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I. Introduction

In accordance with the Legislature's directive in section E.227 of Act No. 74 of 2021, the Commissioner of Financial Regulation hereby submits to the House Committees on Health Care and on Human Services and the Senate Committee on Finance and on Health and Welfare this report, which contains the Department's findings and recommendations on (1) alignment of the Essential Health Benefit Benchmark Plan with state health care reform goals and (2) the impact of including additional benefits.

The Department of Financial Regulation and the Agency of Human Services, along with several stakeholders, convened a working group to analyze the current Essential Health Benefit (EHB) benchmark plan. The Department held 9 meetings with the EHB working group from August 2021 to January 2022. The purpose of the meetings was to look at whether the current EHB benchmark plan aligns with the State's Health Improvement Plan and All-Payer Accountable Care Organization (ACO) Model Agreement, as well as to examine the potential impacts of modifying the plan to include coverage of additional benefits.

The analysis of the EHB benchmark plan is being funded by the State Flexibility to Stabilize the Market Cycle II Grant Program awarded to the Department of Financial Regulation by the Centers for Medicare and Medicaid Services (CMS). The goal of the grant-funded work is to assess whether modification of the plan will increase affordability for consumers and provide an EHB benchmark plan that best reflects the needs of the State's health insurance market and population, in accordance with applicable EHB benchmark plan selection criteria.

II. Background

The Affordable Care Act requires individual and small group plans to cover 10 categories of essential health benefits (EHBs). 42 U.S.C. § 18022. The EHB categories are:

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.

The specific parameters of each benefit are defined in state-specific EHB-benchmark plans. See 45 C.F.R. § 156.100, et seq. In 2011, states had the option of choosing their benchmark plan from the largest of the three largest small group products, the largest commercial HMO, the State employee health plan, and the federal employee health benefits plan. The State of Vermont analyzed the first three plans but did not analyze the federal employee health benefit plan. In 2012, the Department of Vermont Health Access proposed the Blue Cross Blue Shield of Vermont (BCBSVT) Consumer Driven Health Plan (CDHP) to the

Green Mountain Care Board as the EHB benchmark plan. The Board approved the recommendation and adopted the BCBSVT CDHP as the EHB benchmark plan for the small group and individual market. Any benefits in addition to those chosen through the EHB plan must be paid for by the state.

Act 74 of 2021

During the 2021 legislative session, Act 74¹ required the Department of Financial Regulation, in consultation with several stakeholders to review Vermont’s benchmark plan and assess the current EHB package to ensure alignment with Vermont’s health care reform goals regarding population health and prevention and the impact of adding additional benefits.

State Benchmark Plan Working Group Membership:

Organization	Name
Department of Financial Regulation	Sebastian Arduengo, Emily Brown, Anna Van Fleet
Department of Vermont Health Access	Adaline Strumolo, Dana Houlihan, Sean Sheehan
Office of the Director of Health Care Reform	Ena Backus, Wendy Trafton
BCBSVT	Sara Teachout
MVP	Jordan Estey
Northeast Delta Dental	Brian Duffy
Vermont Hospital Association	Devon Green
Vermont Medical Society	Jill Sudhoff-Guerin
Vermont Legal Aid	Mike Fisher

Essential Health Benefit Plan Updates

In the Final 2019 HHS Notice of Benefits and Payment Parameters², the federal government allowed states an opportunity to update benchmark plans for years 2020 and beyond. States have three options for updates:

- Select a benchmark plan used by another state during the 2017 plan year;
- 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
- Select a set of benefits to constitute the State’s benchmark plan.

There are two tests which a state benchmark selection must pass: first, the scope of benefits must be at least equal to those in a typical employer plan. Second, the benchmark plan cannot “exceed the

¹ Act 74 of 2021, Sec. E.227, available at

<https://legislature.vermont.gov/Documents/2022/Docs/ACTS/ACT074/ACT074%20As%20Enacted.pdf>.

² Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 F.R. 16930 (Apr. 17, 2018), available at <https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019>.

generosity” of either the benchmark plan in place for 2017 or any benchmark plan options the state had available in 2017.

The typicality test requires that the expected value of the proposed EHB benchmark plan is equal to the scope of benefits provided under a typical employer plan. The generosity test allows a state to increase the value of the benchmark plan only if the new benchmark does not offer a more generous scope of benefits than the most generous plan available in 2017. Under the federal guidelines, a state’s new benchmark plan cannot exceed the generosity of the most generous comparison plans even by a small amount, or the state must pay the excess cost. For example, if the State’s proposed additional benefit combined with the existing benefits exceeds 100 percent of the expected value of the most generous “Comparison Plan”, the state would not pass the generosity test and would be required to defray the cost of the additional benefit.

To add benefits without incurring additional costs to the State, Vermont must show that doing so would not cause its benchmark plan to exceed the generosity of any of the following plan options available in 2017:

- 1) *Small group market health plan*. The largest health plan by enrollment in any of the three largest small group insurance products by enrollment, as defined in 45 C.F.R. § 159.110, in the State’s small group market as defined in § 155.20.
- 2) *State employee health benefit plan*. Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in Vermont.
- 3) *Federal Employees Health Benefits Program (FEHBP)*. Any of the largest three national FEHBP plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 U.S.C. § 8903.
- 4) *HMO*. The coverage plan with the largest insured commercial non-Medicaid enrollment offered by a health maintenance organization operating in the State.³

To show that adding benefits to Vermont’s current benchmark plan would not cause the plan to exceed the generosity of the 2017 plan options, the State must provide an actuarial certification to that effect and report to CMS. The report is based on an analysis of all plan options in comparison to the current benchmark plan.

Under 45 C.F.R. § 156.111, there are several other procedural steps the state would then have to take to update the plan with CMS, including providing a reasonable public notice and an opportunity for public comment on the chosen benchmark plan benefit design. Under 18 V.S.A. § 9375(b)(9), the updated plan would also need to be reviewed and approved by the Green Mountain Care Board. The following timeline illustrates those steps:

³ See 45 C.F.R. § 156.100, available at <https://www.govinfo.gov/content/pkg/CFR-2013-title45-vol1/pdf/CFR-2013-title45-vol1-sec156-100.pdf>.

Task	Date	Detail
Legislative Report with Findings	January 2022	Summary of work to date and benefit proposal
Presentation to GMCB	February 2022	Presentation to Board for Qualified Health Plan (QHP) approval
GMCB Public Comment Period	February - March 2022	
CMS Update	March 2022	Prior to CMS-required public comment period
Public Comment Period	March/April 2022	30-day public comment period
Official CMS Submission	April 2022	
CMS Review and Finalization	May-August 2022	
New Plan Review	March 2023	DFR to review new contract language. GMCB to review premium impact.
Implementation of New Plans	January 2024	Plans with new benefits effective for plan year 2024

III. Alignment with State Health Care Reform Goals

Act 74 asked the Department to review Vermont’s benchmark plan to assess whether the plan is appropriately aligned with Vermont’s health care reform goals regarding population health and prevention. These goals are set forth in the Vermont All-Payer ACO Model Agreement (also referred to as “Agreement”) and the Department of Health’s State Health Improvement Plan.

All-Payer ACO Model Agreement

The All-Payer ACO Model Agreement is a contract between the Centers for Medicare and Medicaid Services (CMS) and the State of Vermont. The Agreement enables Medicare to align with Medicaid and commercial payers to explore new ways of financing and delivering health care in Vermont. The Agreement requires Vermont to meet three high level population health goals:

- Improving access to primary care
- Reducing deaths due to suicide and drug overdose
- Reducing prevalence and morbidity of chronic diseases

These population health goals were used as a lens under which each potential additional benefit was analyzed. In the benefits section below, the report identifies how each benefit would help Vermont accomplish these population health goals.

State Health Improvement Plan

The State Health Improvement Plan (SHIP) outlines strategies and priorities for Vermont to improve health outcomes with the goal of working towards health equity, affordability, and access. The top strategies for SHIP include investing in policies and infrastructure that create healthy communities; investing in programs that promote resilience, connection and belonging; expanding access to integrated person-centered care; and adopting organizational and institutional practices that advance equity with the goals of improving outcomes in six priority health and social conditions:

- Child Development
- Chronic Disease
- Mental Health
- Oral Health
- Substance Use
- Social Determinants: Housing, Transportation, Food, Economic Security

The goals of the SHIP are reflected in the All-Payer ACO Model Agreement's high level population health goals. For the purposes of the benchmarking exercise, the group focused on how each benefit would most fully meet the goals of providing services that are available, accessible, and affordable while also working towards accomplishing improved health and social outcomes.

IV. Benefit Analysis

Summary

In accordance with Act 74 of 2021, the Department analyzed several benefits, including those specified in the act, as well as benefits to better align the current benchmark plan with state health care reform goals. The group looked at each benefit from several perspectives including the actuarial value, alignment with state health policy goals, and the potential impact and value for policyholders enrolled in the current benchmark plan. Throughout several meetings, the working group heard from stakeholders and experts on several benefits. Based on the provided information and actuarial data, the group discussed whether and how the benefits should be included in the benchmark plan.

The group considered several other benefits including tobacco treatment, lactation consultations, and mental health and substance use disorder treatment. These benefits were considered due to their alignment with state health care reform goals as outlined and a study of other states' benchmarking activity. After an analysis of the current benchmark plan, it was determined that these additional benefit considerations were already substantially covered in the State's existing plan.

Several states have used the benchmarking process to improve mental health and substance use disorder treatment. Due to Vermont's comprehensive mental health parity law and past legislative actions, Vermont's benchmark plan already covers all the benefit additions made in this area by other states, including coverage of naloxone, removal of barriers to medication-assisted treatment for opioids, and alternative treatment options.

The analysis also compared the current benchmark plan to other Northeast states and found that Vermont's benefits align with other states in the region. Where Vermont's plan did not align, the working group considered the impact of doing so.

A gym membership benefit was also considered and not recommended at this time due to concerns around geographic equity, cost, as well as the benefit currently being offered under some non-standard plans.

Hearing Aids

Hearing aids are currently not covered as an EHB in Vermont. Vermont and Pennsylvania are the only two states in the Northeast Region that do not offer hearing aid coverage as an EHB. The working group heard from stakeholders on potential impacts associated with a hearing aid benefit, as well as suggestions to align any recommendation with the current benefit design under Vermont Medicaid.

Most people who need hearing aids meet the definition of disabled under Section 504 of the Americans with Disabilities Act. Hearing loss can happen when any part of the ear or hearing system is not functioning. Hearing loss can range from mild hearing loss where a person may hear some speech sounds to not having the ability to hear any speech. According to a 2015 presentation from the President's Council of Advisors on Science and Technology, a single hearing aid typically costs approximately \$2,400, which most consumers pay completely out-of-pocket.⁴ While hearing aids may not benefit individuals with a profound hearing loss, they are an important treatment and intervention option for many individuals with hearing loss.⁵

Approximately 6% of Vermonters experience serious difficulty hearing⁶ and it is estimated nationally that approximately 15% of American adults aged 18 and over report some trouble hearing.⁷ In Vermont, insurance coverage for hearing aids is available for individuals enrolled in Medicaid. Fully insured large and small group as well as individual health insurance coverage does not provide hearing aids or a hearing examination, creating a cost barrier to access this important benefit.

Alignment with Vermont Health Care Reform Goals

Adding a hearing aid benefit would strongly support many of the State's health care reform goals. Hearing loss and lack of access to hearing aids have several social and economic impacts, which extend beyond the direct benefit itself. Due to the high cost of hearing aids, many individuals with hearing loss cannot

⁴President's Council of Advisors on Science and Technology, Presentation, Aging America & Hearing Loss: Imperative of Improved Hearing Technologies (Oct. 2015), *available at* <https://obamawhitehouse.archives.gov/sites/default/files/microsites/ostp/PCAST/PCAST%20hearing%20letter%20report.pdf>.

⁵ Centers for Disease Control and Prevention, Health Report, Hearing Loss in Children (2021), *available at* <https://www.cdc.gov/ncbddd/hearingloss/index.html>.

⁶ Vermont Department of Health, Vermont State Health Assessment (June 1, 2018), *available at* <https://www.healthvermont.gov/sites/default/files/documents/pdf/VT%20State%20Health%20Assessment%202018%20Full%20Report.pdf>.

⁷ National Institute on Deafness and Other Communication Disorders, Quick Statistics About Hearing (2021), <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing>.

afford conventional hearing aids. Individuals with hearing loss are more likely to be unemployed or partly unemployed, less likely to have any wage income, and likely to earn a lower wage than those without hearing loss,⁸ resulting in greater economic inequality.

In addition to the socio-economic impacts, individuals with hearing loss are at elevated risk of several negative health outcomes. Studies suggest hearing loss is associated with an increase in psychological distress and utilization of mental health services in adults,⁹ as well as substance use disorders¹⁰ and age-related hearing loss is associated with cognitive decline, cognitive impairment, and dementia.¹¹ For children, the inability to access hearing aids has a detrimental impact on development in many respects. Overall, hearing loss and disabilities disproportionately impact people of color, LGBTQ adults, as well as older Vermonters. Adding a hearing aid benefit would make hearing aids more accessible, affordable, and support health and economic equity for individuals with disabilities.

Infertility Coverage

The current Vermont EHB benchmark plan covers diagnosis for infertility but does not cover treatment for infertility. Currently 15 states have mandates which cover infertility including Colorado which will include infertility treatment in 2022 through its own benchmark plan change.¹² While infertility treatment can be hugely beneficial for individuals who require fertility assistance, low utilization and a limited number of providers offering in vitro fertilization (IVF) can make the benefit expensive to provide. Because infertility treatment does not directly help restore or maintain the patient's health or prevent the reasonably likely onset of a health problem, most health insurers do not consider it medically necessary even if it is not specifically excluded from coverage.

Infertility is often defined as the inability to conceive during a specified period of time.¹³ Infertility can impact both men and women. Impaired fecundity is the condition wherein it is difficult for a woman to get pregnant or to carry a pregnancy to term whereas iatrogenic infertility is a result of a medical procedure to treat another condition, such as cancer.

Infertility affects 10-15% of heterosexual couples with 6% of married women in the U.S. reporting experiencing infertility. Treatment for infertility can include medication to induce ovulation, surgery to repair anatomical or physiological issues, intrauterine insemination, assisted reproductive technologies

⁸Jung D. and Bhattacharyya N., *Association of Hearing Loss with Decreased Employment and Income among Adults in the United States*, 121 *Annals of Otolaryngology & Laryngology* 12, at 771-775 (Dec. 2012).

⁹ Bigelow R.T., et al., *Association of Hearing Loss With Psychological Distress and Utilization of Mental Health Services Among Adults in the United States*, 3 *JAMA Netw Open*. 7 (July 20, 2020), available at <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2768374>.

¹⁰ Michael M. McKee, et al., *The Relationship Between Hearing Loss and Substance Use Disorders Among Adults in the U.S.*, 56 *Am. J. Preventive Med.* 4, Volume 56, Issue 4, 2019.

¹¹ Loughrey DG, Kelly ME, Kelley GA, Brennan S, Lawlor BA. Association of Age-Related Hearing Loss With Cognitive Function, Cognitive Impairment, and Dementia: A Systematic Review and Meta-analysis. *JAMA Otolaryngol Head Neck Surg.* 2018;144(2):115–126.

¹²Gabriela Weigel, Usha, Ranji, Michelle Long, and Alina Salganicoff, Issue Brief, *Coverage and Use of Fertility Services in the U.S.*, Kaiser Family Foundation (Sep. 15, 2020), available at <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s>.

¹³ Loretta Gavin, et al., *Providing Quality Family Planning Services Recommendations of CDC and the U.S. Office of Population Affairs*, 63 *MMWR* 4, at 15 (Apr. 25, 2014), available at <https://www.cdc.gov/mmwr/pdf/rr/rr6304.pdf>.

(ART), including IVF and fertility preservation services. According to the Centers for Disease Control and Prevention, ART accounted for 2.1% of all infants born in the United States in 2019.¹⁴ The ART rate in Vermont is above the national average, with 414 ART procedures performed in 2019 or 3,619 ART procedures performed per 1 million women aged 15–44 years.¹⁵

Alignment with Health Care Reform Goals

While not closely aligned with health care reform goals in the state, adding infertility treatment may contribute to the overall wellbeing of individuals and lower the risk of certain chronic conditions.¹⁶ Infertility benefits have historically been designed around heterosexual relationships; inclusion of benefits such as donor and surrogacy services can create equity between those in heterosexual relationships and those in same-sex or other non-heteronormative relationships who are unable to build a family without the assistance of ART.¹⁷

Dental and Vision Care

Currently the benchmark plan covers pediatric dental and vision services. Under 45 C.F.R. § 156.115, non-pediatric dental services and non-pediatric eye exam services are prohibited from being considered as an EHB.¹⁸ Therefore, the State would be unable to add adult dental and adult vision as a benefit through the benchmarking process. If the state wants to include adult dental and adult vision services in the benchmark plan a legislative mandate requiring the coverage in the individual and small group market would need to be put in place and would require the state to defray the costs of these services.

Adult dental and vision benefits were considered as an addition to the benchmark plan. Act 74 asked the Department to specifically consider dentures. During the analysis and consultation with experts in the benefit area, it was suggested from a model of care perspective that saving teeth rather than replacing them is preferred when considering a dental benefit. Providing a preventive dental benefit such as two annual cleanings would have a greater impact on Vermonters' oral health as opposed to dentures, a benefit which is mostly needed due to lack of regular dental care. Generally older people are more likely to need dentures, making a preventative dental benefit more relevant to the population enrolled in the exchange where many older adults switch to Medicare upon their 65th birthday.

An estimated 93 million adults in the United States are at high risk for serious vision loss, but only half visited an eye doctor in the past 12 months. People with vision loss are more likely to report depression, diabetes, hearing loss, stroke, falls, cognitive decline, and premature death. Decreased ability to see often

¹⁴ Centers for Disease Control and Prevention, State-Specific Assisted Reproductive Technology Surveillance (Dec. 27, 2021), <https://www.cdc.gov/art/state-specific-surveillance/index.html#key>.

¹⁵ Centers for Disease Control and Prevention, State-Specific Assisted Reproductive Technology Surveillance 2019 Data Brief (Oct. 2021), available at <https://www.cdc.gov/art/state-specific-surveillance/2019/pdf/State-Specific-ART-Surveillance-U.S.-2019-Data-Brief-h.pdf>.

¹⁶ Murugappan G., et al., *Increased risk of incident chronic medical conditions in infertile women: analysis of US claims data*, 220 Am. J. Obstet. Gynecol. 5 at 473.e1-473.e14 (May 1, 2019).

¹⁷ See David Kaufman, *The Fight for Fertility Equality*, N.Y. Times, at D1 (July 23, 2020), available at <https://www.nytimes.com/2020/07/22/style/lgbtq-fertility-surrogacy-coverage.html>.

¹⁸ 45 C.F.R. § 156.115, available at <https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-B/section-156.115>.

leads to the inability to drive, read, and travel in unfamiliar places, thus substantially compromising quality of life. The cost of vision loss, including direct costs and lost productivity, is estimated to exceed \$35 billion nationally. Typical adult vision benefits include services such as a dilated eye exam and associated vision materials such as glasses' frames and lenses, and contact lenses.¹⁹

Alignment with Health Care Reform Goals

A dental benefit would be widely beneficial to policyholders and align well with state health policy goals. Oral health is a top priority under the State Health Improvement plan and is an essential and integral component of overall health throughout life.²⁰ In 2016, 73% of adults ages 45-64 with disabilities have lost at least 1 tooth to decay or gum disease. Integrating a preventive dental benefit into the benchmark plan would make oral health more accessible and affordable.²¹ Coverage of vision services would also align with the high-level population health improvement goals contained in the All-Payer ACO Model Agreement. As noted above, vision loss can contribute to poor health outcomes.

Durable Medical Equipment

Durable Medical Equipment (DME) is currently a covered benefit under the existing Vermont Benchmark Plan. DME is an essential health benefit under the rehabilitative and habilitative services and devices category. DME is equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of an illness or injury and is appropriate for use in the home.²²

After hearing from interested parties and working group members, there was a consensus that the current DME benefit did not need expansion. Concerns were raised regarding the prior authorization requirements and availability of DME due to current supply chain issues. The Department of Financial Regulation plans to examine the current prior authorization requirements to ensure the DME benefit is readily accessible to those who need it.

Medically Tailored Meals and Nutritional Counseling

Medically tailored meals are not currently a covered benefit in the Vermont benchmark plan. Food has historically not been a common benefit under health insurance coverage, but there is a growing body of

¹⁹ Centers for Disease Control and Prevention, Fast Facts of Common Eye Disorders (June 9, 2020), <https://www.cdc.gov/visionhealth/basics/ced/fastfacts.htm>.

²⁰ Vermont Department of Health, Health Report, *Burden of Oral Disease in Vermont* (2013), available at https://www.healthvermont.gov/sites/default/files/burden_of_oral_disease.pdf.

²¹ Vermont Department of Health, *Vermont State Health Improvement Plan*, at 15 (Dec. 31, 2018), available at https://www.healthvermont.gov/sites/default/files/documents/pdf/ADM_State_Health_Improvement_Plan_2019-2023.pdf.

²² Social Security Administration, Program Operations Manual System (POMS), HI 00610.200 Definition of Durable Medical Equipment, available at <https://secure.ssa.gov/poms.nsf/lnx/0600610200>.

research demonstrating that food used as a medical intervention can be a powerful tool for improving health outcomes, especially for those who have chronic conditions such as diabetes and heart disease.²³

Medically tailored meals are meals developed to address a dietary need of an individual's medical condition. Other models of food as medicine are medically tailored food packages and nutritious food referrals. Medically tailored meals, while present in some commercial health insurance markets, would be a novel benefit for inclusion as an EHB. More research is needed at this point to consider adding medically tailored meals to Vermont's benchmark plan.

Alignment with Health Care Reform Goals

According to the Vermont Department of Health, food insecurity impacts 10% of Vermonters in 2017.²⁴ Food insecurity is defined as the uncertain ability to obtain healthy food because of financial or access limitations.²⁵ Food as medicine programs can be effective and low-cost methods for improving health outcomes and lowering health care utilization. Prescription drugs, such as insulin, used to treat chronic conditions are a leading driver of health care costs. Integrating a food benefit to help prevent the utilization of expensive drugs, would help move Vermont towards a more affordable health system.

Food insecurity is a root cause of chronic conditions, and individuals experiencing food insecurity are 65% percent more likely to be diabetic and 66% more likely to have a heart attack or heart failure.²⁶ Here in Vermont, 64% of adults had at least one chronic disease in 2016, costing \$2.17 billion in that same year. Being overweight or obese increases the risk for serious illnesses and chronic conditions such as diabetes, heart disease, and some cancers. Today, Vermonters are more likely to die from largely preventable chronic diseases than from an infectious disease. Poor nutrition contributes to the development and severity of chronic conditions.

Primary Care

The legislature also asked the Department to look at the impact of eliminating cost share for two primary care visits. Currently under the benchmark plan, one preventative annual visit is covered without cost share and a few non-standard plans offer more than one visit without cost-share.²⁷

Primary care services are defined as:

²³ Harvard Law School, Center for Health Law and Policy Innovation, Presentation, *Food is Medicine: Peer-Reviewed Research in the U.S.* (Dec. 2020), available at https://chlp.org/wp-content/uploads/2013/12/Food-is-Medicine_Peer-Reviewed-Research-in-the-U.S.1.pdf.

²⁴ Vermont State Health Improvement Plan, *supra* note 21, at 14.

²⁵ America's Health Insurance Plans, Issue Brief, Access to Healthy Foods: Social Determinants of Health (May 2018), available at https://www.ahip.org/wp-content/uploads/2018/05/HealthyFoods_IssueBrief_4.18_FINAL.pdf.

²⁶ Feeding America & the National Foundation to End Senior Hunger, The Health Consequences of Senior Hunger in the United States: Evidence from the 1999-2014 NHANES, at ii (Aug. 16, 2017), available at <https://www.feedingamerica.org/sites/default/files/research/senior-hunger-research/senior-health-consequences-2014.pdf>.

²⁷ Insurers are allowed to offer non-standard plans and contain benefits which can deviate from the standard benchmark plan benefit design. See 33 V.S.A. § 1806.

Health services provided by health care professionals who are specifically trained for and skilled in first-contact and continuing care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis, and includes pediatrics, internal and family medicine, gynecology, primary mental health services, and other health services commonly provided at federally qualified health centers. Primary care does not include dental services.²⁸

Primary care is most of the care that people receive and has been shown to improve health outcomes, lower costs across the health care system, and improve quality of care outcomes. Promoting utilization of preventive services, such as primary care, reduces downstream costs and preventable disease and death. Evidence shows that higher overall spending on primary care has led to better health outcomes and lower spending on chronic conditions.²⁹

The benchmarking process allows states to add benefits which are currently not included in the state's benchmark plan. The process does not impact the associated cost share a benefit will be subject to. Primary care is currently a covered benefit, and therefore adjusting the cost sharing level is a process that is not a covered change under the benchmarking process described in Section II above. The Standard QHP Design Working Group address plan design, and adjustments to cost shares. The group is currently considering a change to the standard out of pocket cost for primary care visits. Important to note is high deductible health plans are now allowed to cover non-preventive services prior to the deductible being met.³⁰ If the State were to allow for two primary care visits to be covered at no cost share, the change would only be impactful for plans without a high deductible.

V. Findings

Plan and Benefit Analysis

Wakely Consulting performed the Typicality and Generosity testing on behalf of the Department. These tests involve an actuarial analysis to determine whether the plan with the incorporated changes would be equal to a typical employer plan but no more generous than the richest plan available. To add benefits to the current benchmark plan under the generosity test, the benefits to be added must not exceed the actuarial value of the richest plan. This analysis provides the amount of actuarial value or the "room" available to modify benefits.

Among the benchmark plan options, the State Employee Health Plan was identified as the richest plan, and therefore was used to determine how much value could be added to the current plan. Effectively the State plan places the ceiling on how much value of EHBs can be added to the current plan. Wakely determined a range between 1.58% and 2.29% of allowed cost available for additional benefits.

²⁸ Act 54 of 2015, Sec. 17, available at

<https://legislature.vermont.gov/Documents/2016/Docs/ACTS/ACT054/ACT054%20As%20Enacted.pdf>.

²⁹ Shi L., *The impact of primary care: a focused review*, Scientifica (Cairo) at 432892 (Dec. 31, 2012), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3820521/>.

³⁰ See 26 U.S.C. § 223.

Discriminatory Benefits

The value of each benefit being considered for inclusion in the 2024 benchmark plan was considered. During the analysis, four potentially discriminatory benefit designs were identified within the existing benchmark plan. Federal law prohibits Qualified Health Plans from containing any design benefit which could discourage enrollment of individuals with significant health needs.³¹ These benefits and the subsequent changes will not be counted towards the generosity test but must be changed to comply with Federal law. The benefits to be adjusted to comply with nondiscrimination requirements are as follows:

- *Nutritional Counseling* - The current benefit states the benefit is unlimited for diabetics but limited to 3 for all others. The change would remove the limitation for policyholders without diabetes.
- *Habilitative* - The current benefit states that the limit does not apply to policyholders under age 21 for treatment of Autism. The change would remove the age limit.
- *Foot Care* - The current benefit excludes foot care except for diabetics. The change would cover foot care for all individuals.
- *Prescribed Food and Nutritional Formulae* - The current benefit excludes coverage except for inherited metabolic disease; to render this benefit non-discriminatory, the State could exclude coverage unless medically necessary for any condition and regardless of age
 - This includes formulas or supplements administered through a feeding tube
 - Also includes 100% amino acid formula, which is currently limited to children under age 5 but age limit would be removed

Essential Health Benefits

Based on the analysis and public process above, hearing aids, infertility coverage, and medically tailored meals were further analyzed, and their financial impacts modeled, for inclusion as new EHBs.

The hearing aid benefit design was modeled on the Vermont Medicaid benefit. The benefit would cover adult and child hearing exams and allow for hearing aids every 3 years subject to medical necessity. Only 11 states explicitly require coverage for adult hearing aids, with over 36 states requiring some level of coverage for children. Many states are adjusting coverage to eliminate age barriers for coverage, which are specifically prohibited under the Affordable Care Act. Vermont and Pennsylvania are the only two Northeast states which do not currently require hearing aid coverage. It is estimated a hearing aid benefit in Vermont would add an additional \$0.30 to \$0.60 per member per month (PMPM) in average market premium.

An infertility benefit was also considered. Infertility benefits are currently covered in most New England states but to varying degrees. Currently the Vermont state employee health plan provides an infertility benefit which served as the model benefit for the working group's analysis. Due to the Vermont plan containing a dollar limitation, it was necessary to equate a quantitative limit for this benefit outside of a dollar limitation. The benefit definition would include coverage for three cycles of IVF, including evaluation, counseling, egg preservation, and other related services. Adding infertility coverage with that definition would add between \$8.00 to \$11.40 PMPM to the average market premium.

³¹ 42 U.S.C. § 18022.

Medically tailored meals would be a novel benefit as an EHB addition. Several variations of a medically tailored meal benefit have been analyzed. More analysis is needed to determine an appropriate benefit for the benchmark plan. A pilot program may be the most reasonable way to introduce such a benefit to obtain Vermont-specific data and better understand the program's influence on the specific market under consideration. The cost impact for adding medically tailored meals as an EHB could vary and more analysis is needed.

Non-Essential Health Benefits

The working group also analyzed additional benefits which are not eligible to be EHBs. Those benefits included adult dental and vision. The benefits were priced to inform any future addition of these benefits through legislative action.

Cost estimates for both a preventive dental and denture benefit were calculated. The preventive benefit including a cleaning and exam every 6 months and adult dentures would increase allowed costs between 1.3% and 1.9%.

An adult vision benefit including an eye exam and eyeglasses or contacts every two years would result in paid costs between 0.6% and 1.0% depending on limits and cost sharing applied.

In addition to considering the above benefits, the working group looked at adding two primary care office visits without member cost-sharing. Because primary care visits are already covered in Vermont's EHB Benchmark Plan, adding the benefit would constitute an adjustment to cost-sharing that could be implemented in the QHP design process. Adding first dollar coverage for two primary care visits would also require the coverage for non-specialist mental health and substance use disorder visits. Changing cost share for a benefit has an impact on the actuarial values of plans and would require the premiums or cost sharing for other services to be increased to offset the impact to the actuarial value.

Conclusion

After considering several benefits, the Department determined that hearing aids, infertility services, and medically tailored meals could be added to the EHB benchmark plan through the federal process. Further research is needed to determine an appropriate benefit design for medically tailored meals. When adding benefits, consideration must be given to cost impact and the overall benefit to the impacted population to ensure that Vermont's benchmark plan is affordable, accessible, and promotes equity among diverse health needs and populations in Vermont.