COMMISSION ON HEALTH CARE REFORM

MINUTES
December 2, 2008

4th Floor Conference Room
Pavilion Building

AGENDA

1. Convene, Review and Approve 11/6/08 Meeting Minutes

2. Pharmacy initiatives: a) Review of legislative initiatives
   Jennifer Carbee, Legislative Council

   Pharmacy initiatives: b) Counter-detailing
   Liz Cote, AHEC Program director, UVM College of Medicine

   Pharmacy initiatives: c) OVHA preferred drug list, multi-state purchasing and PBM
   Joshua Slen, Director, OVHA

   Pharmacy initiatives: d) 340B pharmacies
   Hunt Blair, Director of VT Public Policy,
   Bi-State Primary Care Association

3. Health Care Reform Implementation: a) Personnel changes
   Susan Besio, Director of Health Care Reform Implementation

   Health Care Reform Implementation: b) Framework for evaluating health reform
   Susan Besio, Director of Health Care Reform Implementation

   Health Care Reform Implementation: c) Health IT fund revenues
   Susan Besio, Director of Health Care Reform Implementation

   Health Care Reform Implementation: d) Green Mountain Care income eligibility
   Betsy Forrest, Health Care Affordability Project Director, OVHA
   and premiums

   Health Care Reform Implementation: e) Green Mountain Care enrollment concerns
   Peter Sterling, Executive Director,
   Vermont Campaign for Health Care Security

4. Approval of Statement on Health Care Costs
   Steve Kappel, Consultant to the Commission
   Don Dickey, Consultant to the Commission
5. Update on Commission Studies: Public financing study
   Steve Kappel, Consultant to the Commission
   Nick Rockler, Consultant to the Commission

MEMBERS PRESENT:
SEN. M. JANE KITCHEL, CO-CHAIR
REP. STEVEN MAIER, CO-CHAIR
SEN. ANN CUMMINGS
SEN. DOUG RACINE
REP. FRANCIS McFAUN
REP. MARK LARSON
JOHN BLOOMER, JR.
WALTER FREED

MEMBERS ABSENT:
REP. HARRY CHEN
SEN. KEVIN MULLIN

Also present: Legislative and Joint Fiscal staff, members of the Administration, and the public.
Meeting recorded: CD HCRC 12/02//08, CD # 1, 2 & 3

Documents distributed:
Doc. #2: The Vermont Academic Detailing Program, Fact Sheet—Liz Cote
Doc. #3: Vermont Academic Detailing Program, FY 09 Updates
Doc. #4: 340B Pharmacy & Vermont’s Community Health Centers
Doc. #5: Overview of Vermont Health Care Reform Evaluations, December, 2008—Susan Besio
Doc. #6: Memorandum to Joint Fiscal Committee: Report on Health IT Fund
Doc. #7: Catamount Health premium increase & $400 earned income disregard—Betsy Forrest
Doc. #8: Lessons from the Public: Steps to Increase Enrollment in Green Mountain Care: Summary of Recommendations—Peter Sterling
Doc. #9: Lessons from the Public: Steps to Increase Enrollment in Green Mountain Care
Doc. #10: Draft commission statement on unsustainable health care cost trends, Draft 1.4, Nov. 26 2008
Doc. #11: Comments from Rep. Topper McFaun re draft statement
Doc. #14: Current Economic Indicators—Kappel and Kavet

Witness list:
Jennifer Carbee, Legislative Council
Liz Cote, AHEC Program director, UVM College of Medicine
Joshua Slon, Director, OVHA
Hunt Blair, Director of VT Public Policy, Bi-State Primary Care
Susan Besio, Director of Health Care Reform Implementation
Steve Kappel, Consultant to the Commission
Jim Hester, Director of the Health Care Reform Commission
Betsy Forrest, Health Care Affordability Project Director, OVHA
Peter Sterling, Executive Director, Vermont Campaign for Health Care Security
Steve Kappel, Consultant to the Commission
Don Dickey, Consultant to the Commission
Nick Rockler, of Kavet and Rockler, Consultant to the Commission
1. **Convened at 1:08 PM**


[“Call to Action—Health Reform 2009: Reforming America’s Healthcare System: A Call to Action,” by Senator Max Baucus, D-Mont., Chair, Senate Finance Committee

The Minutes from Nov. 6, 2008 were approved.

2. **Pharmacy initiatives: a) Review of legislative initiatives**

   Jennifer Carbee, Legislative Council

   **Documents distributed:**

   Jennifer Carbee reviewed all of Vermont’s prescription drug initiatives to date. They include:
   - Medicaid, Dr. Dynasaur, VPharm, VHAP Pharmacy, VScript, and Health Vermonters.
   - Vt. Prescription Drug Purchasing
   - Controlling Prescription Drug Costs
   - Preferred Drug Lists (PDL)
   - Cost Containment Initiatives Related to Pharmacies and Providers
   - Cost Containment Initiatives Related to Drug Companies
   - Cost Containment Strategies

   Q: US prices vs. importation—changes due to currency devaluations?
   Q: Do we have evidence of the value of these various strategies (not just in the state programs)?
   Q: What do we need to do to capture this data re outcome measures?

2.b. **Pharmacy initiatives: b) Counter-detailing**

   Liz Cote, AHEC Program director, UVM College of Medicine

   **Documents distributed:**
   Doc. #2: The Vermont Academic Detailing Program, Fact Sheet
   Doc. #3: Vermont Academic Detailing Program, FY 09 Updates

   Liz Cote gave an overview of academic detailing:
   - Topics from AHEC’s presentations to providers
   - Teams and supporters
   - FY 09 YTD Snapshot—sessions delivered, evaluations, etc.
Scheduling a presentation session
- The Maine-Vermont-New Hampshire Initiative
- Data Mining and Act 80
- Manufacturer fee (still pending the Vermont lawsuit)
- New Hampshire’s Rx privacy law has just been upheld

Discussion re what it would take to expand this program to Rx for children: mostly, more funding. They are still trying to expand beyond the current eight counties, for the adult program.

2.c. Pharmacy initiatives: c) OVHA preferred drug list, multi-state purchasing and PBM
   Joshua Slen, Director, OVHA

Drug spending overall from 2007 to 2008 grew by 3%, but rebates grew by 12%, so overall, spending in Vermont’s Rx drug programs has gone down. This has been true for the past five years.

Last year’s spending, net of rebates: $76 million. They serve 150,000 Vermonters.

The generic substitution rate in Vermont is 64% in the Vermont Medicaid program; the overall generic substitution rate is greater than 98%. These rates compare very favorably to national data.

Q: What Vermont legislation passed in the past several years has been the most beneficial?
A: (Ann Rugg): The history of the statutory language has been the base for the success we have had.

Discussion: Specialty pharmacy issues—this is relatively new—the are seeing the benefits from recent legislation. (“Specialty pharmacy” means rare, high-cost and complex drug regimes.) Discussion of drug therapy management.

Joshua Slen: A reminder that regarding Act 80, OVHA is not yet implementing a number of provisions due to finding shortfalls (due mostly to the Vermont lawsuit).

Q: What about lowering Rx drug costs for all the other Vermonters, beyond those in OVHA programs?
A: From Joshua’s perspective, we are not reducing costs for the other 450,000 Vermonters.

Discussion followed—this is not cost shifting—MVP representative commented that OVHA rates and regulations do not negatively impact MVP.

2.d. 340B Pharmacies
   Hunt Blair, Director of VT Public Policy, Bi-State Primary Care

Documents distributed:
Doc. #4: 340B Pharmacy & Vermont’s Community Health Centers

Hunt Blair: This program DOES have the ability to impact drug process for other Vermonters. Drug pricing is a lot like airline seat pricing—so it is very difficult.

Topics from his presentation:
• What is 340B?
• How has 340B developed in the state?
• 340B today in Vermont
• The future of 340B

The whole area is painfully arcane and complex. The community health centers and clinics have not yet been able to have a statewide program, but they are working together as much as possible. They have set up an organization: Pharmacy Network LLC, which operates Community Health Pharmacy. They are working to allow local community pharmacies to participate. However, the federal regulations are complicated. They are planning multiple contracts.

They have programs in much of the state; here are the geographical areas where they do not have programs:
- Windham
- Windsor
- Bennington
- Addison.
They are also thin in the Northeast Kingdom.
Re Windham and Windsor, the Springfield Hospital is re-applying for FQHC status; Bennington groups were not interested in their programs yet. In Addison County they are developing a five-town consortium.

Q: What is the impact of 340B programs on people who are above 200% of the Federal Poverty Level?—both numbers and dollars?
A: They are working on this. Trying to expand benefits the uninsured and under-insured people who are above the 200%. They are working with the Blueprint for Health to integrate prescribers and suppliers for patients.

3. Health Care Reform Implementation

a) Personnel changes
Susan Besio, Director of Health Care Reform Implementation

Joshua Slen is leaving as Director of OVHA. Susan is taking on Joshua’s job; and she will continue as Director of Health Care Reform Implementation. She believes that there are close intersections between the two jobs. She also believes, regarding our state government, that the previous “silos” that isolated departments are now more integrated. She plans to bring a high-level person to OVHA to be Assistant Director of Health Care Reform Implementation.
Craig Jones will now work full-time from the Vermont Department of Health, rather than splitting his time between Burlington and Montpelier. Diane Hawkins will go with Susan to OVHA, and will still support Craig Jones as well.

Concerns from Commissioners: Susan’s work provided coordination, a locus of accountability for health care reform issues, including monitoring implementation. Will this now be lost?
A: Susan will keep both the authority and the responsibility. This is a clear directive from the Governor and the two Agency Secretaries. She is also very pleased to be now getting additional
staff, plus organizational and structural support. She will also have the new Assistant Director of Health Care Reform Implementation. In addition, there are now strong relationships between BISHCA and OVHA—and both departments are now consulting regularly and closely with the private health insurance carriers. Her biggest concern is her learning curve re the Medicaid program.

Discussion followed: statutory issues re the legislation that helped create both Susan’s and Craig’s jobs; is OVHA the right place for Vermont health care reform to reside; will this change lead over time to loss of focus on health care reform (Susan’s brief has now moved several steps away from the Governor); what about perception of her authority—loss of focus on health care reform—is the Administration moving health care reform to a back burner? Susan: She is personally committed to keeping health care reform at the top of the agenda. She believes that we can make the pros outweigh the cons.

Discussion continued. Susan is doing a national web cast on health care reform.

3.b. **Health Care Reform Implementation: Framework for evaluating health reform**

Susan Besio

*Document distributed:*
Doc. #5: Overview of Vermont Health Care Reform Evaluations, December, 2008—Susan Besio

Susan reviewed the various initiatives in place to evaluate Vermont’s health care reform initiatives, and the areas they are evaluating:

- Affordability of health insurance and enrollment
- Access to health care providers
- Financial sustainability for coverage initiatives
- Quality of care
- Population health
- Health information technology

She reviewed the timing of interim reports and final reports.

3.c. **Health Care Reform Implementation: Health IT fund revenues**

Susan Besio

*Document distributed:*
Doc. #6: Memorandum to Joint Fiscal Committee: Report on Health IT Fund

To date, the amount collected is about 60% of the estimate. They are working with the Joint Fiscal Office to find out why the receipts are different from estimates.

Q: There appear to be discrepancies in fees paid.

A: Susan will look into this and report back.
3.d. Health Care Reform Implementation: Green Mountain Care income eligibility and premiums
   Betsy Forrest, Health Care Affordability Project Director, OVHA

   Document distributed:
   Doc. #7: Catamount Health premium increase & $400 earned income disregard

   This “disregard” was created at the end of last legislative session, following early state revenue downgrades. There is a federal match—so it actually creates a positive impact on the state budget. Overall impact in people enrolled in Catamount Health premium assistance program: more people are paying a lower premium.
   The charts in the handout illustrate mitigating the impact of the premium increase for most beneficiaries.

   Other updates re then enrollment process: all organizations are working together to improve the enrollment process. They have eliminated one form and one step in the application process.

   Q re web site: are the exceptions to the one-year period made clear?
   A: Yes, the screening tool addresses this. But they will take a closer look to make sure it is very clear.

3.e. Health Care Reform Implementation: Green Mountain Care enrollment concerns
   Peter Sterling, Executive Director, Vermont Campaign for Health Care Security

   Documents distributed:
   Doc. #8: Lessons from the Public: Steps to Increase Enrollment in Green Mountain Care: Summary of Recommendations—Peter Sterling
   Doc. #9: Lessons from the Public: Steps to Increase Enrollment in Green Mountain Care

   Peter Sterling reviewed the summary of the recommendations from the Vermont Campaign for Health Care Security. They are in four areas:

   I. Reduce CHAP and VHAP Premiums
      This is by far the number one reason we hear from uninsured Vermonters and those who work on the frontlines with low and middle income Vermonters for people not enrolling. Even the subsidized premiums in CHAP, when combined with the plan’s other out of pocket expenses, are far too costly for many Vermonters.
   II. Make Changes to the Eligibility Criteria
   III. Make it Easier for the Public to Complete the Application Process
   IV. Make Administrative and Structural Changes to State Government
      [The Summary document (one page) is attached as Appendix A.]

   Peter also distributed the full Report.
   Peter Sterling reiterated their key finding: The number one reason why people do not enroll is that premiums are too high.
   Representative Maier gave Peter sincere thanks for his work and the work of the Vermont Campaign for Health Care Security.
4. **Revised Commission Statement on Health Care Costs**

   Steve Kappel, Consultant to the Commission
   Don Dickey, Consultant to the Commission

   **Documents distributed:**
   Doc. #11: Comments from Rep. Topper McFaun re draft statement

   Don Dickey reviewed the comments process; there is a lengthy document of 33 pages of all the comments received to date—this is available on request.

   Don reviewed the latest changes in this draft, pursuant to Commissioners’ comments:
   They are in the discussions of cost shift, impact of federal policies, and legal and practical barriers.

   Senator Racine reviewed the background concerns that initiated this statement on costs.
   Don Dickey noted that this document is intended simply to provide a framework for discussion.
   The various drafts have gone to Commissioners, and have gone out for public review and comment; have also been posted on the HCRC web site.
   The goal is to finish this statement today. But they have received an important set of additional comments, from Rep. Topper McFaun. Rep. McFaun’s comments have showed that some of the language in the most recent draft could be misinterpreted. So Don and staff have prepared one more draft, for today:
   This is Doc. #12, Draft commission statement on unsustainable health care cost trends, Draft 1.5, Dec. 2, 2008.

   Don reviewed these newest edits for commissioners.
   Discussion re the current title—it needs to be changed. Consensus on a new title:
   “Background Statement on Health Care Cost Trends and Where We Are Today,” from the Health Care Reform Commission.

   Rep. McFaun explained that his main concern was re the opinions on page 1: they appeared to close off options. The people want immediate relief. They may not be able to get it, but we need to be open to all avenues for reform. His was trying to respond to concerns he heard while campaigning: this is the most urgency he has ever seen.

   Senator Racine offered new suggested language: “Many ideas proposed an answers are perceived as not feasible, but are worthy of renewed study.”
   Don will also add this text at the beginning of the section on cultural, political and legal viability.

   Sen. Racine moved the adoption of this statement as just edited. Sen. Cummings seconded.
   Rep. McFaun expressed his appreciation of the Commissioners’ willingness to make these changes.
   The statement was adopted by unanimous vote. Commissioners will get clean copies.
5. **Update on Commission Studies: Public financing study**  
Steve Kappel, Consultant to the Commission  
Nick Rockler, Consultant to the Commission

Documents distributed:  
Doc. #14: Current Economic Indicators, etc.—Kappel and Kavet

Steve Kappel gave an overview of this project—this is a follow-on to the previous financing study. The purpose is to focus on alternative ways of raising money, and to measure the broader impact of the potential macroeconomic effects. They held other variables as constant as possible. They hope for a back-and-forth discussion with commissioners to refine the scenarios they have developed. There are three scenarios:
- The first model, which they will discuss today, is to raise funds and transfer some of the costs from insurance companies to a publicly-financed system.
- The second model, which they will work on in the future, is to establish mandates, a la Massachusetts.
- The third model, which they will explore if there is time, is to explore having employers no longer involved in the financing of health care.

He introduced Nick Rockler, who is a partner with Tom Kavet in the firm Kavet and Rockler. Sen. Kitchel noted time constraints this afternoon, and suggested a brief presentation, with the consultants available afterwards to answer more questions.

Nick Rockler reviewed the chart, “Tax Capacity Gap for Healthcare Financing.” Pursuant to Senator Racine’s earlier comments, the chart shows that none of the current methods we use for health care financing (personal income tax, sales and use tax, and wage and salary tax) come anywhere near to keeping pace with the rate of growth in costs.

He handed out a set of flow charts [Doc. #14: Current Economic Indicators] which indicate the impacts of various changes in tax revenues and the estimated impacts on expenditures. He reviewed the models, assumptions, data and conclusions. These are not recommendations—they are hypotheticals: if you do this, that may happen. These are extreme macroeconomic scenarios, and the next step is to build real case scenarios.

They have looked at the direct impacts of raising additional revenues, and also at the indirect impacts. Following today’s discussions, it is clear they also need to look at the distributional impacts as well—who are the winners and losers.

The first page of the flow charts presents current economic indicators.  
The first scenario, second page, is “Personal Income Tax Impact Estimation.” In the interests of time, he will review this model and let commissioners review the rest on their own.  
The second scenario, page 3, is “Sales Tax Impact Estimation,” and the third scenario, page 4, is “Payroll Tax Impact Estimation.”  
Page 5 shows the overall “Healthcare Expenditure Impact Estimation”.  
Page 6 is “Proprietors’ Income Impact Estimation,” and page 7 is “Percent change from baseline—2010.”

Discussion followed, regarding various potential impacts of the various scenarios.
Jim Hester noted that the discussion and questions show the complexity of the topic. Perhaps we should identify a subgroup of commissioners who would work with the consultants to refine the various scenarios. A group volunteered:

Rep. McFaun
Rep. Maier
Sen. Cummings
Sen. Racine
John Bloomer.
(Steve Kappel will contact the two absent commissioners.)

The meeting adjourned at 4:20 PM.

Respectfully submitted,
Loring Starr

Attached: Appendix A:
LESSONS FROM THE PUBLIC: STEPS TO INCREASE ENROLLMENT IN GREEN MOUNTAIN CARE (Summary)
APPENDIX A

LESSONS FROM THE PUBLIC:
STEPS TO INCREASE ENROLLMENT IN GREEN MOUNTAIN CARE

Summary of Recommendations

I. Reduce CHAP and VHAP Premiums
This is by far the number one reason we hear from uninsured Vermonters and those who work on the frontlines with low and middle income Vermonters for people not enrolling. Even the subsidized premiums in CHAP, when combined with the plan’s other out of pocket expenses, are far too costly for many Vermonters.

II. Make Changes to the Eligibility Criteria
1. Allow the self-employed who shut their businesses down to enroll in Catamount Health/VHAP
2. Allow additional deductions from self-employment income to accurately reflect take home pay
3. Allow those with incomes over 300% FPL and access to ESI to enroll in Catamount Health
4. Allow a 30 day grace period for those who would lose coverage for nonpayment of premium
5. Eliminate the 12 month waiting period for Catamount Health and VHAP
6. Eliminate Catamount Health’s pre-existing condition clause
7. Allow families the option of whether or not to include 18-21 year olds in their household eligibility calculation

III. Make it Easier for the Public to Complete the Application Process
1. The state needs to offer more one-on-one assistance to those applying
2. Make notices from the state clearer and combine notices and letters. Many applicants express frustration with both the wording and the number of letters received during the application process. Some have received multiple mailings on the same day with contradictory information.
3. Make it possible to apply and track the status of an application online. This would reduce both the time needed to apply and the number of calls to Maximus and DCF staff.
4. Keep applications active for one year. Applicants reapplying within a year could update their application in the state system with new information and have their eligibility re-determined.
5. Allow verification of citizenship and identity by authorized individuals. Currently, applicants usually have to go to the nearest AHS office to show proof of citizenship and identity, a significant barrier for those who may not have transportation or work during AHS office hours.
6. Revise the CHAP/VHAP application (010B) to make it easier to complete by the public
7. Eliminate ESI and make Catamount Health a public program. This would eliminate two time consuming and often frustrating steps in the enrollment process.

IV. Make Administrative and Structural Changes to State Government
1. Place responsibility for CHAP and ESI programs in one department within state government
2. Have dedicated state staff accountable for accurate and timely answers to public inquiries
3. Allow applicants to have a caseworker at Maximus
4. Fill vacant assistor spots at OVHA
5. Expand Maximus hours beyond regular working hours
6. Develop and implement training for all state staff who interact with uninsured Vermonters