Proposed Amendment for Stakeholder Process to Address Unaffordable Cost Sharing in Vermont Health Connect Bronze Plans Through Adjustment of the Limit to Out-of-Pocket Prescription Drug Coverage

- Out-of-pocket prescription drug coverage makes other parts of the bronze plans, such as co-insurance and co-pays less affordable for Vermonters. Furthermore, given the federal requirements of an out-of-pocket maximum, the limit to out-of-pocket prescription drug coverage may prevent plans from reaching the statutorily required 60% AV level for bronze plans. As a result, insurers may not be able to offer as many or any bronze plans for 2018 without adjustment to the limit to out-of-pocket prescription drug coverage.
- This proposed language would provide a stakeholder process and public process overseen by the Green Mountain Care Board to develop bronze plans with lower co-pays, deductibles, and co-insurance, but a higher the limit on out-of-pocket prescription drug coverage
- As long as it meets federal standards, there will be at least one standard bronze plan that will retain the limit on out-of-pocket prescription drug coverage for those Vermonters who need it

Sec. X. ADJUSTMENT OF OUT-OF-POCKET PRESCRIPTION DRUG COVERAGE FOR QUALIFIED HEALTH BENEFIT PLANS; STAKEHOLDER PROCESS

The Department of Vermont Health Access, in consultation with interested stakeholders, including health insurers offering qualified health benefit plans and the Office of the Health Care Advocate, shall evaluate alternatives to the limit on out-of-pocket prescription drug coverage established in 8 V.S.A. § 4089i for bronze qualified health benefit plans, while still promoting the goals in 33 V.S.A. § 1806(b), but shall maintain at least one standard bronze plan at or below the limit on out-of-pocket prescription drug coverage established in 8 V.S.A. § 4089i.

(a) For the nonstandard bronze plans, and prior to the date qualified health plan forms must be filed with the Department of Financial Regulation, a health insurer offering qualified health benefit plans may seek approval from the Green Mountain Care Board for one or more modifications of the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i. In considering the health plan's request, the Green Mountain Care Board shall offer any interested

party an opportunity to comment on the recommendation to modify the out-of-pocket prescription drug limit. The Green Mountain Care Board shall also determine the maximum deviation from the out-of-pocket prescription drug limit that the Department of Financial Regulation may approve in the form filing process for the nonstandard bronze plan considered and shall make that determination prior to the form filing deadline.

(b) For the development of the standard plan designs, the Department of Vermont Health Access shall establish a multi-stakeholder qualified health plan workgroup that shall meet and discuss plan design options at least six times prior to the date plans are filed for approval. Such multi-stakeholder group shall include representatives of the health insurers offering qualified health benefit plans, the Office of the Health Care Advocate, members of the Medicaid and Exchange Advisory Board, consumers, and any other interested members of the public. For standard bronze plans, the Department of Vermont Health Access shall consult the qualified health plan workgroup and, following the principles in 33 V.S.A. § 1806, may recommend one or more modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i. Notwithstanding 8 V.S.A. § 4089i, the Green Mountain Care Board may approve modifications to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i and the Department of Vermont Health Access shall certify at least one standard bronze plan that includes the out of pocket prescription drug limit established in 8 V.S.A. §4089 as long as it is in compliance with federal standards and may certify one or more standard bronze qualified health benefit plans with a modification to the out-of-pocket prescription drug limit established in 8 V.S.A. § 4089i.

Sec. X. ADJUSTMENT OF OUT-OF-POCKET PRESCRIPTION DRUG COVERAGE FOR QUALIFIED HEALTH BENEFIT PLANS; REPORTS

(a) On or before February 15, 2017, DVHA shall report to the to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on the following:

(1) an overview of the cost-share increase trend for bronze qualified health plans from 2014 to 2017 with the limit on out-of-pocket prescription drug coverage established in 8 V.S.A. § 4089i in place;

(2) detailed information regarding lower cost-share for selected services due to flexibility to increase the limit on out-of-pocket prescription drug coverage established in 8 V.S.A. § 4089i on bronze qualified health plans for 2018;

(3) a comparison of 2018 bronze qualified plan designs between plans where there is flexibility on the limit on out-of-pocket prescription drug coverage established in 8 V.S.A. § 4089i and where there is not;

(4) information on stakeholder group process and information studied to determine cost share changes for all 2018 bronze qualified health plans, including prior year utilization trends, consumer feedback from carriers, health benefit exchange outreach and education, and pertinent national studies;

(5) a comparison of cost-share information for standard bronze qualified health plans from states with federally facilitated marketplaces compared to Vermont's health benefit exchange; and

(6) an overview of the health benefit exchange outreach and education plan for enrollees in bronze qualified health plans.

(b) On or before February 1, 2018, DVHA shall report to the to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on the following:

(1) enrollment trends in bronze qualified health plans; and

(2) recommendations from the stakeholder group on whether to continue the limit on out-of-pocket prescription drug coverage established in 8 V.S.A. § 4089i.