ONE BALDWIN STREET
MONTPELIER, VT 05633-5701

REP. MICHAEL OBUCHOWSKI, CHAIR
SEN. ANN CUMMINGS, VICE-CHAIR
SEN. DIANE SNELLING, CLERK
REP. JANET ANCEL
SEN. SUSAN BARTLETT

PHONE: (802) 828-2295
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REP. CAROLYN BRANAGAN
REP. MARTHA HEATH
REP. MARK LARSON
SEN. RICHARD SEARS, JR.
SEN. PETER SHUMLIN

STATE OF VERMONT
LEGISLATIVE JOINT FISCAL COMMITTEE

AGENDA

Tuesday, June 29, 2010

Ethan Allen Room, State House

10:00 a.m. I. Call meeting to order and approve minutes of November 12, 2009

10:05 a.m. II. Health Care Design Contract Approval
[Sec. 6 (b)(1) of Act 128 of 2010]
a) Overview of Joint Fiscal Committee responsibility
1) Robin Lunge, Legislative Counsel
2) Stephen Klein, Chief Fiscal Officer
b) Presentation of health care recommendations
Senator Jane Kitchel, Co-chair, Health Care Reform Commission
Representative Steve Maier, Co-chair, Health Care Reform Commission
c) Committee Discussion and Decision

11:15 a.m. III. Update on Federal Application regarding the high-risk health insurance pool program
[VT: Sec. E.230 (b) of Act 156 of 2010]
[Fed.: PL 111-148 of 2010 as amended by PL 111-152 of 2010]
Christine Oliver, Deputy Commissioner, BISHCA
Rebecca Heintz, Assistant General Counsel, BISHCA
Michael Bertrand, Commissioner, BISHCA
Herb Olsen, General Counsel, BISHCA

11:30 a.m. IV. Fiscal Officer's update – Stephen Klein
a) Update on Challenge for Change process *[Act 68 and Act 146 of 2010]*
b) Joint Fiscal Office contracts update
c) Revenues, economic initiatives, other matters

11:55 a.m. V. Next Meetings
a) Thursday, July 15, 2010, 9:30 a.m., Room 10, State House
(Emergency Board 1:00 p.m.)
b) Friday, September 10, 2010

12:00 p.m. Adjourn

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STATE OF VERMONT
LEGISLATIVE JOINT FISCAL COMMITTEE

Tuesday, June 29, 2010

Minutes

Members present: Representatives Obuchowski, Ancel, and Heath, and Senators Cummings, Bartlett, Sears, and Shumlin.

Other Attendees: Representative Steve Maier and Senator Jane Kitchel, Administration, Joint Fiscal Office, and Legislative Council staff, various media, lobbyists, and advocacy groups, and members of the public.

The Chair, Representative Obuchowski, called the meeting to order at 10:07 a.m., and a motion was made by Representative Heath to approve the November 12, 2009, minutes, which motion was adopted.

I. **Health Care Design Contract Approval** – Robin Lunge gave a synopsis of Act 128, Sec. 6(b)(1) and the decision by the Health Care Reform Commission (HCRC) of the preferred proposal. HCRC met and interviewed 2 of the 3 proposers in executive session on June 28 after receiving public comments. HCRC voted to suggest to the Joint Fiscal Committee that Hsiao, Gruber, and Kappel be hired as the consultants.

Representative Steve Maier, Co-chair of HCRC, explained why the HCRC chose the Hsiao proposal out of the 3 submitted, and Senator Jane Kitchel, Co-chair of HCRC, informed the committee on why the legislation [consultant work] was important to Vermont's health care system.

Senator Cummings, a member of HCRC, stated that it was important to have a system that works and is viable for Vermont. Representative Ancel agreed strongly with HCRC's decision, and then proceeded to make a motion (below).

In accordance with Sec. 6(b)(1) of Act 128 of 2010, the Legislative Joint Fiscal Committee accepts the Health Care Reform Commission's recommendation of William C. Hsiao, Steve Kappel, and Jonathan Gruber's proposal.

Senator Peter Shumlin thanked HCRC for their hard work, and explained that when he met with the Hsiao team earlier in the year, leadership convinced them that Vermont was different from the rest of the U.S. because it realized the importance of health care, and politics was not an issue here.

Senator Susan Bartlett stated that all 3 proposals included expansive and in-depth information on Vermont's health care situation and the possible foreseeable political ramifications from outside sources.

Representative Obuchowski asked for a vote on the pending motion from Representative Ancel, and the committee voted in favor of the motion.

Senator Kitchel concluded the discussion by noting the two additional members appointed by the President Pro Tempore and the Speaker of the House, Con Hogan and Former Senator James Leddy, requested by Act 128. She indicated that they had been very helpful in reaching a decision.

The Chair declared that the committee was ahead of schedule and then rearranged the agenda until the next witness could arrive. A discussion ensued on possible next JFC meeting dates, and September 10, 2010, was decided upon. The November JFC meeting date would be confirmed at a later date.

IV. Fiscal Officer's update – Stephen Klein - Joint Fiscal Office contracts update

Mr. Klein gave an update on a new Public Strategies Group (PSG) contract, and explained that the second of the Challenges for Change quarterly reports was due in early July of 2010. PSG's contract proposal included assistance with reports, workshops, and training. The new proposed contract totaled $90,000 with $60,000 guaranteed and $30,000 based on performance.

Mr. Klein explained that the Hsiao contract would be prepared now. Arnie Gundersen's would be retained for 3 days a month to monitor the Vermont Yankee facility through January 2011, at which point the new legislature would reconsider that contract. Steve Gold would be retained to consult on the Vermont Training Program report for $15,000. After the consensus revenue forecast in July 2010, the revenue forecaster contract (Tom Kavet) would go out to bid. A contract with Hans Kastensmith would be renogotiated through the Joint Fiscal Committee rather than the HCRC, with clearer goals and outcomes. Deb Brighton's contract was estimated at $15,000 - 20,000, and contains an increase from the $75 an hour she received the last five years, to $85 an hour. Ms. Brighton is currently the only known analyst that could address data based on Act 60 (1997) and Act 68 (2003) questions by the legislature and the administration.

c) Revenues, Economic Initiatives, and Other Matters

Mr. Klein explained that the Legislature and Joint Fiscal Office's budget would have a carryforward for FY 2010 as would the Legislative Council. Revenues to the state had two more days before final numbers would be released. The state had made its target in corporate and paid income returns. Income withholding was over by $2 million, and rooms and meals and sales tax numbers were not yet available.

Mr. Klein explained the preliminary results of the Joint Fiscal Office evaluations sent to the Legislature. The Office received 77 electronic responses to date through Survey Monkey, which was up significantly from prior years. A full report would be given at the JFC July 15, 2010 meeting.

Chair Obuchowski queried about the reductions in force at the Department of Fish and Wildlife, and Mr. Klein responded the administration had chosen a different course from that suggested by legislative intent.

Representative Heath asked for clarification on the changing of the administration and the budget process. Mr. Klein and Representative Ancel explained there would be a transition team from the outgoing and incoming Governors that would prepare the budget for the Legislature for the 2011 session. Mr. Klein further offered that JFO would proceed with the revenue forecast and work to put together budget options.

a) Update on Challenge for Change process ***[Act 68 and Act 146 of 2010]***

Senator Snelling gave an update on the Challenges for Change process, and reiterated that the second quarterly report was due in early July. She invited JFC to attend the Joint Legislative Accountability Committee meeting July 12. A further progress report would be given at the July JFC meeting.

III. Update on Federal Application regarding the high-risk health insurance pool program - *[VT: Sec. E.230 (b) of Act 156 of 2010] - [Fed.: PL 111-148 of 2010 as amended by PL 111-152 of 2010]*

Christine Oliver, Deputy Commissioner, Banking, Insurance, Securities, and Health Care Administration, referenced a handout of the statutory language, and proceeded to give an update on the state's application regarding the federal high-risk health insurance pool program. The federal government was unwilling to pickup the costs, under Catamount, for a preexisting condition; therefore, the department was applying for a separate pool in order to use the money. The questions were: how do you define a preexisting condition? should it be defined broadly or narrowly? and how many would be covered? Ms. Oliver handed out a letter that was sent to the federal government asking for an extension of time because of the current date of application of July 1, 2010 (see letter for explanation). The estimated grant was $8 million to Vermont but was dependent on the federal criteria that were yet to be determined.

Representative Ancel inquired whether the funds would be ongoing, and Ms. Oliver responded it was one-time money. Senator Shumlin asked if the $8 million was the maximum amount the state could achieve through the grant, and Ms. Oliver responded affirmatively. Michael Bertrand, Commissioner of BISHCA, added that the $8 million had been set aside for Vermont, but receiving the funds depended on whether the state could conform to the federal criteria. Senator Shumlin queried whether Vermont's congressional delegation had been kept up-to-date on the state's application, and Ms. Oliver stated yes. Although not as to the most recent information. Representative Obuchowski asked whether a notice of application had gone out to the public, and Rebecca Heintz, Assistant General Counsel for BISHCA, explained that the department had not started the application form yet. Ms. Oliver added that the department would make the application available to the committee for approval once it was created.

Commissioner Bertrand explained a concern that Vermont would have to continue in the federal program for a year, and that the state could not switch until after six months on the program to a Vermont health care entity, such as Blue Cross Blue Shield.

The Committee adjourned at 11:10 a.m.

Respectfully Submitted,

Theresa Utton-Jerman, Legislative Joint Fiscal Office

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– File only –

MEMORANDUM

To: Chair, Representative Michael Obuchowski, and Members of the Legislative Joint Fiscal Committee

From: Stephen Klein, Fiscal Officer

Date: June 23, 2010

Subject: Special Meeting of the Joint Fiscal Committee, June 29, 2010

The primary purpose of the Special Meeting of the Joint Fiscal Committee is to carry out our responsibilities under Section 6 (b)(1) of Act 128 of 2010, which requires that Joint Fiscal Committee accept, reject, or modify the Health Care Commission's proposal for hiring a consultant with demonstrated experience in designing health care systems. This will be first on our agenda and we have budgeted an hour and a half.

Under Section 6 of Act 128:

> By February 1, 2011, one or more consultants of the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general assembly and the governor at least three design options, including implementation plans, for creating a single system of health care which ensures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multi-payer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act. [See attachment].

The Joint Fiscal Office has access to $300,000 to contract for this study. Three bidders have applied for the contract. All three have submitted bids that use all of the allotted funds. In this mailing you will receive copies of the three proposals. You should be aware that these proposals are not public information or public records and will not be until the bid has been awarded and a contract has been finalized. So the materials should not be shared. Robin Lunge has enclosed a memorandum on the public records aspects of the materials.

As the Committee will be working from a recommendation from the Commission, there will be no formal interview with the finalists. Joint Fiscal Committee members have been invited to participate in the Commission on Health Care Reform deliberations on June 28th, if they so choose. An agenda for that meeting is also enclosed.

The recommendation to the Joint Fiscal Committee will be presented by the Co-Chairs of the Health Care Reform Commission, Senator Jane Kitchel and Representative Steve Maier.

The last half hour of the meeting will be a series of updates and planning for upcoming meetings, and we are scheduled to be done by noon.

Attachment Sections 2 and 3 of Act 128

Sec. 2. PRINCIPLES FOR HEALTH CARE REFORM
The general assembly adopts the following principles as a framework for reforming health care in Vermont:
(1) It is the policy of the state of Vermont to ensure universal access to and coverage for essential health services for all Vermonters. All Vermonters must have access to comprehensive, quality health care. Systemic barriers must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting, and health care costs must be contained over time.
(2) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms in the health care system.
(3) Primary care must be preserved and enhanced so that Vermonters have care available to them; preferably, within their own communities. Other aspects of Vermont's health care infrastructure must be supported in such a way that all Vermonters have access to necessary health services and that these health services are sustainable.
(4) Every Vermonter should be able to choose his or her primary care provider, as well as choosing providers of institutional and specialty care.
(5) The health care system will recognize the primacy of the patient-provider relationship, respecting the professional judgment of providers and the informed decisions of patients.
(6) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be evaluated for improvement in access, quality, and reliability and for a reduction in cost.
(7) A system for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and reducing care that does not improve health outcomes, must be implemented for the health of the Vermont economy.
(8) The financing of health care in Vermont must be sufficient, fair, sustainable, and shared equitably.
(9) State government must ensure that the health care system satisfies the principles in this section.

Sec. 3. GOALS OF HEALTH CARE REFORM
Consistent with the adopted principles for reforming health care in Vermont, the general assembly adopts the following goals:
(1) The purpose of the health care system design proposals created by this act is to ensure that individual programs and initiatives can be placed into a larger, more rational design for access to, the delivery of, and the financing of affordable health care in Vermont.
(2) Vermont's primary care providers will be adequately compensated through a payment system that reduces administrative burdens on providers.
(3) Health care in Vermont will be organized and delivered in a patient-centered manner through community-based systems that:
(A) are coordinated;
(B) focus on meeting community health needs;
(C) match service capacity to community needs;
(D) provide information on costs, quality, outcomes, and patient satisfaction;

(E) use financial incentives and organizational structure to achieve specific objectives;
(F) improve continuously the quality of care provided; and
(G) contain costs.
(4) To ensure financial sustainability of Vermont's health care system, the state is committed to slowing the rate of growth of total health care costs, preferably to reducing health care costs below today's amounts, and to raising revenues that are sufficient to support the state's financial obligations for health care on an ongoing basis.
(5) Health care costs will be controlled or reduced using a combination of options, including:
(A) increasing the availability of primary care services throughout the state;
(B) simplifying reimbursement mechanisms throughout the health care system;
(C) reducing administrative costs associated with private and public insurance and bill collection;
(D) reducing the cost of pharmaceuticals, medical devices, and other supplies through a variety of mechanisms;
(E) aligning health care professional reimbursement with best practices and outcomes rather than utilization;
(F) efficient health facility planning, particularly with respect to technology; and
(G) increasing price and quality transparency.
(6) All Vermont residents, subject to reasonable residency requirements, will have universal access to and coverage for health services that meet defined benefits standards, regardless of their age, employment, economic status, or town of residency, even if they require health care while outside Vermont.
(7) A system of health care will provide access to health services needed by individuals from birth to death and be responsive and seamless through employment and other life changes.
(8) A process will be developed to define packages of health services, taking into consideration scientific and research evidence, available funds, and the values and priorities of Vermonters, and analyzing required federal health benefit packages.
(9) Health care reform will ensure that Vermonters' health outcomes and key indicators of public health will show continuous improvement across all segments of the population.
(10) Health care reform will reduce the number of adverse events from medical errors.
(11) Disease and injury prevention, health promotion, and health protection will be key elements in the health care system.

Attachment Section 6 of Act 128 of 2010

Sec. 6. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN
(a)(1)(A) By February 1, 2011, one or more consultants of the joint legislative commission on health care reform established in chapter 25 of Title 2 shall propose to the general assembly and the governor at least three design options, including implementation plans, for creating a single system of health care which ensures all Vermonters have access to and coverage for affordable, quality health services through a public or private single-payer or multipayer system and that meets the principles and goals outlined in Secs. 2 and 3 of this act. The proposal shall contain the analysis and recommendations as provided for in subsection (g) of this section. (B) By January 1, 2011, the consultant shall release a draft of the design options to the public and provide 15 days for public review and the submission of comments on the design options. The consultant shall review and consider the public comments and revise the draft design options as necessary prior to the final submission to the general assembly and the governor.
(2)(A) One option shall design a government-administered and publicly financed "single-payer" health benefits system decoupled from employment which prohibits insurance coverage for the health services provided by this system and allows for private insurance coverage only of supplemental health services. (B) One option shall design a public health benefit option administered by state government, which allows individuals to choose between the public option and private insurance coverage and allows for fair and robust competition among public and private plans. (C) A third and any additional options shall be designed by the consultant, in consultation with the commission, taking into consideration the principles in Sec. 2 of this act, the goals in Sec. 3, and the parameters described in this section.
(3) Each design option shall include sufficient detail to allow the governor and the general assembly to consider the adoption of one design during the 2011 legislative session and to initiate implementation of the new system through a phased process beginning no later than July 1, 2012.
(b)(1) No later than 45 days after enactment, the commission shall propose to the joint fiscal committee a recommendation, including the requested amount, for one or more outside consultants who have demonstrated experience in designing health care systems that have expanded coverage and contained costs to provide the expertise necessary to do the analysis and design required by this act. Within seven days of the commission's proposal, the joint fiscal committee shall meet and may accept, reject, or modify the commission's proposal.
(2) The commission shall serve as a resource for the consultant by providing information and feedback to the consultant upon request, by recommending additional resources, and by receiving periodic progress reports by the consultant as needed. In order to maintain the independence of the consultant, the commission shall not direct the consultant's recommendations or proposal.
(c) In creating the designs, the consultant shall review and consider the following fundamental elements:
(1) the findings and reports from previous studies of health care reform in Vermont, including the Universal Access Plan Report from the health care authority, November 1, 1993; reports from the Hogan Commission; relevant studies provided to the state of Vermont by the Lewin Group; and studies and reports provided to the commission.
(2) existing health care systems or components thereof in other states or countries as models.

(3) Vermont's current health care reform efforts as defined in 3 V.S.A. § 2222a.
(4) the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act.
(d) Each design option shall propose a single system of health care which maximizes the federal funds to support the system and is composed of the following components, which are described in subsection (e) of this section:
(1) a payment system for health services which includes one or more packages of health services providing for the integration of physical and mental health; budgets, payment methods, and a process for determining payment amounts; and cost reduction and containment mechanisms;
(2) coordinated regional delivery systems;
(3) health system planning, regulation, and public health;
(4) financing and estimated costs, including federal financings; and
(5) a method to address compliance of the proposed design option or options with federal law.
(e) In creating the design options, the consultant shall include the following components for each option:
(1) A payment system for health services. (A)(i) Packages of health services. In order to allow the general assembly a choice among varied packages of health services in each design option, the consultant shall provide at least two packages of health services providing for the integration of physical and mental health as further described in subdivision (A)(ii) of this subdivision (1) as part of each design option. (ii)(I) Each design option shall include one package of health services which includes access to and coverage for primary care, preventive care, chronic care, acute episodic care, palliative care, hospice care, hospital services, prescription drugs, and mental health and substance abuse services. (II) For each design option, the consultant shall consider including at least one additional package of health services, which includes the services described in subdivision (A)(ii)(I) of this subdivision (1) and coverage for supplemental health services, such as home- and community-based services, services in nursing homes, payment for transportation related to health services, or dental, hearing, or vision services. (iii)(I) For each proposed package of health services, the consultant shall consider including a cost-sharing proposal that may provide a waiver of any deductible and other cost-sharing payments for chronic care for individuals participating in chronic care management and for preventive care.
(II) For each proposed package of health services, the consultant shall consider including a proposal that has no cost-sharing. If this proposal is included, the consultant shall provide the cost differential between subdivision (A)(iii)(I) of this subdivision (1) and this subdivision (II). (B) Administration. The consultant shall include a recommendation for: (i) a method for administering payment for health services, which may include administration by a government agency, under an open bidding process soliciting bids from insurance carriers or third-party administrators, through private insurers, or a combination. (ii) enrollment processes. (iii) integration of the pharmacy best practices and cost control program established by 33 V.S.A. §§ 1996 and 1998 and other mechanisms to promote evidence-based prescribing, clinical efficacy, and cost-containment, such as a single statewide preferred drug list, prescriber education, or utilization reviews. (iv) appeals processes for decisions made by entities or agencies administering coverage for health services.
(C) Budgets and payments. Each design shall include a recommendation for budgets, payment methods, and a process for determining payment amounts. Payment methods for

mental health services shall be consistent with mental health parity. The consultant shall consider: (i) amendments necessary to current law on the unified health care budget, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations, in order to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured. (ii) how to align the unified health care budget with the health resource allocation plan under 18 V.S.A. § 9405; the hospital budget review process under 18 V.S.A. § 9456; and the proposed global budgets and payments, if applicable and recommended in a design option. (iii) recommending a global budget where it is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination. Any recommendation shall include a process for developing a global budget, including circumstances under which an entity may seek an amendment of its budget, and any changes to the hospital budget process in 18 V.S.A. § 9456.(iv) payment methods to be used for each health care sector which are aligned with the goals of this act and provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles. Payment methods may include: (I) periodic payments based on approved annual global budgets; (II) capitated payments; (III) incentive payments to health care professionals based on performance standards, which may include evidence-based standard physiological measures, or if the health condition cannot be measured in that manner, a process measure, such as the appropriate frequency of testing or appropriate prescribing of medications; (IV) fee supplements if necessary to encourage specialized health care professionals to offer a specific, necessary health service which is not available in a specific geographic region; (V) diagnosis-related groups; (VI) global payments based on a global budget, including whether the global payment should be population-based, cover specific line items, provide a mixture of a lump sum payment, diagnosis-related group (DRG) payments, incentive payments for participation in the Blueprint for Health, quality improvements, or other health care reform initiatives as defined in 3 V.S.A. § 2222a; and (VII) fee for service. (v) what process or processes are appropriate for determining payment amounts with the intent to ensure reasonable payments to health care professionals and providers and to eliminate the shift of costs between the payers of health services by ensuring that the amount paid to health care professionals and providers is sufficient. Payment amounts should be in an amount which provides reasonable access to health services, provides sufficient uniform payment to health care professionals, and assists to create financial stability of health care professionals. Payment amounts shall be consistent with mental health parity. The consultant shall consider the following processes: (I) Negotiations with hospitals, health care professionals, and groups of health care professionals; (II) Establishing a global payment for health services provided by a particular hospital, health care provider, or group of professionals and providers. In recommending a process for determining a global payment, the consultant shall consider the interaction with a global budget and other information necessary to the determination of the appropriate payment, including all revenue received from other sources. The recommendation may include that the global payment be reflected as a specific line item in the annual budget. (III) Negotiating a contract including payment methods and amounts with any out-of-state hospital or other health care provider that regularly treats a sufficient volume of Vermont residents, including contracting with out-of-state hospitals or health care providers for the provision of specialized health services that are not available locally to Vermonters. (IV) Paying the amount charged for a medically necessary health service for which the individual received a referral or for an emergency health service customarily covered and received in an out-of-state hospital with which there is not an established

contract; (V) Developing a reference pricing system for nonemergency health services usually covered which are received in an out-of-state hospital or by a health care provider with which there is not a contract. (VI) Utilizing one or more health care professional bargaining groups provided for in 18 V.S.A. § 9409, consisting of health care professionals who choose to participate and may propose criteria for forming and approving bargaining groups, and criteria and procedures for negotiations authorized by this section. (D) Cost-containment. Each design shall include cost reduction and containment mechanisms. If the design option includes private insurers, the option may include a fee assessed on insurers combined with a global budget to streamline administration of health services. (2) Coordinated regional health systems. The consultant shall propose in each design a coordinated regional health system, which ensures that the delivery of health services to the citizens of Vermont is coordinated in order to improve health outcomes, improve the efficiency of the health system, and improve patients' experience of health services. The consultant shall review and analyze Vermont's existing efforts to reform the delivery of health care, including the Blueprint for Health described in chapter 13 of Title 18, and consider whether to build on or improve current reform efforts. In designing coordinated regional health systems, the consultant shall consider: (A) how to ensure that health professionals, hospitals, health care facilities, and home- and community-based service providers offer health services in a coordinated manner designed to optimize health services at a lower cost, to reduce redundancies in the health system as a whole, and to improve quality; (B) the creation of regional mechanisms to solicit public input for the regional health system; conduct a community needs assessment for incorporation into the health resources allocation plan; and plan for community health needs based on the community needs assessment; and (C) the development of a regional entity, organization, or another mechanism to manage health services for that region's population, which may include making budget recommendations and resource allocations for the region; providing oversight and evaluation regarding the delivery of care in its region; developing payment methodologies and incentive payments; or other functions necessary to manage the region's health system. (3) Health system planning, regulation, and public health. The consultant shall evaluate the existing mechanisms for health system and facility planning and for assessing quality indicators and outcomes and shall evaluate public health initiatives, including the health resource allocation plan, the certificate of need process, the Blueprint for Health, the statewide health information exchange, services provided by the Vermont Program for Quality in Health Care, and community prevention programs. (4) Financing and estimated costs, including federal financing. The consultant shall provide: (A) an estimate of the total costs of each design option, including any additional costs for providing access to and coverage for health services to the uninsured and underinsured; any estimated costs necessary to build a new system; and any estimated savings from implementing a single system. (B) financing proposals for sustainable revenue, including by maximizing federal revenues, or reductions from existing health care programs, services, state agencies, or other sources necessary for funding the cost of the new system. (C) a proposal to the Centers on Medicare and Medicaid Services to waive provisions of Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act if necessary to align the federal programs with the proposals contained within the design options in order to maximize federal funds or to promote the simplification of administration, cost-containment, or promotion of health care reform initiatives as defined by 3 V.S.A. § 2222a. (D) a proposal to participate in a federal insurance exchange established by the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 in order to maximize federal funds and, if applicable, a waiver from these provisions when available. (5) A method

to address compliance of the proposed design option or options with federal law if necessary, including the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010; Employee Retirement Income Security Act (ERISA); and Titles XVIII (Medicare), XIX (Medicaid), and XXI (SCHIP) of the Social Security Act. In the case of ERISA, the consultant may propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options. (f)(1) The agency of human services and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the commission and its consultant have the information necessary to create the design options. (2) The consultant may request legal and fiscal assistance from the office of legislative council and the joint fiscal office.
(3) The commission or its consultant may engage with interested parties, such as health care providers and professionals, patient advocacy groups, and insurers, as necessary in order to have a full understanding of health care in Vermont. (g) In the proposal and implementation plan provided to the general assembly and the governor as provided for in subsection (a) of this section, the consultant shall include:
(1) A recommendation for key indicators to measure and evaluate the design option chosen by the general assembly. (2) An analysis of each design option, including: (A) the financing and cost estimates outlined in subdivision (e)(4) of this section; (B) the impacts on the current private and public insurance system; (C) the expected net fiscal impact, including tax implications, on individuals and on businesses from the modifications to the health care system proposed in the design; (D) impacts on the state's economy; (E) the pros and cons of alternative timing for the implementation of each design, including the sequence and rationale for the phasing in of the major components; and (F) the pros and cons of each design option and of no changes to the current system. (3) A comparative analysis of the coverage, benefits, payments, health care delivery, and other features in each design option with Vermont's current health care system and health care reform efforts, the new federal insurance exchange, insurance regulatory provisions, and other provisions in the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010. The comparative analysis should be in a format to allow the general assembly to compare easily each design option with the current system and efforts. If appropriate, the analysis shall include a comparison of financial or other changes in Medicaid and Medicaid-funded programs in a format currently used by the department of Vermont health access in order to compare the estimates for the design option to the most current actual expenditures available. (4) A recommendation for which of the design options best meets the principles and goals outlined in Secs. 2 and 3 of this act in an affordable, timely, and efficient manner. The recommendation section of the proposal shall not be finalized until after the receipt of public input as provided for in subdivision (a)(1)(B) of this section. (h) After receipt of the proposal and implementation plan pursuant to subdivision (g)(2) of this section, the general assembly shall solicit input from interested members of the public and engage in a full and open public review and hearing process on the proposal and implementation plan.

To: All Interested Parties
From: Jim Hester, Director, Health Care Reform Commission
Date: June 22, 2010
Subject: Bids Opened for Health Care Reform Study

The Joint Fiscal Committee and Health Care Reform Commission (HCRC) received three qualified bids by consultants applying for the contract to conduct a Health Care Design Study required by Act 128 of 2010.

The contracted consultant will be tasked with developing proposals for outlining at least three design options, including implementation plans, for creating 1) a single payer system, 2) a public option, and 3) a third design to be determined by the consultant. The three respondents were:

- The Lewin Group (Falls Church, VA)
- Mathmatica Policy Research, Inc. (Washington, DC)
- William C. Hsiao, Ph.D, FSA (Cambridge, MA), Steven Kappel, MPA (Montpelier, VT) and Johnathan Gruber, Ph.D, (Cambridge, MA)

The proposals will be evaluated in accordance with the qualifications contained in Act 128 and the criteria contained in the RFP. The Commission's evaluation form is posted on the website listed below and the public is welcome to submit comments on the form by June 25th at noon.

The HCRC is scheduled to meet on June 28th to develop a recommendation which will be provided to the Joint Fiscal Committee (JFC) at its special meeting to award the contract scheduled for June 29th. Public comments regarding the expertise and background of bidders are welcomed. Written comments to the HCRC and the JFC should be submitted by June 25th at 3:00pm for the review of Commission members prior to the HCRC meeting. The public will also have a brief opportunity for public comment at the June 28 th HCRC meeting, but the strong preference is to provide written comments prior to the meeting.

The HCRC will meet on Monday, June 28th at 9:30 a.m. at the Statehouse in Room 10. The Joint Fiscal Committee will meet Tuesday, June 29th at 10 a.m. at the Statehouse in the Ethan Allen Room.

Written public comments on the form or bidders may be sent to:
The Commission on Health Care Reform
14-16 Baldwin Street
Montpelier, VT 05620
healthcomments@leg.state.vt.us

For a timeline of the RFP process and related materials visit:
http://www.leg.state.vt.us/JFO/Healthcare%20Study%20Design.htm
http://www.leg.state.vt.us/CommissiononHealthCareReform/

Act 156 of 2010

Sec. E.230 FEDERAL HEALTH CARE GRANT FUNDING TO SUPPORT CATAMOUNT HEALTH

(a) It is the intent of the general assembly that the state maximize federal funding opportunities to expand access to health care coverage for uninsured and underinsured Vermonters. The general assembly is aware of upcoming federal funding opportunities related to the creation of a high-risk pool and supports using the Catamount Health program, to the extent practicable, to leverage applicable federal funds while keeping eligibility standards consistent across all of the state's health care programs.

(b) The commissioner of banking, insurance, securities, and health care administration shall notify the members of the joint fiscal committee by telephone and provide the members with a copy of the application by electronic mail prior to applying for federal funding under the high-risk health insurance pool program authorized by Section 1101 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, for the purpose of supporting the Catamount Health program or the market security trust provided for in 8 V.S.A. § 4062d. If feasible given the federal time lines, the commissioner shall make reasonable efforts to provide notice, a copy of the application, and an opportunity for the members to respond at least 3 business days prior to the application deadline.

(c)(1) Notwithstanding 32 V.S.A. § 5, and with the approval of the secretary of administration, the commissioner of banking, insurance, securities, and health care administration shall request approval from the joint fiscal committee to accept federal funding under the high-risk health insurance pool program authorized by Section 1101 of the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, for the purpose of supporting the Catamount Health program or the market security trust provided for in 8 V.S.A. § 4062d.

(2) The commissioner of banking, insurance, securities, and health care administration shall provide the joint fiscal committee with information on whether the proposal is budget neutral or financially beneficial to the state, as determined by the commissioner in consultation with the commissioner of the department of Vermont health access. If the grant meets the criteria under this subsection and notwithstanding 32 V.S.A. § 5, the commissioner may accept the grant after approval by a majority of voting members of the joint fiscal committee.

(d) Upon approval by the joint fiscal committee as part of the review under subsection (c) of this section or at a later meeting and notwithstanding 8 V.S.A. § 4080f (Catamount Health), 33 V.S.A. § 1973 (Vermont health access program), 33 V.S.A. § 1974 (employer-sponsored insurance assistance program) and 33 V.S.A. Chapter 19, Subchapter 3A (Catamount Health assistance program), the commissioner of banking, insurance, securities, and health care administration and the secretary of human services may waive the statutory requirements establishing the 12-month uninsured requirement and the pre-existing condition exclusion provisions if necessary to permit the state to accept grant funds under the federal high-risk pool program. The request to waive the statutory requirements shall specify a time period ending no later than June 30, 2011.

Joint Fiscal Committee Motion 6/29/2010:

In accordance with Sec. 6 (b)(1) of Act 128 of 2010, the Legislative Joint Fiscal Committee accepts the Health Care Reform Commission's recommendation of William C. Hsiao, Steve Kappel, Jonathan Gruber's proposal.

III.

State of Vermont
Department of Banking, Insurance,
Securities and Health Care Administration
89 Main Street
Montpelier, VT 05620-3101
www.bishca.state.vt.us

Consumer Assistance Only:
Insurance: 1-800-964-1784
Health Care Admin.: 1-800-631-7788
Securities: 1-877-550-3907

June 25, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight, HHS
HHH Building, Room 738 G
200 Independence Avenue, SW
Washington DC 20201

Re: Preliminary High Risk Pool Proposal

Dear Mr. Angoff:

Attached is a preliminary proposal for a potential way that Vermont could access the funding allocated to Vermont pursuant to the Patient Protection and Affordable Care Act Section 1101. Although we are committed to working with our federal partners to establish a successful program, we note that operational realities of such a program may ultimately result in a program which the state cannot support.

Vermont has been a leader in promoting health care access to its residents. In fact, many of the federal reforms being implemented will require the rest of the nation to abide by laws and practices which have long been in place in Vermont. However, because of our proactive approach to health care, we are struggling to develop a program under PPACA § 1101 which utilizes the available funding efficiently. As we note in our memo, we believe this funding could help many more Vermonters and provide far more relief if we could use it to enhance our current programs.

We look forward to your comments regarding the attached proposal. Please contact myself at (802) 828-2380 or Christine Oliver at (802) 828-2919 with any questions.

Sincerely,

Michael S. Bertrand
Commissioner

cc: Governor James H. Douglas

State of Vermont
Department of Banking, Insurance
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89 Main Street, Drawer 20
Montpelier VT 05620-3101
www.Bishca.state.vt.us

For Consumer Assistance Only:
Insurance 800-964-8427
Securities 877-550-3907
Health Care Admin 800-631-7788

MEMORANDUM

To: U.S. Department of Health and Human Services

From: Christine M. Oliver, Vermont Division of Health Care Administration Deputy Commissioner

Date: June 25, 2010

Re: **Federally Funded High Risk Pool Proposal**

This memo outlines Vermont's preliminary proposal for accessing funding authorized pursuant to Section 1101 of the Patient Protection and Affordable Care Act of 2010. We do not believe this proposal utilizes the federal dollars for Vermonters in the most efficient or effective manner, however, after extensive conversations with officials in the Department of Health and Human Services, it seems to be the only approach that will be acceptable to the Federal Government.

Like several other states that have taken steps in recent decades to expand health care coverage to our citizens, we have found the development of this proposal to be a challenge. Our preference would have been to use these funds to enhance existing programs, which we believe would have benefited more Vermonters. With that, we note this is a preliminary proposal. As we work to finalize the specific details relating to this proposal, it is possible that unanticipated obstacles may result in the creation of a program which is not in the best interests of the state, in which case Vermont will not be able to sign a contract for this program.

CURRENT VERMONT INSURANCE MARKET

In Vermont, since 1992, health insurers in the small group and nongroup market have been required to guarantee acceptance of all insureds. 8 V.S.A. §§ 4080a and 4080b.[1]

[1] Vermont statutes are available on-line at http://www.leg.state.vt.us/statutes/statutes2.htm.

Thus, Vermont has no individuals that are denied insurance because of a health condition – the specific population targeted in PPACA § 1101. However, in both the small group and nongroup market, some preexisting condition exclusions are allowed.[2]

In 2005, the Vermont State Legislature and the Governor passed a law creating Catamount Health, a product designed to provide lower cost high quality health insurance to the uninsured. 8 V.S.A. § 4080f. Catamount Health is a public-private partnership. Vermont's two registered nongroup health insurers (Blue Cross Blue Shield of Vermont and MVP Health Insurance Company) enroll those eligible for Catamount. These carriers administer benefits and pay providers as with a traditional insurance plan.

Catamount premiums, however, are subsidized by the state, up to 300% of the federal poverty level. Premiums are subsidized with a combination of state and federal funds, in accordance with Vermont's Medicaid section 1115 waiver. The Vermont Medicaid Office, the Office of Vermont Health Access,[3] determines the level of premium subsidy to which an individual is entitled. After receiving premium assistance approval, the individual then enrolls in the Catamount insurance plan through the carrier of his or her choice. As income levels fluctuate, mechanisms are in place to move people between Catamount, Vermont Health Access Plan, and traditional Medicaid. This is intended to be as streamlined as possible.

Catamount benefits are largely dictated by the legislation which created the program and are generally considered high quality. Catamount carriers must provide coverage for "primary care, preventive care, chronic care, acute episodic care, and hospital services." 8 V.S.A. § 4080f(c). Cost-sharing is dictated by statute. Currently, Catamount health plans have a $250 deductible for an individual ($500/family) for in-network and $500 for out-of-network ($1,000 for a family).[4] Catamount provides for 20% co-insurance in-and out-of-network and a $10.00 office co-payment. Prescription drugs are provided without a deductible, but are subject to a co-pay ($10 for generic drugs, $30 for drugs on the preferred drug list, and $50 for nonpreferred drugs). As provided in statute, Catamount cost sharing is capped at $800 ($1,500 for a family) for in-network services and at $1,500 for out-of-network costs ($3,000 for a family). Prescription drug payments do not count toward out-of-pocket maximums. The actuarial value of the plan has been calculated at 83%.

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[2] Both small group and nongroup carries are allowed to impose preexisting condition exclusions up to 12 months. In the small group market, the "look back" period is limited to 6 months, in the nongroup period it is 12 months. Such exclusions are not allowed with evidence of sufficient continuous creditable coverage. See 8 V.S.A. §§ 4080a(g) and 4080b(g).

[3] Vermont's Office of Vermont Health Access will become the Department of Vermont Health Access effective July 1, 2010.

[4] Catamount deductibles and some cost-sharing are scheduled to be increased for policies renewing on or after October 1, 2010.

For preventive services all cost-sharing is waived. Additionally, all cost sharing is waived for chronic care if the insured individual is actively participating in a carrier's chronic care management program.[5] Although Catamount Health has a pre-existing condition exclusion, such exclusion,[6] is waived for chronic care if the individual is actively participating in the chronic care management program.

In order to facilitate affordability, the Catamount Health provider reimbursement is less than that typically provided by commercial insurers. By statute, Catamount Health insurers pay health care professionals 110% of Medicare reimbursement. Hospitals charges are calculated using a cost-to-charge ratio approved by the Health Care Administration Division adjusted for each hospital to ensure payments are at 110% of a hospital's actual cost to provide the service.

Catamount premium rates are filed for approval with the Health Care Administration Division and must be approved prior to implementation. "A rate shall be approved if it is sufficient not to threaten the financial safety and soundness of the insurer, reflects efficient and economical management, provides Catamount Health at the most reasonable price consistent with actuarial review, is not unfairly discriminatory, and" otherwise complies with the law. 8 V.S.A. § 4080f(g)(2). Currently, the full price cost of Catamount for an individual $442.25 for an individual. Subsidized premiums range from $60 to $208 for individual coverage per month.

In order to be eligible for Catamount Health, a person must be uninsured for twelve months or subject to one of the exceptions. There are numerous exceptions to the 12 month uninsured requirement, but exceptions include losing coverage due to loss of employment, a divorce, death or aging off a parent's plan. 8 V.S.A. § 4080f(a)(9). As of March 2010, Catamount Health had 11,488 enrollees.[7]

HIGH RISK POOL PROPOSAL

Ideally, Vermont would have chosen to use the federal funds allocated to Vermont to enhance existing programs. We believe this would have allowed the most people to benefit from the federal funding. However, current state legislation authorizing us to make the necessary changes to Catamount requires that such changes be budget neutral. Because HHS has interpreted the federal statute to prohibit the use of federal

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[5] In the Catamount program, chronic care management programs are mandated for certain conditions and must be approved by the state. Such programs must be consistent with Vermont's Blueprint for Health, a multi-faceted program currently focusing on medical homes, community health teams, wellness and prevention. See the 2009 Annual Report at: http://healthvermont.gov/prevent/blueprint/documents/Blueprint_AnnualReport_2009_0110rev.pdf

[6] By statute, pregnancy is not a pre-existing condition.

[7] Of these, only 1,733 pay full price, not subsidized premium. Please note that all children in Vermont under 300% of the poverty level are enrolled in Vermont's Dr. Dynasaur. As such, very few children are currently enrolled in Catamount.

dollars to fund any existing state assumed risk or risk assumed beyond that mandated by statute, there is no way to enhance the Catamount program without some negative impact on the state budget. Furthermore, we have concerns that trying to use the federal funding within existing programs, but only for individuals eligible for the high risk pool funding, may be prohibitively expensive from an administrative perspective.

As such, Vermont is proposing to create a separate pool of insureds comprised of "eligible individuals" as described below.

The state, in partnership with BCBSVT, [8] would create a risk pool which would be modeled on Catamount, but without the state subsidy. The coverage would be identical to Catamount, except that there would be no pre-existing condition exclusion. Provider networks and reimbursement would be the same as current Catamount. The premium charged for the product would be the Catamount full cost premium.[9] Catamount is a pure community rated product – there is no deviation in rates for age or any other factor.

In order to be eligible for the new program, individuals would have to be citizens of the U.S., would have to have been uninsured for at least six months, and would have to have a pre-existing condition.[10] There would be no allowance for exceptions to the uninsured requirement as there is in current Catamount. BCBSVT would manage eligibility determinations. Uninsured status would be established through self-certification.[11] Citizenship would be established as directed by HHS. The method of establishing a preexisting condition is yet to be determined, but would likely involve identifying such condition on the application.

It is expected the federal funding would cover all of the claims costs which were not supported by the premiums collected, as well as BCBSVT's administrative costs of administering the program. The program would include a mechanism whereby enrollment would be halted if it appeared that the $8,000,000 in federal funding was going to be exhausted before January 1, 2014. If the program ran out of funding, or appeared to be ready to run out of funding, enrollees would automatically be enrolled into the current nongroup market.

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[8] BCBSVT is a nonprofit medical service corporation

[9] As noted, the current Catamount individual premium is $442.25. Carriers are allowed to seek increases in of the premium on a quarterly basis, although an individual's premium rate is guaranteed for twelve months and does not change until renewal.

[10] We are still analyzing how best to define pre-existing condition.

[11] Catamount uninsured status is established through self-certification. However, both carriers check applicants against past insureds. BCBSVT has a sufficiently large market share, that such cross check is reasonably effective in ensuring that individuals have been uninsured. Cross checks have not revealed any significant fraud in this area.

Taking this approach is not ideal. Not being able to leverage the $8,000,000 in our current programs and the Catamount risk pool means that far less people will benefit from the federal dollars. However, because the federal funds under current statutory interpretation appear to be unavailable for any currently assumed state risk or risk beyond the federally defined "eligible individual," attempting to leverage our current programs would result in a negative impact on the state budget, is not permitted under current state law, and is contrary to Vermont's interests especially in these difficult economic times. In addition, we are uncertain whether there is a viable target population for this program. Furthermore, it is unclear how this program will impact current risk pools. It is possible the amount of money allocated to Vermont will not be sufficient to cover the target population, particularly since we cannot pool the risk with better risk to offset high cost individuals.

Finally, there are elements of unfairness associated with the introduction of this product. For example, those individuals who have elected to purchase Catamount, but are subject to the pre-existing condition limitation, will not have access to this federally subsidized coverage.

Notwithstanding its limitations, Vermont intends to proceed with a high risk pool application in accordance with the conceptual proposal outlined above, and subject to Vermont's acceptance and execution of the terms of a contract.

Act 156 of 2010

Sec. E.230 FEDERAL HEALTH CARE GRANT FUNDING TO SUPPORT CATAMOUNT HEALTH

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(d) Upon approval by the joint fiscal committee as part of the review under subsection (c) of this section or at a later meeting and notwithstanding 8 V.S.A. § 4080f (Catamount Health), 33 V.S.A. § 1973 (Vermont health access program), 33 V.S.A. § 1974 (employer-sponsored insurance assistance program) and 33 V.S.A. Chapter 19, Subchapter 3A (Catamount Health assistance program), the commissioner of banking, insurance, securities, and health care administration and the secretary of human services may waive the statutory requirements establishing the 12-month uninsured requirement and the pre-existing condition exclusion provisions if necessary to permit the state to accept grant funds under the federal high-risk pool program. The request to waive the statutory requirements shall specify a time period ending no later than June 30, 2011.

STATE OF VERMONT
HOUSE OF REPRESENTATIVES
115 STATE STREET
MONTPELIER, VT
05633-5201

June 1, 2010

Rep. Shap Smith
Speaker of the House
115 State Street
Montpelier, Vermont 05633-5201

Dear Speaker Smith,

Thank you for appointing me to the Joint Fiscal Committee. I welcome the responsibility to represent my House colleagues on this important committee and will certainly do my best to make sure all their views are heard.

I have informed Joint Fiscal Committee Chairman Obuchowski that I am unavailable to attend the special meeting scheduled for June 29 because of a previously scheduled surgery. However, I should be able to attend the July 15 meeting and all meetings after that.

Sincerely,

Rep. Carolyn Branagan

Copies: Sen. Peter Shumlin
Steve Klein, JFO
Emily Bergquist, LC
Rep. Patti Komline