2011 Governor's Health Care Reform Legislation
SUMMARY PREPARED BY
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GOALS FOR 2011:

1. Control health care costs;
2. Meet minimum federal requirements for establishing a health insurance exchange as a necessary precursor to application for implementation grant;
3. Lay the structural foundation for a "single payer exchange";
4. Make a clear commitment to multi-year reforms that will create a "real" single payer (includes all Vermonters, is publicly financed and is decoupled from employment).

THREE STAGES OF HEALTH REFORM, 2011-2014 (AND BEYOND):

Exchange ➔ Single Payer Exchange ➔ Single Payer

BUILDING BLOCKS:

- Blueprint for Health (patient-centered medical home)
- Health information technology
- Vermont Health Reform Board
- Vermont Health Benefit Exchange
- Green Mountain Care (single payer)

COMPONENTS OF THE PROPOSED LEGISLATION:

1. Principles – largely restated from Act 128 (2010) (Sec. 1)

2. Strategic Plan for a Single Payer and Unified Health System (Sec. 2)

- Upon receipt of necessary waivers, all Vermonters are eligible for Green Mountain Care (GMC)
- Includes Medicaid and Medicare, employers who choose to participate, and state and local employees
- Secretary of Administration or designee shall seek all necessary waivers
- Report-backs (See 5. Below)
    - Integration plan (Sec. 8)
        - How to fully integrate or align coverage for Medicaid, Medicare, private insurance, state employees, municipal employees in exchange
    - Financing plan (Sec. 9)
        - How to finance care for full coverage – through exchange and through GMC -- and other needed initiatives
    - Health Information Technology Assessment (Sec. 10)
    - Health System Planning, Regulation, Public Health (Sec. 11)
    - Payment Reform; Regulatory Process (Sec. 12)
    - Workforce Issues (Sec. 13)
    - Medical Malpractice Study (Sec. 14)
- Secretary of Administration or designee shall implement following:
    - July 1, 2013: exchange enrolls individuals and employer groups <100
    - July 1, 2016: exchange enrolls employer groups >100
    - January 1, 2014: BISHCA requires that all individual and small group insurance products are sold through the exchange
    - January 1, 2014: BISHCA requires all large group health insurance to align with that which is offered in the exchange

3. Cost Control and Payment Reform (Sec. 3)

- Create Vermont Health Reform Board: five members
- Appointed by Governor, six-year terms, chair is paid full-time and others are paid half-time
- Members: expert in health policy; practicing health care professional; hospital rep; health insurance purchaser; consumer rep
- Duties:
    - On cost:
        - Establish cost containment targets and budgets for each sector of the health care system
        - Develop global budget
        - Review BISHCA decisions on insurance rates

  - Develop and implement payment reform pilots
  - Review and approve global budgets and capitated payments
  - Review and approve fee-for-service payments
  - Provide guidance to exchange re: rates paid to insurers
- On quality:
  - Evaluate system-wide performance
- On payment methodologies:
  - Eliminate cost shifting
  - Negotiate consistent provider reimbursement across payers
  - Identify innovative payment methodologies
- On payment reform pilots:
  - Develop pilot projects to: manage total health care costs, improve health care outcomes, provide a positive health care experience for patients and providers, align with the Blueprint for Health strategic plan

4. Public-Private Single Payer System (Sec. 4)

Vermont Health Benefit Exchange 33 V.S.A. Chapter 18, Subchapter 1

- Established July 1, 2011, and given the following duties:
  - One exchange for individuals and businesses
  - Exchange includes small group, up to 100 employees
  - Duties include those required by federal law
  - Determines eligibility for Medicaid or other state/federal health insurance programs (**Sec. 5 & 6** – moves eligibility from DCF to DVHA)
  - Negotiates and collects premiums
  - Contracts selectively with insurer(s)
  - Sets requirements of participation for insurer(s): provider payment, administrative systems, etc. (see QHP requirements below)
  - Unless PPACA waiver is obtained, Exchange also provides access to two federal plans
  - Input from consumers and health care professionals through an advisory board which replaces the Medicaid Advisory Board (Sec. 7 & 30(a))

Green Mountain Care (single payer) 33 V.S.A. Chapter 18, Subchapter 2

- Established upon receipt of an ACA waiver, and given the following duties:
  - Comprehensive coverage for all Vermonters; emphasis on primary care; "smart-card" technology
  - Annual budget proposal consistent with VHCRB recommendations
  - Green Mountain Care Fund created for pooling funding streams

- **Both exchange and GMC incorporate:**
  - Minimum benefits established by the Vermont Health Reform Board
  - Mental health parity
  - Additional benefits for Medicaid if necessary
  - Provisions for supplemental and retiree benefits
  - Blueprint – all must have medical home

- Administrative simplification – shall establish systems for reducing complexity

5. **Report-backs**
   - **Integration plan (Sec. 8)**
     - How to fully integrate or align Medicaid, Medicare, private insurance, state employees, municipal employees in exchange
     - Whether to establish Basic Health Plan option to ensure affordable coverage for low-income Vermonters
     - Specific changes needed to integrate private insurance and whether to continue to allow associations
     - Create a common benefit package in the exchange, including analysis of current insurance mandates and affordability of cost-sharing
   - **Financing plan (Sec. 9)**
     - How to finance care for full coverage – through exchange and through GMC -- and other needed initiatives
   - **Health Information Technology Assessment (Sec. 10)**
     - Reassess HIT progress in light of new goals
   - **Health System Planning, Regulation, Public Health (Sec. 11)**
     - Recommend modifications to unify existing systems engaging in planning, public health and quality
   - **Payment Reform; Regulatory Process (Sec. 12)**
     - Reviews current regulation that may apply to payment reform pilots to determine if it is in alignment with goals
   - **Workforce Issues (Sec. 13)**
     - How to optimize licensing and scope of practice for current primary care workforce
     - Create a plan for workforce retraining to address dislocation due to administrative simplification when Green Mountain Care is implemented
   - **Medical Malpractice Study (Sec. 14)**

6. **Immediate Initiatives**
   - **Rate Review (Sec. 15)**
     - Provides for final review of rate increases by the Vermont Health Reform Board
     - Broadens rate review criteria to include affordability, quality, and access
   - **Employer Health Benefit Information (Sec. 16)**
     - Requires employers to provide employees with an annual statement of total premium costs for health benefits to inform employees of total premium costs
   - **Statewide Preferred Drug List (Secs. 17 – 24)**
     - Directs the Drug Utilization Review Board to create a statewide preferred drug list to be used by Medicaid, insurers, and state and municipal employees
     - Allows self-insured employers to elect to use the PDL

    - Provides for variants from the PDL for Medicaid where supplemental rebates are cost-effective
    - Conforming amendments to existing law establishing Medicaid PDL and rebates
- **Repeals the Public Oversight Commissio (Sec. 30(b))**
    - Reduces administrative burden for certificate of need requests

7. Conforming Amendments to Current Law

- **Secretary of Administration (Sec. 25)**
    - Revises current statute directing Sec. of Administration to coordinate heath reform to reflect new and changed initiatives
- **Department of Health (Sec. 26)**
    - Revised duties to include a state health improvement plan
- **VHCURES (Sec. 27)**
    - Ensures Vermont Health Reform Board has use of VHCURES data
- **PPACA Grants (Sec. 28)**
    - Extends date from July 1, 2011 to July 1, 2014
    - Allows agencies to apply for federal grants
- **Primary Care Workforce Committee (Sec. 29)**
    - Allows committee to work for one additional year
    - New recommendations due in March 2011
- **Effective Dates (Sec. 31)**