



STATE OF VERMONT

Summary of Health Care Reform Analysis

8/10/09

- ❖ **Vermont, Massachusetts, Maine, and other states with Medicaid waivers that already align with the goals of federal health care reform should be supported in current efforts and investments to cover the uninsured.**
 - Maintenance of eligibility and provider rate requirements put unequal fiscal burdens on state resources, particularly for those states that have been leaders in health care reform, and limits state flexibility needed during tight fiscal times.
 - Financial assistance should be provided to states that are leading the way in health care reform by providing bonuses or increases in federal financial participation for populations with incomes above the expanded FPL level and below the top of the federal exchange.
 - H3200 ensures that state health care reform leaders have some flexibility, but additional financial resources are needed.

- ❖ **Private insurance provisions must allow sufficient flexibility for states that have engaged in private insurance reform efforts.**
 - States should be provided with policy options and flexibility that permit them to choose whether to continue existing public-private insurance programs included in Medicaid waivers or to enroll beneficiaries into the federal exchange.

- ❖ **Administrative, transition, and start-up expenses must be provided to states.**

- ❖ **On-going state-federal partnerships must be maintained.**
 - H.3200 guarantees continued federal participation through the extension of Section 1115 waivers.

- ❖ **Initiatives to reduce costs and improve delivery of health care should be encouraged and supported.**
 - Medicare and Medicaid rules should allow mechanisms for states to include Medicare and Medicaid participation in multi-payer health care delivery reform.
 - H3200 and the Senate HELP proposal include language to ensure states can proceed with Medicare participation.
 - H3200 ensures that Vermont's innovated pharmaceutical and medical device gift ban and disclosure law is minimally preempted.
 - Comparative effectiveness research should be available immediately to inform decisions about coverage.

- ❖ **Initiatives increasing access to services must be supported.**



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Analysis of Health Care Reform

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Federal health care reform will offer benefits to Vermonters facing health care coverage, access, and cost concerns. However, the scope and nature of a federal initiative makes it imperative that the fiscal and policy interplay between federal reform and existing state efforts is understood and considered. States like *Vermont, Massachusetts, and Maine* have been leaders in health reform, serving as testing grounds for many of the provisions in the emerging versions of the federal health care legislation. Federal legislation needs to recognize on-going state efforts, particularly those that have been innovative, while not exacerbating the already ominous fiscal burdens and looming budgetary deficits. To that end, our goal is to highlight some of the issues about which states like Vermont are concerned.

COVERAGE ISSUES

1. **States should be supported in current health care reform efforts and investments to cover the uninsured.**
 - ❖ *States that have higher levels of Medicaid coverage should be rewarded not penalized.* Different states provide different levels of coverage, both in income and benefits, and cover different groups of people.
 - Vermont has been on the leading edge of coverage, reaching 300% FPL and offering broad benefit designs to diverse populations through Medicaid waivers and state-only programs.
 - New York expanded Medicaid coverage to single adults and childless couples with income up to 100% FPL, to parents with income up to 150% FPL, and to children in families with income up to 400% FPL through a waiver.
 - Maine has likewise expanded coverage through MaineCare to children, pregnant women, and parents with incomes up to 200% FPL through a Medicaid waiver and CHIP.
 - ❖ Federal reform should create a uniform floor for states, but allow flexibility. States that provide higher levels of coverage should have the flexibility to augment or withdraw existing programs without repercussions as long as they do not go below the uniform floor or minimum standards. During tight budget times, requiring maintenance of eligibility and requiring a minimum provider reimbursement rate for certain services provides very little flexibility for states, especially if the state has a waiver limiting the state's ability to modify benefits (including,

in Vermont's case, optional benefits for mandatory populations). In addition, CMS has interpreted the maintenance of eligibility provisions in ARRA to preclude Vermont from increasing beneficiary premium contributions for Catamount Health – a private insurance product with state subsidies for those under 300% FPL – even if the private product's premium increases. This puts additional fiscal pressures on state budgets while further limiting the state's ability to manage the Medicaid budget.

- ❖ When Vermont and other states offer coverage above the minimum levels required by federal law, federal matching dollars should continue to be available to encourage states to provide coverage at that higher existing level. To fail to do so creates a financial incentive to reduce coverage and eligibility. In addition, federal financial participation should be structured in such a way that states are encouraged to exceed the minimum level and to achieve universal coverage.
- ❖ As health care spending continues to surpass revenues, a federal approach of 100% cost coverage in initial years with a declining federal contribution over time would be problematic in the out-years. It is critical that federal health care reform be sustainable for federal and state partners.
- ❖ Also, while financial increases to providers – especially primary care providers – through changes in reimbursement rate requirements will reduce the shift of unreimbursed costs to private payers, this change will increase the fiscal burden for states like Vermont that have been struggling to contain their Medicaid deficits. Otherwise, states will need to cut benefits to afford the mandated provider rate increases. Vermont is unlikely to benefit from the 100% federal funding for the increase in primary care rates because the state increased rates to Medicare levels in 2006 in order to enhance access to these services.
 - *Suggestion:* States could be encouraged to maintain eligibility through enhanced federal financial participation, bonuses, or a mechanism *other than* mandatory maintenance of eligibility, which limits state flexibility. If this is not feasible, maintain the House provision requiring CMS to maintain financial participation as long as states must maintain eligibility.
 - *Suggestion:* Maintain provisions in the bills for full federal funding for expanded Medicaid income eligibility and allow waiver populations to be included as “new beneficiaries,” as in the House bill.
 - *Suggestion:* Provide financial assistance for states that are leading the way in health care reform by providing a modest bonus or increase in federal financial participation for populations with incomes above the expanded FPL level and below the top of the federal exchange.
 - *Suggestion:* Maintain the House provision which allows CMS to waive part of the maintenance of eligibility requirement for states with Medicaid waivers which support individual and group market products pre-empted by federal law.

- *Suggestion:* Include provisions currently in the House bill which provide on-going resources to states to meet any reimbursement rate requirement and enhance resources available to states that have already increased their rates.
2. **Private insurance provisions must allow sufficient flexibility for states that have engaged in private insurance reform efforts.**
- ❖ Several states, including Vermont, Massachusetts, and Maine, have expanded coverage using a public-private partnership model. Many other states have also targeted their reform efforts to the uninsured.
 - ❖ For example, Vermont’s Catamount Health is a private, individual market insurance product. For individuals with incomes under 300% of FPL, the state provides a premium subsidy to assist with the cost. This subsidy (for individuals with incomes up to 200% of FPL) is included in Vermont’s Medicaid waiver. The state picks up the full amount of the subsidy for individuals with incomes between 200% and 300% of FPL (although this may change soon if a waiver amendment is approved by CMS).
 - ❖ Maine has created DirigoChoice, an insurance product for small businesses, individuals, and the self-employed. Many individuals receive a subsidy of between 20 to 80% of the premium and cost-sharing.
 - *Suggestion:* Consider existing state definitions of “uninsured” to ensure that individuals currently covered by a state would not lose coverage due to a more restrictive federal definition. For example, the Bush administration issued a letter regarding SCHIP coverage that was much more restrictive than many current state SCHIP programs and could have resulted in children who were currently enrolled in SCHIP funded programs being dropped and thus becoming uninsured.
 - *Suggestion:* Maintain policy options and flexibility that permit states to choose whether to continue existing public-private insurance programs included in Medicaid waivers or to enroll beneficiaries into the federal exchange.
 - *Suggestion:* For non-traditional Medicaid populations currently receiving premium assistance for a state insurance product, do not require the state to wrap benefits.

ADMINISTRATION & TRANSITION

3. Administration, Transition and Start up expenses must be provided to states.

- ❖ The Medicaid application process must be simplified and funds provided for modernization efforts.
 - In both Vermont and New York State, about half of the uninsured are currently eligible for public coverage but are not enrolled. In

New York, a good number of these uninsured were enrolled in public programs at some point, but lost eligibility due to complex renewal processes.

- Massachusetts has implemented a Virtual Gateway (VG), or centralized Web-based portal, to streamline the MassHealth (Massachusetts Medicaid program) enrollment application process. This innovation has resulted in increased efficiencies, such as a reduction in paper processing and reduced claims processing time, and an automated document match to verify certain eligibility requirements.
 - *Suggestion:* Provide simplified eligibility rules for Medicaid to decrease administrative burdens and costs on states.
 - *Suggestion:* Provide additional federal funds for information technology and modernization efforts.
 - *Suggestion:* Allow for federal 90/10 funding for these expenses, similar to health information technology (HIT) costs under ARRA and 90/10 funding for claims processing (MMIS) system replacements.

- ❖ There will be major costs for states to make the required changes to Medicaid eligibility systems, including redetermination of timeframes and income eligibility amounts, data exchange interfaces with the Connector/Exchange, and new reporting requirements as well as administrative costs to implement the changes (e.g., staff training, beneficiary notices and education).
 - *Suggestion:* Allow for federal 90/10 funding for these expenses, similar to health information technology (HIT) costs under ARRA and 90/10 funding for claims processing (MMIS) system replacement.
 - *Suggestion:* Provide legal authority and financial support for state implementation to start immediately. States are continually updating laws and programs. For example, Vermont is embarking on replacing its eligibility computer system this fall; it would be fiscally prudent to develop the new eligibility system based on the federal reforms rather than redoing the system in two years.
 - *Suggestion:* Allow for sufficient time in federal implementation time frames to account for the part-time nature of smaller state legislatures. For example, some provisions of the Deficit Reduction Act of 2005 (DRA) did not take into account the necessity of state legislative action prior to implementation of new federal requirements. States without full-time legislatures then faced the threat of federal penalties, through no fault of the state, because it was impossible to comply with the DRA without state legislative action.

- ❖ It is unclear what additional regulatory tasks will become state responsibilities in order to make state insurance products compatible with federal health care reform.
 - *Suggestion:* Clarify any enhanced roles delegated to states in regulating health care reform, such as approving plans or certifying system participants, as this will require significant state costs.
 - *Suggestion:* Provide federal financial support and resources if states are being asked to take on new private insurance regulatory responsibilities.
 - *Suggestion:* Eliminate the requirement contained in the House bill that a state must contribute toward the federal subsidy for additional state insurance requirements.

4. Ongoing state-federal financial partnerships must be maintained.

- ❖ State flexibility has been a continued strength of health care reform.
 - *Suggestion:* As part of the federal change, states should retain flexibility through a waiver process or other means to experiment with program improvements and efficiencies.
- ❖ Small and rural states have very different dynamics and needs, in terms of how the health care system is accessed and administered, than do large and more urban states. A one-size-fits-all approach should not be applied to national health care reform.
 - *Suggestion:* Distribution formulas and requirements should be different for small and large states. This is especially important in the Northeast, where health care service areas often span state boundaries.
- ❖ When Congress implemented Medicare Part D, it instituted the “clawback” provision whereby states paid the federal government based on a formula intended to reflect the estimated savings realized by states as a result of Medicare Part D. However, this provision has had a negative fiscal impact for Vermont and has penalized states that had more generously provided prescription drug coverage to seniors. States must know what their fiscal liabilities will be in the short term and long term.
 - *Suggestion:* “Clawback” and other similar provisions that can be re-adjusted at the federal level without state involvement should not be included in federal health care reform.

DELIVERY SYSTEM & PAYMENT REFORMS

5. Initiatives to reduce costs and improve the delivery of health care must be encouraged and funded.

- ❖ States should have flexibility to create multi-state service areas and plan arrangements, including demonstration projects in Medicare.
 - Vermont’s health care delivery system includes substantial overlap with neighboring states, notably New Hampshire and New York. For example, Dartmouth- Hitchcock Medical Center (located in

Lebanon, New Hampshire) and Fletcher Allen Health Care (located in Burlington, Vermont) have dual state catchment areas. New England and surrounding states benefit from the opportunity to work together in the delivery of health care.

- The New York metropolitan area is often referred to as the “tri-state area” in light of significant traffic across state lines for work, leisure, and health care. New York City’s academic medical centers have service areas that extend beyond state lines, reaching into New Jersey and Connecticut.
- ❖ Medicare and Medicaid rules should allow for waivers or other mechanisms for states to include Medicaid and Medicare participation in multi-payer health care delivery reforms, such as:
 - The Vermont Blueprint for Health medical home pilot projects, which combine support for community health teams and payment of a care management fee directly to primary care practices.
 - Pilot projects for services to individuals eligible for both Medicare and Medicaid, which achieve Medicare savings and allow significant portions of those savings to be reinvested into state health care efforts that better serve the individuals involved.
 - Savings sharing models using Accountable Care Organizations (ACOs), including programs to encourage ACOs which include Federally Qualified Health Centers (FQHC’s).
 - *Suggestion:* Maintain the provisions in the House bill relating to medical home pilots, community health teams, and ACOs, but delete language restricting a physician from participation in both a medical home pilot and an ACO pilot. These programs compliment each other and the medical home is a strong foundation for an ACO.
- ❖ The Medicare Payment Advisory Commission (MedPAC) is a 17-member commission that advises Congress on Medicare payment. MedPAC should include additional representation from small, rural states if it is to take a more active role as part of national health care reform. Currently only one of the members is from a small state (South Dakota).
- ❖ The requirement that a patient must have been in the hospital for at least three days prior in order to be eligible for nursing home coverage by Medicare should be eliminated. This could provide significant fiscal relief for states and help ensure the right care in the right setting at the right time. Medicaid currently accounts for approximately 50% of nursing home expenditures in Vermont, while Medicare accounts for only 20%.
- ❖ Disproportionate Share Hospital (DSH) payments have become important parts of the financial fabric of state health care systems. For example, New York received \$1.6 billion in Medicaid DSH funding, representing over 3 percent of total spending on health care services in that state. These funds provide crucial support to New York’s (and Vermont’s) public hospitals as well as supporting care to the uninsured throughout the state. DSH reduction or elimination could create reductions in coverage and should be

postponed until clear evidence is available that shows uninsured and uncompensated care rates in the state have declined and/or offsetting federal programs or funding is in place.

- ❖ Medicare coverage of advance care planning consultation, payment incentives for primary care, and increasing Medicare reimbursement improve the health care delivery system.
 - *Suggestion:* Maintain the House provisions relating to Medicare, including the sustainable growth rate formula and the floor for the GPCI calculation.
- ❖ State efforts to reduce health care costs in the area of prescription drugs and medical devices should be recognized and not preempted. The proposed Physician Payments Sunshine Act, which discloses payments to physicians, contains a preemption provision.
 - *Suggestion:* Do not preempt state law in this area or, in the alternative, maintain a clear provision to ensure that states (including Vermont) with state laws banning certain gifts and requiring disclosure of payments may exceed the floor proposed by the federal bill, similar to the House bill.
- ❖ In addition, state efforts to provide unbiased education to prescribers, such as University of Vermont's academic detailing program, would benefit from federal financial support. The program in Pennsylvania has demonstrated significant savings to that state's Medicaid program.

6. Initiatives increasing access to services must be supported.

- ❖ **Increasing the number of health care providers is crucial in ensuring access to services.**
 - Loan repayment programs for health care providers have been an important part of health care efforts to ensure sufficient access to health care. For example, Doctors Across New York provides funding for practice start-up as well as loan forgiveness for physicians willing to practice in underserved areas (both rural and urban), and in underrepresented medical specialties, especially primary care.
 - The University of Vermont and state college curricula have been designed to assist with Vermont's health system needs. This type of integration between training and education to ensure the adequacy of services is very important for small states to address physician and nurse shortages as well as other access issues particular to rural areas.
 - Prior federal efforts to address the shortage of primary care providers have focused on expanding medical education loan repayment through the National Health Service Corp (NHSC).
 - *Suggestion:* Liberalize the existing definition of a "health shortage area in order to make the loan repayment funds more widely available. For example, there is a national shortage of primary care providers and dentists that treat under-served populations.

- ❖ Reimbursement for culturally and linguistically appropriate services in Medicaid, CHIP, and Medicare will increase appropriate access to services.
 - *Suggestion:* Maintain the provisions in the House bill.
- ❖ Access to care is improved by providing consumers with ombudsmen to assist in resolving issues and disputes regarding coverage and benefits. Vermont has successfully provided increased access to services by supporting a Health Care Ombudsman's Office, which assists consumers in navigating and understanding health care coverage options and issues.
 - *Suggestion:* Ensure that consumers have advocates to assist them in accessing coverage by creating and supporting state ombudsmen's offices, similar to the system provided for in the Older American's Act or the Vermont system described in 18 V.S.A. § 4089w.
 - *Suggestion:* Maintain the provisions establishing a federal ombudsman program in the House bill and the provisions for enrollment assistance in the Senate HELP Committee bill.

FINANCING OF HEALTH CARE REFORM

7. Taxability of health care payments impact on state revenues.

- ❖ Changes in tax policy concerning health care expenditures by employers and employees will also impact state tax obligations in states, like Vermont, whose taxable income and revenues are linked to federal taxable income. This will increase the tax burden on lower and middle income Vermonters in the short run, which may have negative affordability implications but result in potentially more state revenue. Vermont is involved in a multi-year review of its tax policy. A delayed effective date for federal tax changes would allow Vermont and other states some time to include these changes in their overall tax policy futures.