BlueCross BlueShield of Vermont
An Independent Licensee of the Blue Cross and Blue Shield Association.

BERLIN HQ
445 INDUSTRIAL LANE
BERLIN, VERMONT 05641

P.O. BOX 186
MONTPELIER
VT 05601-0186

800 247 2583
800 922 8778
802 255 4550

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To: Chair Lyons and Members of the Senate Health and Welfare Committee

From: Sara Teachout, Director of Government Relations

RE: S.132 an act relating to health care reform implementation

Blue Cross believes that together we can build a transformed health care system in which every Vermonter has health care coverage, and receives timely, effective, affordable care. Towards this vision, we are a collaborative partner in the state's many health care reform efforts. This is best accomplished by payers, providers, and state government all working together to achieve these goals. The legislation you are considering, **S.132**, modifies many of our health care reforms. Our comments on the sections pertaining to health insurance and our role in these efforts are included below.

Sections 1-2: AHS to coordinate all State initiatives relating to health care reform
State government spearheading our state's health care reform initiatives is vital for success. Vermont's current health care oversight structure, with multiple separate divisions of state government all overseeing different and overlapping aspects of regulation, reform implementation, and operational issues is administratively cumbersome, complex, and expensive. One state entity should be designated to create the future reformed health care system and another to focus on regulating the current system. Oversight of reform and regulation both at the GMCB are in conflict, with the regulatory focus merely on financially constraining all aspects of the health care system – mainly the hospitals and the insurers – while simultaneously expecting investments in new reform initiatives including technology, programming, risk sharing, data and administration.

Blue Cross supports having one consistent and coordinated approach for all Vermont's myriad health care reform efforts and centralizing these decisions and leadership at Agency of Human Services could help unite these efforts. Conversely, consolidating the state's health insurance regulatory functions at the Department of Financial Regulation would also enable efficient and effective government regulation, in coordination with state health care reform objectives and under the umbrella of all insurance regulation and guidance of the National Association of Insurance Commissioners (NAIC). The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators across the country to establish standards and best practices, conduct peer review, and coordinate regulatory oversight across the states.

Section 3-4: Accountable Care Organizations
The All Payer Model (APM) is the state's priority health care reform effort through the federal agreement with CMS/CMMI that requires the work to be organized through an accountable care organization (ACO) through the end of the five-year waiver period. Health care reform, including both payment and delivery system reform, is a difficult and agonizingly slow process as we have watched with frustration here in Vermont. It takes time and dedication to organize our health care system on a voluntary basis, and the unfortunate setback of the COVID pandemic during

critical performance years certainly impacted the successes we anticipated. Transparency and accountability are paramount to this effort and Vermonters deserve to understand and review the work of these organizations. Nonetheless, the constant interference, realignment of priorities, and myriad of statutory interventions, additions, and modifications serve to distract and dilute the focus of the ACO on the important work of delivery system reform.

Section 8: GMCB review of health care contracts and fee schedules

Blue Cross has substantial concerns regarding the contracting provisions proposed in S.132 which would cause significant system disruption and add additional costs to ratepayers, without a clear benefit.

The Department of Financial Regulation (DFR) currently has regulatory authority over insurer-provider contracts in order to protect consumers, ensure fair negotiations between both parties to these agreements, and regulate fair contracting standards. This proposal creates a duplicate system of review at the Green Mountain Care Board (GMCB) where additional staff, resources and expertise would be required. These new costs are borne by Vermont ratepayers as the GMCB would "billback" to the health insurers, adding charges to premiums.

Contract and fee schedule review is no small task. In addition to contracts with the 14 hospitals, Blue Cross has over 2,000 provider contracts. The goal of this additional regulatory oversight is not explicit in the draft language, only the directive to adopt "rules and standards" for contract and fee schedule review. The GMCB already has broad regulatory authority over many aspects of the state health care system, and including direct oversight and approval of all payer contracts is a labor intensive undertaking whose goals are vague and may be better achieved through a different avenue or approach.

Section 9: Elimination of confidentiality, 120-day minimum review period, and mandatory two-year contracts

The elimination of contract confidentiality provisions would create an unequal competitive environment for health insurers regulated by the GMCB who compete against national competitors without GMCB oversight and are not required to release contract and fee schedule information publicly. This would put Blue Cross at a distinct disadvantage for future provider negotiations, challenging our ability to attract new members and expand our policy risk pools, effectively driving up rates for our members.

The requirement for 120-day period for contract consideration and negotiation is unnecessary. Blue Cross has no limit on consideration for initial contracts and allows 60-days for modifications. A statutory 120-day consideration period for contract terms may slow the timely execution of contract provision updates. Provider contracts are "evergreen" meaning they do not expire or change until a new contract is executed.

The GMCB conducts health insurance rate review and hospital budget approvals annually and therefore two-year contract requirements cannot be consistent with GMCB orders.

Section 10: GMCB Report on Contract and Fee Schedule Oversight
If the Legislature and the GMCB intend to pursue contract and fee schedule oversight, the report required here should be conducted *before* the statutory implementation language in Section 8 (effective April 2022) becomes law so that adequate staff and resources are dedicated to the project, and the additional administrative burden can effectively be written into rates. There should also be an evaluation of whether this addition to the GMCB regulatory scope will achieve the specific goals in an efficient manner that will add value to the health care system and not duplicate the existing DFR regulatory authority.

Section 11: Durable Medical Equipment
Durable medical equipment (DME) and medical implants is an area of health care that could benefit from public scrutiny and oversight, but we would recommend a different approach. The focus should be the reasons for the exorbitant costs of this equipment and the financial transactions between DME suppliers and providers that were cited in this recent *Health Affairs* article Medical Device Firm Payments To Physicians Exceed What Drug Companies Pay Physicians, Target Surgical Specialists.

DME coverage and benefit information is included in all of the forms and benefit documents approved by DFR and provided to members. Blue Cross has never prevented information about costs and options from being shared with our members such as through "gag" clauses.

Our goal is to ensure that our members are able to live a full and healthy lives. The MSRP of a 2021 Tesla Model 3 is $38,490. It is baffling that the cost of wheelchair can easily approach $60,000. Every foot pedal and arm rest costs thousands more than the sum of its parts. The exorbitant prices of durable medical equipment is should be addressed rather than constantly shifting from cost-share to premiums. Since 2016, the cost per member per month (PMPM) of wheelchairs alone has increased by 41% - over 10% per year. We strongly encourage the committee to address the root costs of DME and ask why a wheelchair costs nearly twice a Tesla.

Section 12: Hearing Aids
The addition of hearing aids to health insurance coverage is one of a large list of priority health coverage expansions identified in draft legislation in recent years. The cost of these numerous additions to health care coverage should be balanced by the impact these expansions will inevitably have on the increase in premiums. Hearing aids are an especially pricy expansion (more on this later). This proposal includes no out-of-pocket patient cost share and is unlimited except by medical necessity. Legislation needs to consider both access and affordability. A thorough actuarial analysis and inclusion of hearing aid costs in the approved health insurance rate increases is absolutely necessary. Public input and consideration of the financial impact of including hearing aids in the state's Benchmark plan is a welcome approach.

The effective date of January 1, 2022 for including hearing aids in the non-Vermont Health Connect plans is not possible. The rates for the large group fully insured plans are already submitted and being reviewed by the GMCB and we anticipate a final rate decision for the 2022 plan year imminently.

If you are not already aware, the FDA is sitting on authority to approve broader technology for hearing aids, and the market is waiting in the wings to step into this space with affordable alternatives (see NYT article: Hearing Aids for the Masses). This is a classic example of a federal mandate that is artificially limiting competition and inflating costs for consumers. Rather than just adding these costs to health insurance premiums, Vermont should push the FDA to approve new technologies.

Section 16: GMCB report on increases in health insurer administrative expenses.
Information about health plan administrative costs is already publicly available in both the GMCB rate filings and the annual financial statements provided to DFR.

Any additional report should contain further context such as the administrative costs of regulation, reporting, taxes and fees in Vermont that are also increasing non-health care costs for consumers. For example, the amounts from the GMCB billed to Blue Cross have increased 136% between 2014 and 2021. In 2014, Blue Cross paid $627K to support the GMCB's activities. Today the payment has increased to $1.5 million in 2021 or 19.5% per year increase on average. Additionally, shifting the responsibility for billing from DVHA to the carriers is moving the cost for this service from the state to ratepayers and will now be a component of health insurer administrative expenses. These state-controlled components of insurer administrative expenses should be recognized as a cost driver to Vermont ratepayers.

Section 19: Reports on primary care cost sharing
Each of these reports will require extensive data and actuarial analysis which will have a cost that is not considered here to the entity required to provide the report to the Legislature.

In conclusion, many of the components of this proposed Legislation are significant endeavors on their own. As a package these proposals—some of which may have conflicting goals—could have a costly and disruptive impact on the state health care system, specifically our state health care reform initiatives.