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Dear Chair Lyons and Members of the Senate Health and Welfare Committee,

The Blueprint for Health's support of care coordination and other programs within the Vermont health care system was a novel approach 14 years ago, but these programs have failed to integrate with concurrent health reform efforts and continue to lack detailed reporting to ensure transparency and the ability to accurately measure quality outcomes. Vermonters must spend their limited health care dollars wisely and efficiently. Increasing funding for this program in the current environment will exacerbate health care costs and compound the enormous pressures on health care premiums.

In calendar year 2021, our member premiums reflected $7.32 million paid into the Blueprint program, and over $67.3 million since its inception. This is a massive amount of funding for a program that cannot provide patient-level reporting data. The Legislature's consultant, Health Systems Transformation LLC, did not recommend an immediate increase in Blueprint payments but instead suggested (page 41) improving the use of claims and patient-level data to make the connection to ongoing return on investment (ROI) analysis. Additionally, "ROI analysis will promote the uptake of Blueprint services, inform payer rate setting, and enable targeted quality improvement efforts." The proposal in S.285 (version 1.2) implements none of these improvements, but instead requires higher payments without any program evaluation, reporting or targeted efforts, further undermining the programs' credibility. Transparency is often cited in the Senate Health and Welfare Committee. An alternative approach to this legislation that focuses on evaluation would significantly increase the transparency of our health care system.

Blueprint has devolved into a narrowly funded program. Originally a number of self-funded employers, many in the health care arena, voluntarily participated, but there has been a continued exodus from the program due to the lack of quality reporting and clarity of outcomes leaving only a handful of self-funded Blue Cross customers contributing. Raising the required per member per month (PMPM) contribution will only increase the pressure on the few remaining employers who voluntarily participate as well as continuing to drive up the monthly cost of premiums for the narrow population of Vermonters who purchase qualified health plans.

Our state's health care programs cannot continue to rely on the shrinking pool of fully-funded commercial insurance plans to pay for the state's systemwide health care reform initiatives. These programs must prove their value in order to have broad financial support. This proposal to increase Blueprint payments is premature, increasing funding

immediately, without following the advice of your consultant to first analyze whether these programs have significant quality outcomes, or whether the Blueprint is prepared to administer additional programs with clear quality metrics.

Vermont's health care reform is in a state of flux. The future of the All Payer Model uncertain and new reform efforts focused on Global Hospital Budgets, among a myriad of other changes being considered this session. The proposal to expand Blueprint is putting the cart before the horse. We should not be asking Vermonters to pay more into a system whose future structure and value is not currently defined or demonstrated.

There are enormous upcoming pressures on health care premiums ranging from relatively small changes to some that will have a significant impact – but each one will result in steadily higher, not lower costs for Vermonters with commercial health insurance coverage. Cost pressures include areas both within and outside of the Legislature's control. Health care policy involves numerous choices and must consider affordability implications equally with access.

- Hospital budgets and their commercial charges are the highest since the GMCB was created. The GMCB is anticipating mid-year hospital budget increases followed by requests in the high teens to 20% in 2023. Expenses, such as the impactful 20% increase in nurses pay at the University of Vermont Medical Center cannot be borne by commercial rate payers alone.

- The Essential Health Benefits Benchmark Plan project resulted in a group of changes to plans for 2023 including three no-cost share primary care and mental health care visits as part of every standard plan, eliminating this as a consumer choice in benefit design. The addition of hearing aids to the benefits in in 2024 is an expensive addition and does not include estimates for the impact of pent-up consumer demand on premiums.

- Ongoing health care reform investments, information technology and data sharing requirements, and the constantly changing direction of the All Payer Model from a focus on achieving scale to fixed prospective payments, a possible move towards Global Hospital Budgets, and the uncertain future of Vermont's waiver agreement with the federal government all have significant system costs.

- Legislative proposals in S.244 mandate a higher percentage of primary care spending would be more likely to increase the total cost of care rather than the intended goal of moving spending to primary care from specialty care or hospital administration. These conversations are happening while we are leaning into value

based payments for primary care programs like the Vermont Blue Integrated Care and other innovative supports for primary care that clearly improve quality outcomes for our members.

- Prescription drug manufacturer price increases continue unabated and H.353, the Pharmacy Benefit Manager (PBM) bill would limit our leverage to negotiate for better drug prices.

- All of this is in addition to the ongoing costs of the COVID-19 pandemic—directly in testing and treatment and indirectly in federal and state emergency rules and regulations—that continues to be funded out of member reserves and is not yet included in premiums. For example, the cost of covering over the counter antigen tests could reach millions of dollars per month with the cumulative numbers becoming staggering.

Given the broad concerns around premium costs and out-of-pocket expenses for Vermonters, we support the development of outcome measures for Blueprint and integration into a large reform vision before arbitrarily expanding the funding.

Each addition and expansion increases the pressure on rising premiums and limits individuals' and employers' ability to purchase health insurance coverage. Collectively every policy change we make must balance both choice and cost to Vermonters, taking into consideration the full spectrum of income, health status, and access to care statewide. We have yet to see a single policy proposal this session that addresses health care affordability. Instead, each proposal further exacerbates the costs to Vermont families who are caught in the middle.

Sincerely,

Sara Teachout
Corporate Director, Government and Media Relations
Blue Cross and Blue Shield of Vermont