VERMONT

State of Vermont
Green Mountain Care Board

Process for Non-Standard QHP Proposal Review

1. Beginning February 1, 2020, and annually thereafter, the Green Mountain Care Board (GMCB or Board) shall approve evaluation criteria for the review of non-standard qualified health plan (QHP) designs. If the GMCB has taken no action to approve evaluation criteria by May 1st, the most recently approved evaluation criteria shall be deemed approved for the next QHP certification cycle.[1]
2. Early in the annual QHP certification cycle, but no later than 30 days prior to the form filing deadline, issuers must notify the Department of Vermont Health Access (DVHA) of their intent to propose a new non-standard QHP or modify an existing non-standard QHP. In the event the federal Draft Notice of Benefit and Payment Parameters or the Draft Actuarial Value Calculator is not published by January 15th, this deadline may be extended upon request.
3. Following notification from the issuer, DVHA will facilitate a meeting or meetings with the issuer and state agencies to discussthe proposal (as needed). DVHA and the Department of Financial Regulation (DFR) may request that the issuer present qualitative and quantitative information regarding the proposed plan or plan changes in order to address potential form filing or certification issues.
4. If the proposal is for significant changes to an existing plan or to sunset an existing plan, the issuer, prior to form filing, must also provide DVHA and DFR with a preliminary proposal for plan mapping for current enrollees in the affected plan for the upcoming annual open enrollment period.
5. Whether proposed changes to an existing plan constitute "significant changes" shall be determined by DFR. Modifications to non-standard QHPs which are permitted under the "exception for uniform modification of coverage" provision of 45 CFR § 147.106(e) do not constitute "significant changes" for purposes of this process (i.e., cost share adjustments to plans which constitute uniform modifications are not subject to Board review under this process).
6. Issuers shall present proposals for new plans and significant changes to existing plans to the GMCB no earlier than forms are filed with DFR and no later than April 15th. Proposals will remain confidential until forms are filed with DFR.
7. Issuers must present qualitative and quantitative information demonstrating the value the proposed plan or plan changes would add to the Vermont market, including but not limited to the evaluation criteria approved by the GMCB.
8. Issuers shall be notified of the presentation date at least 30 days in advance and all proposals must be presented on the same day.
9. After considering the information presented to the GMCB, the GMCB shall approve proposals for new plan designs and significant changes to existing plan designs that add value to the Vermont marketplace. In the event the Board does not approve a proposed plan design, the issuer may file a request for reconsideration with the Board within 10 days of the Board's order. In the alternative, the issuer may refile forms with DFR for its currently approved plan design or its currently approved plan design with modifications that do not exceed those permitted under the "exception for uniform modification of coverage" under 45 CFR § 147.106(e).

[1] Evaluation criteria for non-standard plan designs for the 2021 plan year shall be approved by the GMCB no later than February 15, 2020.

10. The GMCB's approval of non-standard plan designs does not guarantee form approval by DFR or certification by DVHA.
11. This process does not eliminate any of the other existing criteria or guiding principles factoring into certification. Final selection of a qualified health plan is at the discretion of the DVHA commissioner prior to open enrollment each year (see 33 V.S.A. § 1806).

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Evaluation Criteria - Non-Standard QHPs

The GMCB shall use the following criteria when determining whether new non-standard plan designs or significant changes[1] to an existing plan design would add value to the Vermont marketplace:

	Criteria	Examples
1	Substantial difference in deductible and/or maximum out of pocket compared to standard plans	Substantial differences in one or more of the following: • Medical deductible • Rx deductible • MOOP
2	Substantial cost share difference for one or more highly utilized services compared to standard plan designs	Specific cost sharing for high utilized services could be adjusted by changing the applicability of the deductible, changing the amount of cost share, or changing whether the cost sharing is coinsurance or copay.
3	Plan structure difference compared to standard plan designs	Change from co-payment to co-insurance (or vice-versa) for inpatient, outpatient, primary care visits, or specialty care visits.
4	Enhances innovation	Promotes preventative health care financial incentives or optimal service delivery location, consistent with and to the maximum feasible extent in support of current health reform goals, with particular emphasis on statewide health outcomes and quality of care targets, especially those addressing chronic conditions.
5	Adds value to the Vermont individual and small business health insurance market	Provide market analysis and other evidence of how the proposal fills a gap in the individual or small group market

Effective Date: February 5, 2020

[1] Modifications to non-standard QHPs which are permitted under the "exception for uniform modification of coverage" provision of 45 CFR § 147.106(e) do not constitute "significant changes" for purposes of the Board's review (i.e., cost share adjustments to plans which constitute uniform modifications are not subject to Board review).