additional Required Benefits (Oct. 23, 2018), <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-Defrayal-State-Benefits.pdf>.

In 2021, the Vermont Legislature tasked the Department of Financial Regulation (DFR) with reviewing Vermont's benchmark plan and assessing its current EHB package to ensure that it aligns with Vermont's health care reform goals regarding population health and prevention, as reflected in the Vermont All-Payer Accountable Care Organization Model Agreement and the State Health Improvement Plan. DFR was also tasked with evaluating the potential impacts of modifying the benchmark plan to include coverage of certain additional benefits. *See* Act No. 74 (2021), § E.227. Beginning in the summer of 2021, DFR, with support from its contract actuaries, convened a working group to examine these issues.

On January 26, 2022, representatives from DFR, DVHA, and the Agency of Human Services presented findings to the Board.⁴ On February 16, 2022, representatives from DVHA recommended that the Board exercise the flexibility available pursuant to 45 C.F.R. § 156.111 to create a new EHB-benchmark plan for plan year 2024 that includes all the existing benefits within the current benchmark plan and coverage for hearing aids – up to one hearing aid per ear every three years and an annual exam. DVHA noted that adding a hearing aid benefit could be expected to improve quality of life for many Vermonters currently unable to afford hearing assistance,

³ The Vermont Health Plan is a licensed health maintenance organization and a for-profit subsidiary of Blue Cross Blue Shield of Vermont.

⁴ Board presentations can be accessed at <https://gmcboard.vermont.gov/board/meeting-information/2022-meetings>.

resulting in improved mental wellbeing and supporting health and economic equity. DVHA also noted that Vermont is currently one of only two northeast states without hearing aid coverage. DVHA did not recommend adding infertility services or medically-tailored meals to the benchmark plan at this time but stated that it would support further exploration for future years.

In a special comment period that ran from January 26 through February 25, 2022, the Board received comments from a number of individuals and organizations supporting DVHA's recommendation to add coverage for hearing aids.

On March 2, 2022, the Board voted unanimously to adopt DVHA's recommendation. The Board expressed frustration that adult dental is not permitted to be an EHB, meaning that the State would be required to defray the cost of these benefits if it mandated that they be covered. The Board also expressed a desire to explore adding coverage for the National Diabetes Prevention Program in a future year. This lifestyle change program has been shown to reduce the risk of developing type 2 diabetes by 58 percent in adults at high risk for the disease. Centers for Disease Control and Prevention, National Diabetes Prevention Program, Research Behind the National DPP, <https://www.cdc.gov/diabetes/prevention/V-behind-ndpp.htm> (page last reviewed Aug. 3, 2021). Given that reducing the prevalence and morbidity of diabetes and other chronic diseases is one of Vermont's key population health and prevention goals, it makes sense to do everything we can to make this program available to as many Vermonters as possible.

SO ORDERED.

Dated: March 7, 2022, at Montpelier, Vermont.

<u>s/ Kevin Mullin, Chair*</u>)	GREEN MOUNTAIN CARE BOARD OF VERMONT
<u>s/ Jessica Holmes</u>)	
<u>s/ Robin Lunge</u>)	
<u>s/ Tom Pelham*</u>)	
<u>s/ Thom Walsh</u>)	
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*Board Member Pelham filed a separate concurring opinion in which Chair Mullin joined.

Board Member Pelham, with whom Chair Mullin joins, concurring.

I reluctantly voted in favor of DVHA's recommendation to change Vermont's EHB-benchmark plan. The review process as it unfolded unfortunately became limited to a few benefit changes with hearing aids being the only substantive change as the result. This relatively minimal result stands in sharp contrast to the "greater flexibility" afforded to states by the Centers for

Medicare and Medicaid Services “to update their EHB-benchmark plans, if they so choose” and the Vermont Legislature’s expectation that the process would “assess whether the benchmark plan is appropriately aligned with Vermont’s health care reform goals regarding population health and prevention, as set forth in the Vermont All-Payer Accountable Care Organization (ACO) Model agreement and the Department of Health’s State Health Improvement Plan: 2019-2023.” Act No. 74 (2021), § E.227.

Context here is important. Vermont’s EHB-benchmark plan is the platform for health plans projected to serve almost 72,000 covered lives in the individual and small group market in 2022. DVHA, January 2022 Individual and Small Group Enrollment Report (Feb. 24, 2022). Premiums in the combined amount of \$529.7 million have been approved for BCBSVT and MVP to support this EHB-benefits coverage, along with substantial additional cost sharing amounts approved recently by DHVA and the Board. *See* Docket Nos. GMCB-005-21rr (2022 BCBSVT Individual), GMCB-006-21rr (2022 BCBSVT Small Group), GMCB-007-21rr (MVP Individual), GMCB-008-21rr (MVP Small Group); DVHA, Presentation of Proposed 2023 Standard Qualified Health Plan (QHP) Designs (Feb. 2, 2022), 17. Clearly, the EHB-benchmark plan is a central component of Vermont’s health care delivery system.

Further, Vermont’s current EHB-benchmark plan may have aged in place. As noted in DFR’s January 26 presentation to the Board, Vermont’s benchmark plan was first approved in 2012 and last approved in 2015, with both approvals selecting the same commercial plan as the basis for the benchmark plan. Yet, a lot has changed since 2012 that might justify a fresh look at the included benefits. Aside from advances in evidence-based medicine and pharmaceuticals, for example, here in Vermont we’ve embarked on a broad-based health care reform effort that seeks to replace traditional fee-for-service with a value-based payment approach emphasizing population health and prevention. Yet, despite what the Legislature asked to be done and the recent flexibility allowed by CMS, there was no effort to align the benchmark plan with the goals of healthcare reform or to examine and update it relative to advances in health care knowledge and practices.

Consider what may be the most demonstrable forgone opportunity – diabetes prevention. The Vermont Department of Health reports that “[d]iabetes is one of the four chronic diseases that are the cause of more than 50% of deaths each year” and that “55,000 have diagnosed diabetes.” Vermont Department of Health, Health Promotion & Chronic Disease, Diabetes, <https://www.healthvermont.gov/wellness/diabetes>. And, given the cost in lives and treasure, diabetes is a primary target of Vermont’s health reform efforts and the state’s adopted health care plan. Yet, diabetes prevention, a low-cost alternative to diabetes treatment, is not now nor will it be in 2024, a benefit available through Vermont’s benchmark plan.

The Vermont Blueprint for Health understands the burden of diabetes in Vermont. Their most recent annual report profiles the prevalence of diabetes in 2019 among their primary-care-attributed-population at greater than 15%, based on claims and clinical data. Vermont Agency of Human Services, 2021 Annual Report Draft on the Vermont Blueprint for Health (Jan. 31, 2022), 30. Hypothetically, if a similar portion of the covered lives in the benchmark plan were diabetic,

more than 10,700 might be eligible for treatment. And what might that treatment annually cost our healthcare system? Based on the BCBSVT Silver Plan, the insurer would pay \$5,600 and the out-of-pocket costs would be an additional \$2,290, for a total \$7,890 per diabetic. Blue Cross Blue Shield of Vermont, Summary of Benefits and Coverage for BCBSVT Silver Plan, https://info.healthconnect.vermont.gov/sites/vhc/files/doc_library/BCBSVT%20Silver%20Plan_0.pdf. If just one-third or 3,530 of the benchmark diabetics sought treatment, the annual cost to the insurer would be almost \$20 million and the annual cost to individuals in cost sharing would be over \$8 million. There can be no doubt, when it comes to diabetes, an ounce of prevention is worth a pound of cure.

Vermont's Blueprint for Health and the Department of Health do offer a self-management program recognized by the Centers for Disease Control and Prevention (CDC) National Diabetes Prevention Program. The CDC states, and the Blueprint promotes, that the CDC program is "a research-based program focusing on healthy eating and physical activity which showed that people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old)." Centers for Disease Control and Prevention, National Diabetes Prevention Program, About the National DPP, <https://www.cdc.gov/diabetes/prevention/about.htm> (page last reviewed Aug. 19, 2021). The Blueprint's 2020 Annual Report states that in 2019 the Blueprint sponsored 30 self-management pre-diabetes workshops with 303 participants and 181 "completers" statewide. In an effort "to streamline and modernize the Self-Management Programming", the Blueprint's draft 2021 Annual Report reveals the Blueprint and the Agency of Human Services have embarked on a restructuring of these programs. Vermont Agency of Human Services, 2021 Annual Report Draft on the Vermont Blueprint for Health (Jan. 31, 2022), 19. Clearly, even if the Blueprint doubled its annual output of "completers," it would be of small impact relative to the pre-diabetic populations covered by the EHB-benchmark plan or Vermonters statewide more generally.

On the other hand, consider the opportunity for the CDC Diabetes Prevention Program becoming an EHB-benchmark plan benefit. Likely the supply/demand relationship would grow as physicians have more opportunities and incentives to refer pre-diabetic patients to the program while the Blueprint and independent providers align themselves to encourage and accommodate such new demand. For the Blueprint, making the program a benefit would provide another revenue source. And, as the benefit fosters the transition from high-cost acute care treatments as profiled above to a time-tested, low-cost prevention remedy, the benchmark plan can play a leading role in reducing the prevalence of a chronic disease while saving through prevention substantial costs in acute care diabetes treatments, the very essence of Vermont's health care reform goals.

It's clear that CMS and the Legislature established an opportunity for a thorough review of Vermont's EHB-benchmark plan. CMS gave states great flexibility to update benchmark plans relative to improvements in health care methods over the past 10 years and the Legislature encouraged the review to align the benchmark plan with State health care reform goals. And though the benchmark plan entails well more than half a billion dollars in premiums and cost sharing revenues, the result of the review embraces not a dollar in savings while affirming the status quo.

While I voted in favor of DVHA’s recommendation because of the inclusion of hearing aids, I also recognize that other possible reforms of substantial merit were left unattended. Possibly the Legislature might reassert its directive for DFR to “assess whether the benchmark plan is appropriately aligned with Vermont’s health care reform goals regarding population health and prevention” for plan year 2025.

s/ Tom Pelham
Member, Green Mountain Care Board

s/ Kevin Mullin
Chair, Green Mountain Care Board

Dated: March 7, 2022

Filed: March 8, 2022

Attest: s/ Jean Stetter
Green Mountain Care Board
Administrative Services Director

NOTICE TO READERS: This document is subject to revision of technical errors. Readers are requested to notify the Board (by e-mail, telephone, or in writing) of any apparent errors, so that any necessary corrections may be made. (Email address: Michael.Barber@vermont.gov).