

**Health Care Reform Commission
Recommendations for 2008 Legislative Session
As adopted December 4, 2007**

I. Introduction

In 2006, Act 191 was passed and signed into law to initiate comprehensive health care reform in Vermont. The legislative intent of Act 191 was as follows:

“It is the intent of the general assembly that all Vermonters receive affordable and appropriate health care at the appropriate time and that health care costs be contained over time. The general assembly finds that effective first steps to achieving this purpose are the prevention and management of chronic conditions; coverage of the uninsured through Catamount Health, a comprehensive and affordable benefit plan with sliding-scale premiums; and providing minimum preventive services starting with immunizations for all Vermonters.”

In the spring of 2007, the Health Care Reform Commission established five workgroups to work on the next steps in health reform. They considered two key questions: 1) Are the major initiatives contained in Act 191 on track to achieve their objectives, or are significant modifications to those initiatives necessary? 2) What new major initiatives should be recommended for legislative consideration in the 2008 session to achieve the objectives of health care reform? This review was conducted working within the overall strategic framework established by Act 191, which assumes that most Vermonters will continue to have access to health insurance through their employers and that health care coverage will be provided through a mix of public and private payers.

The overall objectives of the review were to:

- Make steady progress towards achieving the six health reform principles in Act 191, the health care reform law passed in 2006
- Ensure that the health reform initiatives touch more Vermonters
- Prioritize initiatives to ensure best use of limited state resources
- Leverage state resources through effective private/public partnerships.

The five workgroups and the key questions addressed were:

1. Expand affordable coverage to more Vermonters *See pg. 3*
 - How can we improve the coverage of Vermonters who currently have insurance, or make it more affordable?
 - How can we make better progress towards the goal of having only 4% of Vermonters uninsured by the end of 2010?
2. Improve the prevention of chronic illness by reducing obesity *See pg.5*
 - How can we achieve a breakthrough improvement in the effectiveness of the programs targeted at reducing obesity by improving nutrition and physical activity?
3. Reduce the rate of increase in costs while improving the health of Vermonters *See pg. 8*
 - What one or two other initiatives hold the greatest promise for this goal?

- How can we modify the state’s administrative and regulatory requirements to help reduce health care costs and unproductive ‘hassles’.
4. Use IT as a catalyst for reform *See pg. 10*
 - How can we accelerate the successful implementation of electronic medical records in independent primary care practices?
 - What are the priorities for implementing key recommendations from the statewide health IT plan which would support health care reform?
 5. What investments do we need to make in the capacity of Vermont’s health care delivery system to ensure success in health care reform? *See pg.12*
 - How can we ensure that Vermont has an adequate capacity for primary care services?
 - How can we ensure an adequate supply of nurses and allied health services staff?

Each workgroup had staff and a resource team who gathered information during the summer and prepared draft documents for discussion. These documents were circulated to the legislative members of the working group as well as to a broad set of interested parties. In the fall, each workgroup convened in a public meeting to review the working papers and options for recommendations. The full commission was also briefed on the options prepared from each workgroup at one of its regular public meetings. Staff prepared a synthesis of the workgroup recommendations into a single overall package of recommendations which were circulated broadly for public comment and reviewed by the full commission.

The final recommendations which follow are organized into the five workgroup topics. Many of the recommendations require funding, and the draft presents initial estimates of their costs. The commission recognizes that state resources are particularly scarce for FY09 and that decisions about the funding of new initiatives will appropriately be made by the 2008 Legislature and the Governor. The recommendations in this report will be forwarded for consideration by the standing committees of the legislature that are responsible for the policy areas covered, and for making the difficult resource allocation decisions inherent in crafting a final budget for the state. We hope that these recommendations provide a solid starting point for that challenging task.

One of the primary drivers of the state budget, and the reasons the resource allocation decisions are so hard, is the impact of increasing medical costs on many sectors ranging from Medicaid to school budgets to the state’s cost of health insurance for its own employees. Increasing costs of coverage have also had a major impact on private employers’ budgets, and have caused a significant decline nationally in the percent of employers who offer health insurance as a benefit. The efforts of state government to improve health insurance coverage and contain costs have come in direct response to this erosion of the availability and affordability of private coverage. As was quoted above, the stated legislative intent of the health reform legislation passed in Act 191 was that “all Vermonters receive affordable and appropriate health care at the appropriate time and that health care costs be contained over time.” Act 191 contained the effective first steps to achieving this purpose and in particular, found that “chronic care management is one tool to contain health care costs and ensure that the costs of Vermont’s health care system become sustainable”. Continued increases in health care costs at their current unsustainable rates represent the greatest single threat to successful health care reform. The commission acknowledges that containing health care costs over time has not yet been achieved and is likely to require significant additional initiatives beyond those recommended here.

II. Recommendations

A. Expand Affordable Coverage

Ensuring that every Vermont resident has access to affordable health insurance coverage is one of the basic objectives of health care reform. Act 191 created Catamount Health as a new insurance offering for the uninsured and provided premium subsidies for individuals with incomes below 300% of the Federal Poverty Level. One of the explicit charges to the Health Care Reform Commission was to explore options for improving coverage for the ‘underinsured’ – Vermonters who currently have insurance that is not affordable, or not meeting their health care needs. The recommendations below are the first step in responding to that task.

1. Improve the health coverage for the ‘underinsured’ population and significantly expand the population benefiting from health care reform.

- a. Create a new health coverage option offered to small employers and individuals, including those who currently have health insurance (working name is HealthyVT). For example, benefit packages could be modeled on small group offerings and one benefit option should be comparable to the benefit design of Catamount Health. The new product would achieve an initial 20-25% premium reduction through a combination of
 - i. Publicly funded reinsurance, similar to Health NY
 - ii. Required enrollee participation in wellness/disease management programs consistent with the Blueprint for Health and employer support of wellness programs, similar to Rhode Island’s HEALTHpact program and Michigan’s Healthy Blue Living.

The design of the program should also result in lower trends in premium increases over time.

Employers offering the HealthyVT product should pay a part of the premium costs and would collaborate in encouraging their employees to complete Health Risk Appraisals and participate in the wellness programs.

Table 1. Costs and Savings Associated with HealthyVT

| Option | Total Public Cost of 10% reinsurance (Millions) Cumulative | Number of Currently Insured Workers | | Premium Savings (Millions) |
|--|--|-------------------------------------|------------|----------------------------|
| | | In Catamount | Cumulative | |
| Offer to insured in firms with workers under | | | | |
| 10 | \$ 7.4 | 19,538 | 19,538 | \$23.4 |
| 25 | \$14.1 | 17,869 | 37,407 | \$44.9 |
| 100 | \$24.4 | 27,111 | 64,508 | \$77.4 |

- b. Enable employee premium payments to qualify for pre-tax dollars by requiring broader use of Section 125 plans, even by employers who do not offer health

- insurance. Cost to the state in lost tax revenues would be approximately \$1 million per year for each 10,000 new people who took advantage of this program.
- c. Explore providing post-divorce coverage for families (S.62).
 - d. Reduce the cost shift: The cost shift to private payers causes a significant increase in commercial health insurance premiums. The first priority is to “Do no harm” by avoiding further increases in commercial premiums due to increased cost shift (FY09 cost ~ \$8 million/yr. with \$3.5 million contributed by the state). The Commission also recognizes the importance of reducing the cost shift over time.

2. Make better progress towards the goal of having only 4% of Vermonters uninsured by the end of 2010.

The current projection is that all of the initiatives of Act 191 will result in 19,000 of the uninsured obtaining health care coverage by the end of 2010. This will result in an uninsured rate of 7.5% in 2010. We need to make modifications that will add another 20-25,000 enrollees during this period if we are to meet the goal of 4% uninsured.

- a. Expand participation in existing Catamount Health product
 - i. Reduce waiting period to six months: 15% increase in eligible pool, new enrollees (3,000) and cost to state (\$5 million) by 2010
 - ii. Add financial hardship category to list of exceptions: criteria include loss of insurance coverage within the last three months due to a ‘qualifying event’, income < 300%, medical expenses greater than X% of income.
- b. Implement automatic eligibility for VHAP and Medicaid eligibles who have incomes low enough that they pay no premium
 - i. Impact: 10,000 people
 - ii. Costs are difficult to estimate, but we have assumed that, in general, this group will use less services than those currently enrolled. An approximate estimate is a total cost of \$26 million/yr, with the state’s share being \$10.5 million/yr
 - iii. Issue: it is not clear exactly how to implement this provision. Unlike some other states like Massachusetts, Vermont has no data base which identifies exactly who these individuals are and how to contact them.
- c. Provide coverage for young adults under their parent’s policies through age 26 regardless of college enrollment.
 - Impact: 16,000 uninsured were 18-26 years old in 2005 (50% = 8,000)
 - Cost: a small (approximately 1%) increase in commercial premiums.

3. Stabilize the individual market.

BISHCA and Blue Cross Blue Shield of Vermont will be proposing specific changes based on Elliot Wicks’ study and other input.

B. Prevent Chronic Illness by Reducing Obesity through Improved Diet and Physical Activity

Reducing the occurrence of chronic illness across Vermont's population is an essential component of improving the health of Vermonters and controlling medical cost increases. The following recommendations will establish a statewide healthy choices initiative using a community prevention model to promote healthy lifestyles for all Vermonters. This initiative will build on the leadership, public health planning expertise and the statewide district office infrastructure of the Vermont Department of Health and enhance ongoing collaboration with other state agencies and community partners. **A breakthrough improvement is required in our existing strategies that support improved eating habits and greater physical activity if we are going to reverse the sustained trend of increased obesity.**

The single biggest driver of increased risk for chronic illness is the long-term trend of escalating obesity, particularly among children. Efforts to halt and reverse obesity trends in Vermont require an environmental change strategy to help change the system that makes Vermonters unhealthy, similar to the comprehensive approach used to combat tobacco use and substance abuse. This initiative will support community-wide prevention planning and implementation to make healthy choices "the easy choice." Vermonters are far more likely to make and sustain healthy choices if the physical, social, and cultural environments where they live, work, and play are conducive to good nutrition and physical activity.

Ensuring stable, sustainable funding for these efforts is critical to their success. Renewing the existing Federal support from CDC to both VDH and the Department of Education is essential. We should also vigorously pursue other outside sources such as Robert Wood Johnson Foundation or the National Governor's Association. The commission recommends that additional state resources of approximately \$1 million in FY 2009 and another \$1 million in FY 2010 be dedicated to achieving this breakthrough.

Some of the possible areas of focus for these additional resources are listed below, but the detailed strategy must be developed in conjunction with the responsible agencies and other stakeholders.

1. State assistance to communities for environmental and policy change

- a. Grants to pilot communities: Retool existing state grant programs to support comprehensive (multi-sector) environmental and policy change in 4-8 pilot communities to promote nutrition and physical activity.
- b. State leadership and support: Increase staff capacity at VDH District Offices to support community planning, technical assistance, training, and evaluation. Use established VDH grant making process to promote community planning and accountability.
- c. Public education (media) campaign: Develop a set of complementary materials that each participating sector (e.g., school, work site, health care, etc.) can utilize, with well-researched and well-coordinated messaging.

2. “Built environments” in communities to support healthy choices

- a. Increase access to healthy foods in Vermont communities, including local foods.
- b. Create healthier communities through pedestrian, biking, and public transportation systems, etc.
- c. Build upon existing legislation that encourages Smart Growth principles in land use planning, growth centers, and downtown revitalization.

3. Healthy School Environments

- a. *School standards*: In collaboration with the schools community, strengthen:
 - i. program standards for nutrition education and physical education
 - ii. physical activity standards
 - iii. nutrition standards for “competitive foods” (i.e., foods sold outside federal meals programs such as a la carte and in vending machines).
- b. *Grants to schools*: Strengthen existing state grant programs to support environmental and policy change in schools.
- c. *Technical assistance and training*: Enhance resources available.

4. Healthy Work Environments

Options include:

- a. *Increased sharing of best practices*: Support public-private collaboration to develop and disseminate resource tools and enhance opportunities for interactive information exchange.
- b. *Small employer incentives and/or small employer assistance*.
- c. *Employee incentives*: Encourage use of economic and other incentives for employee participation in wellness programs.
- d. *Insurer innovation and leadership*: Enhance incentives for private health insurers to strengthen employee wellness and healthy lifestyle interventions.
- e. *State employee wellness program / health benefit program*: Strengthen the existing portfolio of exemplary practices for promoting wellness and healthy lifestyles.

5. Medical Home: Best-Practice Prevention of Overweight in Children

- a. *Provider training*: Promote clinical practice changes through toolkits and hands-on trainings based on best-practice guidelines for early identification, assessment, and treatment of overweight by the primary care practice team.
- b. *Stakeholder review of reimbursement for best practices* for assessment, prevention and treatment of obesity.
- c. *Integrate Supportive Services*: Use pilot programs to forge closer links between “medical home” primary care practices and “public health” supports, such as WIC clinics, and non-medical counseling and behavioral interventions.
- d. *Increase the proportion of mothers who breastfeed their infants and toddlers*.

6. Encourage/Leverage the “Industry Response” to the Obesity Epidemic

- a. Decrease marketing of low-nutrition foods to children: Direct Attorney General’s Office to report on options, such as collaborative efforts with the Alliance for Healthier Generation, State governors, NCSL, etc.
- b. Use mechanisms of state government to support industry awareness of the “business case” for promoting healthy food and beverage choices: Encourage business leaders to make their brands “publicly accountable” for making healthy options available to children and youth and their relatives.

C. Reduce the Rate of Increase in Costs while Improving the Health of Vermonters

If the gains in insurance coverage are to be sustained, health care reform must be broadened to include other approaches to control medical costs. The following recommendations focus on restructuring the financial incentives driving the largest components of medical costs and on continuing to reduce administrative and regulatory costs.

1. Restructure hospital and physician incentives at the community level. Commission staff should develop a preliminary design for a pilot for an Accountable Care Organization (ACO) which could be implemented in calendar year 2009. The ACO would be a vehicle for enabling a regional health care delivery system composed of key providers of primary and secondary care within a community to foster a shared accountability for both the costs and quality of care of the population they serve. The ACO would have financial incentives to recapture part of the savings realized by operating more effectively, e.g. reducing the volume of questionable surgical procedures, and to avoid future capacity driven growth. These incentives would reward effective population based care, rather than high margin specialized services.

2. Control hospital costs.

Hospital costs represent the largest single component of medical expenses and the tools used to contain future cost increases should be reviewed including:

- a. Revising Public Oversight Commission/BISHCA annual review of hospital budgets to create more effective incentives for reducing hospital costs.
- b. Considering the use of global budgets and a restructuring of the financing of hospital care as proposed in H.304.

3. Promote private long term care insurance.

For long-term care, begin a process that encourages Vermonters of middle and high incomes to reduce their dependence upon public programs funded with Medicaid dollars and that identifies (or creates) affordable private alternatives.

- a. Enabling legislation (H.08)
- b. Consumer and employer education
- c. Consumer protection.

4. Change state administrative and regulatory requirements to help reduce health care costs.

A number of parties are already developing recommendations in this area which the standing committees should consider. The initiatives include:

- a. BISHCA is developing recommendations in a number of areas, e.g. Rule 10 simplification.
- b. The Administrative Simplification group created in Act 191 will be submitting recommendations to the administration and legislature in five different areas by 1/1/08.
- c. The Vermont Association of Hospitals and Health Systems is reviewing regulatory requirements administered by a range of agencies including BISHCA, AHS and others and will be preparing recommendations on areas where the “juice is not worth the squeeze”.

- d. The Vermont Medical Society supports legislation that establishes Fair Trade Standards for Health Insurance Companies. Sources of provider dissatisfaction identified in the BISHCA provider satisfaction surveys included claims payment processes, prior authorization processes, pharmacy management, and ineffective communications between providers and insurers. The Vermont Medical Society will be working with state government, insurers and the legislature to modify policies, regulations and laws to address these issues.

D. Use Health Information Technology to Improve Performance

The improvements in performance required to improve quality, slow the rate of increase in medical costs, and reduce administrative costs and hassles will require more effective use of information technology to transform the current paper based system. The following recommendations build on the solid foundation which has been built over the last three years.

1. Promote Electronic Medical Records (EMR's).

Accelerate the successful implementation of Electronic Medical Records, particularly in smaller, primary care practices that are not hospital owned, by expanding VITL's EMR pilot program.

- a. Scope:
 - i. ~ 320 physicians in 120 non-hospital primary care practices that do not have EMR
 - ii. Resource center for implementation support for any small practices that have adopted EMR
- b. Estimated cost: \$20-25 million total over five years: \$4-5 million/yr. total with \$3- 4 million coming from state revenues
- c. Revenue sources:
 - i. Hospital support for non-owned practices (e.g., SW Vermont Medical Center has proposed \$400 K/yr for three years)
 - ii. Physician contribution
 - iii. State support for initial capital costs through VITL or bonding entity
 - iv. Potential modifier on physician claims for services provided using an EMR which would add a small payment to support ongoing operating costs.

2. Assess electronic prescribing (e-Rx).

Commission staff should work with the VITL Project Review Committee to analyze and make recommendations on e-Rx implementation strategies to make e-Rx available state wide to all physicians as soon as reasonably possible. The assessment would consider issues such as

- a. Best methods of access including free standing handheld options, web based options and e prescribing modules integrated with Electronic Medical Records.
- b. Costs and benefits of e Rx in Vermont, business model, including providing financial incentives to providers to adopt and use e prescribing
- c. Ensuring privacy and security of prescription data, with controls over data mining
- d. Minimizing the manual entry of data by interfacing data from practice management systems or electronic claims data sources through the VITL operated Vermont health information exchange
- e. Building on the learnings of other initiatives such as the National ePrescribing Patient Safety Initiative (NEPSI), Partners Health Care (Massachusetts), and others.
- f. Assessing the readiness of pharmacies to participate in e prescribing and the impact on independent pharmacies.

3. Support VITL legislation.

Clarify and enhance VITL's role in planning and supporting the implementation of key health IT infrastructure in the state.

- a. VITL should be granted the responsibility to update the Vermont Health Information Technology Plan to include
 - i. Reassessment of interoperability standards since many are still evolving and new ones will be developed
 - ii. Inventory of EMR deployments to monitor progress against targets in Plan
 - iii. Review of Privacy and Security challenges
 - iv. Strategic guidance for state HIT projects
 - v. Strategy for continued role as neutral convener of stakeholders
 - vi. Strategy for creating and updating the Master Indexes of Patients, Providers and Sites, and the Record Locators for Clinical Data.
- b. Grant immunity to VITL when operating the statewide HIEN in good faith and adhering to professional standards. VITL would still be liable for gross negligence. However, VITL would be protected from civil, criminal and administrative liability for “bad” decisions made by providers based on “bad” data (as defined by VITL implementation guide) exchanged through the HIEN.
- c. Support \$1.2m direct appropriation for FY 2009
- d. Assess need for penalties and other enforcement tools for inappropriate disclosure of protected personal health information
- e. Eliminate quarterly reporting to HAOC and Secretary of Administration. VITL would continue making an annual report to the legislature and administration. VITL would also continue publishing minutes of VITL meetings.

E. Invest in Vermont’s Health Care Delivery System and Public Health Programs to Ensure Success in Health Care Reform

These recommendations cover three areas: recruiting and maintaining healthcare staff, leveraging existing professional capacity with technological tools or new staffing patterns, and enhancing “system-ness” and accountability within the public health infrastructure.

1. Recruit and Maintain Healthcare Staff.

The aging population, expanded access to health care among the previously uninsured, and the transition to more chronic care management will increase demand for practitioners at a time when supply of professionals is stretched in many places. Most importantly, the mal-distribution of health care workers in the state means that while some parts of the state have sufficient capacity, other areas (including more rural areas) face chronic shortages that undermine access to care. Furthermore, Vermont faces critical shortages of nurse faculty, making it difficult to train sufficient number of nurses, and insufficient numbers of adequately trained allied health staff (laboratory technicians, radiation technologists, etc) to meet the growing demand.

- a. Expand loan repayment programs (from \$1.4 million to \$2.0 million/yr)
- b. Support for nursing education
 - i. Faculty salaries: (\$425 thousand/ yr.)
 - ii. Patient simulators (\$70 thousand – one time)
- c. Establish and encourage “Healthcare Employee Pipeline Collaborative”
 - i. Fund coordinating body (\$50 thousand/yr).

2. Leverage Existing Professional Capacity with Technological Tools or New Staffing Patterns.

In addition to prioritizing actions to increase the health care workforce capacity in the state, Vermont should invest in new models of care delivery that may be more efficient, high quality and more cost-effective for our communities. The remote nature of many of the primary care settings and the low volume of patients may not justify full-time staff with particular expertise (i.e. psychiatrists), especially when the supply of such experts is limited. Technological support at the provider and consumer level or new staffing models could alleviate some of the stresses on primary care practices as well as increase access to quality care in rural areas. Over the past four decades, community health worker programs, telemedicine and tele-psychiatry have been established as a means to provide crucial medical services in remote areas.

- a. Support tele-medicine and other provider-based technologies: pilot in tele-child psychiatry in seven community health centers (\$250 thousand)
- b. Enhance oversight of criteria for changes in licensing and professional scope of practice. Currently all licensing boards in Vermont consider only issues of safety in making a change or a recommendation; the Boards do not consider the implications on cost, access to care or cost-effectiveness in making a judgment on scopes of practice or licensing decisions. Including evaluation of proposals for cost and access considerations would require a legislative change in authority for the licensing boards and would mandate hiring additional staff with these skills.

3. Enhance “System-ness” and Accountability within the Public Health Infrastructure.

The Blueprint for Health launched a new process of integration and coordination in Vermont’s health care delivery system at the community and state-wide levels. However, in order to achieve real system-ness, Vermont also needs to work toward integration among public health services and infrastructures at the state and community level as well as enhance health system planning.

- a. Fund VDH regional offices to integrate services at the community level
- b. Revisit or Revise the Health Resource Allocation Plan (HRAP)
 - i. Revise legislative language for HRAP development process. BISHCA is currently surveying stakeholders to develop recommendations for how to improve the HRAP.
 - ii. Support new Director of Health System Planning position within the Agency of Administration.