Health Care Reform Legislation 2006 – present

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Background – Basic Facts

• There are about 620,000 Vermonters
• Approximately 47,286 (7.61%) of them are uninsured
• Health care spending on Vermont residents is projected to be about $4.9 billion in 2009

• Source: all figures from JFO based on BISHCA data
History: 2005 - 2008

  - See Act summaries for complete description
- Act 71 (2007)
  - included in separate Rx presentation
- Act 192 (2008)
- Act 203 (2008)
Health Care Reform Goals

• Increase Access to Affordable Coverage and Care
  – Catamount Health
  – Premium Assistance
  – Reduction in VHAP & Dr Dynasaur premiums
  – Immunizations

• Systems Improvements
  – Chronic Care Management
    • Blueprint for Health
    • Medicaid Chronic Care Initiative
  – Health Care Information Technology

• Contain Costs
  – Cost Shift Reduction
  – Administrative simplification
2006 Health Care Reform
Catamount Health

Eligibility

• Not everyone is eligible
• Depends on duration of uninsurance, reason for coverage loss
• Eligibility rules were designed to parallel VHAP
• General rule is 12-month period of uninsurance before eligible for Catamount Health, but several exceptions apply
Catamount Health – Definition of “Uninsured”

For purposes of Catamount Health, a person is uninsured if he or she does not qualify for Medicare, Medicaid, VHAP, or Dr. Dynasaur, and he or she:

• Had no private or employer-sponsored insurance within the 12-month period before application;

• Has had a high-deductible nongroup plan ($≥$10,000 for an individual; $≥$20,000 for two person/family) for at least 6 months; or

• Lost coverage during prior 12 months for specified reason (list of exceptions to waiting period)
Catamount Health - Eligibility

Exceptions to 12-month waiting period for loss of coverage during prior 12 months:

• Private or employer-sponsored coverage ended:
  – Loss of employment, *including a reduction in hours*
  – Death of principal policyholder
  – Divorce or dissolution of civil union
  – No longer receiving coverage as a dependent
  – No longer receiving COBRA or VIPER

• College- or university-sponsored coverage ended because of graduation, leave of absence, *or decrease in hours below threshold for eligibility*
Catamount Health – Premium Assistance

• Sliding scale from below 175% of poverty ($18,200 per year for an individual) to 300% of poverty ($31,200 per year)
• Beneficiary premium ranges from $60 per month (below 175% of poverty) to $185 per month (up to 300% of poverty)
• No assistance above 300% of poverty
Catamount Health – Full Cost

Current premiums:

- **Individual**: $393.11 per month
  (Blue Cross Blue Shield of VT & MVP Health)
- **Two person**: $786.22 per month
  (Blue Cross Blue Shield of VT & MVP Health)
- **Two person (parent and child)**: $746.90 per month
  (MVP Health only)
- **Family**: $1,100.70 per month
  (Blue Cross Blue Shield of VT & MVP Health)
2006 Health Care Reform
Employer-sponsored Insurance

• Premium assistance
  – To purchase health insurance through an employer

• Who?
  – VHAP eligibles
  – Catamount Health eligibles

• When must someone pursue ESI?
  – Cost-effective to the state for individual to go to employer’s plan versus VHAP or Catamount Health

• How much?
  – Sliding-scale individual contributions mirror VHAP/Catamount Health
2006 Health Care Reform
Catamount Health – Funding

• Employer assessment – through DOL
  – Employers that don’t offer insurance
  – Non-eligible employees of employers who offer
  – Uninsured employees of employers who offer
  – Does not include seasonal or part-time employees in some instances

• Portion of cigarette and tobacco taxes

• Medicaid waiver to allow federal funding for CHAP
  – approved for individuals with incomes at or below 200% FPL
Chronic Care: The Issue

• 75% of Health Care Spending
• More than half of all Vermont adults have one or more chronic conditions
• 75-80% of health care spending is for persons with chronic illness
• Only 55% of chronically ill Vermont patients receive the right care at the right time
2006 Health Care Reform
Chronic Care: Strategies

• Blueprint for Health
• Medicaid Chronic Care Management Program
• Align other programs with Blueprint
  – State employee health plan
  – Employer-sponsored Insurance program
  – Catamount Health Plan
Chronic Care: Medicaid Chronic Care Management

- Identify individuals with one or more chronic conditions (using claims data)
- Conduct health risk assessments (HRAs) for all beneficiaries identified
- Stratify the population into “high”, “middle”, “low” risk groups
- Conduct evidence-based care management interventions for each risk group (intensity of intervention varies by group)
- Coordinate with:
  - Care coordination program – 1-2% of individuals with most complex health needs
  - Blueprint
  - Choices for Care
2006 Health Care Reform Cost Shift Initiatives

• Medicaid Increases for Primary Care Providers, Hospitals, & Dentists
• Cost Shift Task Force Report
• Hospital Cost Shift Reporting Changes
• Standardized Hospital Uncompensated Care and Bad Debt Policies
2007 Health Care Reform
Discrimination Prohibition

• Prohibits discrimination in hiring and among employees based on health coverage status

• Civil action
2007 Health Care Reform: Outreach & Enrollment

• Established outreach initiative (Act 71)
• Improvements to access (Act 71)
  – Forms for easily available
  – Simple, uniform form
2008 Health Care Reform
Expanding Affordable Coverage

- BISHCA to develop rules for split benefit design
- Waiver amendment request to reduce waiting period for Catamount Health and VHAP from 12 to 6 months
- High-deductible plan exception to CH waiting period
- Pregnancy not a preexisting condition for Catamount
- Preexisting condition amnesty: 6/10/08 – 11/1/08
- Relaxation of 75% Rule
2008 Health Care Reform
Preventing Chronic Conditions Through Healthy Lifestyles

• Communities to develop plans to identify and prioritize wellness and healthy living needs
• Inventory of coordinated school health programs (due 1/15/09)
• New nutrition guidelines for competitive food and beverage sales in schools in place for 2008-2009 year
• Nutrition policies in Vermont schools – report due 1/15/09
Preventing Chronic Conditions (cont)

- Commissioner of Health and others to recommend increasing healthy choices in communities, such as promoting physical activity, increasing access to health foods, and promoting good nutrition – report due 1/15/09
- Workgroup on healthy worksites – report due 1/15/09
- Promoting healthy weight through primary care – report due 1/15/09
Preventing Chronic Conditions (cont)

- CHAMPPS /Fit and Healthy Advisory Council to advise Commissioner of Health on ways to increase physical activity, improve nutrition, and reduce overweight and obesity
- Menu labeling and artificial trans fat-free Vermont by 2011 – report due 1/15/09
- Cervical cancer and HPV module allowed in schools, Dept. of Education to update existing module
- UVM and AHEC to conduct academic detailing
Health Care Reform
Health Information Technology

• Multi-payer database improvements (Act 70 – 2007)
• VITL (Act 70 – 2007) & Interim IT Fund
• E-Health Record Pilot (Act 70 – 2007)
• E-prescribing study (Act 203 - 2008)
• Health IT Fund (Act 192 - 2008)
• Health Care IT Reinvestment Fee (Act 192)
  – Quarterly fee for health insurers, who choose to pay either:
    • 0.199% of all claims the insurer paid for its Vermont members in the last quarter, or
    • Annual fee payable quarterly – based on BISHCA’s calculation of insurer’s proportionate share of claims over last four quarters multiplied by the revenue that would be generated if all insurers paid 0.199%
2008 Health Care Reform
Fair Standards for Provider Contracts with Insurers

• Prohibits retrospective denials of paid claims after 12 months (exceptions for fraud/mistake)
• Prohibits insurers from arbitrarily changing the code on a billed claim in order to pay a lower reimbursement (exceptions for fraud/mistake)
• Requires insurers to make payment on claims where prior authorization was required and received (exceptions for fraud/mistake)
2008 Health Care Reform Studies

• Feasibility study of community-based payment reform and integration of care, including ACO model (HCRC)
• Merger of individual and small group markets (HCRC)
• Public financing (HCRC)
• Fair and transparent standards for provider and insurer contracts (Vermont Medical Society, others) – 1/15/09
• Use of restrictive covenants in health care provider employment contracts (VMS, others) – 1/15/09
• timely payment of worker’s compensation claims, improved fairness and efficiency in the worker’s compensation system (VMS, others) – 1/15/09
Questions?