

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

- H.524 (2005) Vetoed
- Act 191 (2006) amended by Act 190 (2006) and Act 70 (2007)
 - See Act summaries for complete description
- Act 71 (2007)
- Act 80 (2007) amended by Act 89 (2008)
 - 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 (\geq \$10,000 for an individual; \geq \$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

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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?