Understanding Health Reform in Vermont

December 2006

Community Catalyst, Inc.
30 Winter St. 10th Floor
Boston, MA 02108
617.338.6035
Fax: 617.451.5838
www.communitycatalyst.org

Introduction

In May of 2006, hard on the heels of Massachusetts, though with much less national fanfare, the state of Vermont passed legislation, known as Catamount Health, that should take major steps to reduce the number of uninsured in that state and bring it within striking distance of universal coverage.[1],[2] The law shares some elements with that of its neighbor to the south but also has many differences. This paper will look at what the Vermont law does, how it came to pass, and what lessons there may be for other states. The first section puts the new law in the context of Vermont's pre-existing health policy framework. The politics of the reform effort are then briefly reviewed. Next we examine the law itself and its likely impact and challenges. The conclusion addresses the lessons that the Vermont experience holds for other states.

Background

As with Massachusetts, Vermont started its most recent drive for health reform from a relatively advantageous place. Only 11% of the state population is uninsured. Vermont boasts the lowest rate of uninsured children in the nation (6%). Public coverage eligibility standards for children go up to 300% of the federal poverty line (FPL) ($49,800 for a family of three) and for non-disabled adults up to 185% FPL.[3] However, these programs do have significant premiums that could suppress enrollment (see table II below), an issue that is addressed at least partially in the new law.

The state median income is slightly above the national average, while the federal matching assistance percentage (FMAP) hovers at a little under 60% (A higher FMAP means a lower per capita income. In comparison, Massachusetts has a 50% FMAP). Although Vermont is not among the wealthiest states, it has one of the lowest rates of poverty or near-poverty in the nation.

Table I: VERMONT AND THE U.S. IN COMPARISON

	VT	US
Uninsured	11%	16%
Uninsured Children	6%	12%
Median Income	$48,508	$46,037
% of Population below 200% FPL	28%	36%
% with Employer Sponsored Insurance	52%	53%
% Under 65 with Public Insurance	23%	16%

[1] H 861, "An Act Relating to Health Care Affordability for Vermonters" available at http://www.leg.state.vt.us/docs/legdoc.cfm?URL=/docs/2006/acts/ACT191.HTM

[2] For more information on the policy and politics of Massachusetts reform see http://www.communitycatalyst.org/resource.php?base_id=1023&PHPSESSID=75d0efd4378913a7e1ce207e0231b28b

[3] www.statehealthfacts.org. Vermont's Medicaid and SCHIP program for children is known as Dr Dynasaur; the program for adults is known as the Vermont Health Access Program or VHAP.

Like Massachusetts, Vermont also has an extensive web of insurance consumer protections including a guaranteed right to purchase insurance for individuals and small groups ("guaranteed issue"), and a prohibition on charging people more based on their health status or other factors ("community-rating"). The level of employer-sponsored insurance is about average while the public coverage percentage is high, despite the low poverty rate. Overall Vermont's low rate of uninsurance is largely attributable to its relatively expansive public insurance programs.[4]

This constellation of strong public health insurance programs and consumer protections in the private insurance market, along with the legacy of policy activism that produced these laws, is the foundation on which the current reform effort rests.

Vermont also has a controversial 1115 Medicaid waiver that puts a cap on total federal Medicaid payments but gives the state additional flexibility to use Medicaid dollars for health purposes that would not otherwise be eligible for federal matching funds. Prior to this new waiver known as the "Global Commitment to Health," Vermont already had a Medicaid waiver that allowed the state to match funds for certain adults who would not otherwise qualify for Medicaid.[5] It is therefore unclear to what extent the state needed the additional flexibility created by the "Global Commitment." The global cap does create a significant financial risk for the state if the cost of the health care coverage expansion grows faster than expected.

Politics of Catamount Health

Vermont has a long history of health reform efforts, some of which resulted in the passage of the programs mentioned above and some of which ended in failure. In some sense this history laid the groundwork for the current reform, but the immediate impetus for the current legislation can be traced back to Democrats retaking control of the legislature in 2004 with health care as one of their top issues. Party leaders felt their credibility was at stake and that they needed to deliver on their campaign promises. In particular Speaker Gaye Symington and House and Senate Health Chairs John Tracey and James Leddy played a leadership role in crafting the legislation. In addition, the President of the Senate, Peter Welch, was running for Congress and wanted significant health reform as an accomplishment to boost his campaign.

Health reform had a near miss in the state in 2005 when legislators passed a bill but could not come to agreement with the governor and did not have the votes to override a veto. This year the same scenario almost repeated itself, with a veto being averted only by a last minute compromise. Interestingly, the issue of whether employers should make some contribution to insurance was not what almost caused the process to break down. The original legislation called for Catamount to be a public program—extending existing public insurance initiatives. The governor wanted Catamount to be offered by private carriers and threatened a veto if this was not done. A compromise was struck which provided that Catamount Health—the new subsidized insurance product--would be offered by private insurers but that the state could compel private carriers to participate if they did not do so voluntarily. In addition, there is a study after two

[4] Ibid, see Table 1
[5] Approved September 2005

years to determine whether it is cost effective to offer the plan through the private sector.[6] (There remains disagreement, both inside and outside the State House, on whether it was better to pass the compromise or make the governor's veto an election issue in the fall).

The role of interest groups

The legislation was influenced, in part, by the work of a broad stakeholder group, "Coalition 21", which started meeting in July 2004. Coalition 21 brought together providers, consumers and business groups in an attempt to create a consensus for reform. The group adopted principles (which ultimately were included in this new legislation) but in the end it had a hard time agreeing on a specific proposal.

Providers (hospitals and physicians), insurers and employers split from Coalition 21 to form a separate working group, but they couldn't agree among themselves on the question of an individual mandate.[7] They did, however, push for -- and win -- a provision to raise Medicaid rates to the Medicare reimbursement level, with a phase-in over time. Employers opposed many of the changes, but they were not a strong enough voice to override the political consensus that something had to be done. Although Coalition 21 members could not ultimately agree on a proposal, the group helped to sustain a dialog among interested parties and legitimized the idea that substantial change was needed. This role parallels the role of the convenings sponsored in Massachusetts by the Blue Cross Foundation which convened stakeholders over a period of several years to discuss health reform.

In the fall of 2005 many Coalition 21 members formed the Vermont Campaign for Health Security to play a more active advocacy role in the reform debate than was possible in Coalition 21 (although the latter continues to exist). Campaign members included the Vermont Teachers Association and Vermont Public Interest Research Group as well as nurses, senior and disability rights organizations, and faith-based groups . As with the business and provider groups, there was some division within the advocacy community (both within and outside the Campaign for Health Security). The advocates split roughly into two camps that could be considered the pragmatists and the idealists. While many activists (the pragmatists) supported the compromise (albeit with reservations) as a step forward and a foundation for future reform, some felt that no bill was better than a compromise and that there was an opportunity to get better legislation after the next election[8]

The role of interest groups in promoting reform was supplemented by direct input from Vermont residents all over the state. Vermont maintains a tradition of direct democracy, and with a small population in a relatively compact area, government remains "close to the people". Direct input on the need for and shape of the legislation was supplied by public field hearings, sponsored by the non-partisan Snelling Center for Government, that gave grassroots Vermonters an

[6] H. 861 op cit

[7] Coalition 21 principles available at http://www.snellingcenter.org/article/view/13353/1/2251/ , Williston Group, December 12, 2005 and Vermont Medical Society, October 16, 2005

[8] This debate on health reform tactics in Vermont goes back at least to 1994 when health reform advocates split over legislation supported by then-Governor Howard Dean. See "Two State Health Care Reform Losses: What Advocates Can Learn, States of Health, Volume 5 No. 1, January 1995.

opportunity to voice their views. Critical themes that emerged from these hearings included support for guaranteeing affordable care for all Vermont residents, a sense of urgency about tackling the problem, and a need to emphasize primary and preventive care. While there was broad agreement that health security was a collective obligation, there was also widespread support for the role of personal responsibility including both making a financial contribution for coverage and taking responsibility for one's own health through healthy behaviors and compliance with medical protocols.[9]

What the legislation does

Major features of the legislation include creation of a subsidized insurance product called Catamount Health, a chronic disease management initiative, and Medicaid provider rate increases. Financing includes a mix of employer assessments, individual premiums, federal funds, and tobacco taxes. Overall, the law is much more specific than the Massachusetts legislation which leaves many critical issues to regulation.

Catamount Health

Eligibility

People whose income is below 300% FPL and have been uninsured for the prior twelve months are eligible for subsidies. Those who have been uninsured for less than twelve months are subject to a "lockout" period. In contrast, the Massachusetts law provides that people with an *offer* of employer coverage are not eligible for subsidies regardless of whether they actually had coverage, but they can obtain coverage after being uninsured for six months compared to a 12-month lockout in Vermont. There is an exception to the lockout for involuntary loss of employer sponsored insurance (ESI).

People who already have insurance (whether ESI or non-group) are ineligible for subsidized coverage even if they have to pay much more than they would for subsidized Catamount coverage. People who do not have ESI and are above the income range for subsidies can purchase Catamount at full cost. The expected full premium cost is about $400 per month, which is somewhat higher than premiums for currently available high-deductible plans. This raises the risk of selection bias, where sicker individuals will choose Catamount's more comprehensive coverage while healthier people will opt for lower premiums but higher cost-sharing. Provider rates for Catamount are pegged to Medicare plus 10%; a rate below the typical reimbursement for private insurance but above Medicaid.

Benefits and cost sharing

[9] Snelling Center for Government, Vermonters Working Together and Speaking Out on Health Care Reform, Fall 2005

Catamount Health covers ambulatory and in-patient care with a particular emphasis on chronic disease management. The benefit is structured as a preferred provider organization (PPO)[10]. In-network deductibles are $250 for an individual and $500 for a family. Out-of-network deductibles are double this amount. In general there is 20% co-insurance. Physician office visits are $10 and there is a three-tier pharmacy benefit with co-payments of $10, $30 and $50. There is an exemption from cost sharing for chronic disease management, and physicians are reimbursed for telephone consultation and specific disease management tasks. The out-of-pocket maximums are $800 for an individual and $1,600 for a family for services provided in network, and $1,500 for an individual and $3,000 for a family for services provided out of network. [See table]

Table II: CATAMOUNT BENEFIT STRUCTURE

	Benefits	Cost Sharing
1.	In-Network Deductible	
	• Individual	$250
	• Family	$500
2.	Out-of-Network Deductible	
	• Individual	$500
	• Family	$1,000
3.	Coverage after Deductible	80%
4.	Physician office visit	$10
5.	Rx Co-payments	3 tiers: $10, $30, $50
6.	Out-of-pocket maximum	
	• Individual (In Network)	$800
	• Family (In Network)	$1,600
	• Individual (Out of Network)	$1,500
	• Family (Out of Network)	$3,000

Premiums and subsidies

Catamount Health includes a sliding scale subsidy to 300% FPL. People are expected to pay about 3.5-5.5% of their income for the coverage(see table below). Subsidies are tied to the cost of the lowest cost Catamount plan, so if someone picked a different plan, their premiums would be higher. (The columns labeled “old” and “new” reflect premiums associated with Dr Dynasaur and the Vermont Health Access Program—Vermont’s names for Medicaid and SCHIP—prior to and after the passage of H 861.)

[10] A PPO is a health coverage plan in which members receive more coverage if they choose health care providers approved by or affiliated with the plan.

Table III: PREMIUM TABLE
VERMONT PUBLIC/SUBSIDIZED INSURANCE PROGRAMS

Income Level	Dr Dynasaur (old)	Dr Dynasaur (new)	VHAP (old)	VHAP (new)	Catamount
0-50% FPL	0	0	0	0	NA: covered by VHAP
50-75% FPL	0	0	$11	$7/mo	NA
75-100% FPL	0	0	$39	$25/mo	NA
100-150% FPL	0	0	$50	$33/mo	NA
150-185% FPL	0	0	$75	$49/mo	NA
185-200%* FPL	$30	$15/mo	NA	NA	$60/ mo 3.7% income
200-225% FPL	$30	$15	NA	NA	$90/ mo 4.9% income
225-250% FPL	$80	$40	NA	NA	$110/ mo 5.4% income
250-275% FPL	$80	$40	NA	NA	$125/ mo 5.6% income
275-300% FPL	$80	$40	NA	NA	$135/mo 5.5% income

Chronic Disease Initiative

Multiple and not entirely coordinated initiatives were adopted to reduce the cost of chronic illness. These initiatives include a population based health initiative for the entire state as well as two case management efforts targeted to high-cost Medicaid enrollees. In addition, as noted above, Catamount benefit design includes specific features such as reimbursement for phone consultation and reduction of cost-sharing for certain chronic illnesses meant to improve care of people with chronic illness. Because Catamount is offered through the private market, the public case management initiatives for high-cost enrollees are not extended to this group of newly insured individuals.

Insurance Reform

Several provisions are meant to improve the operation of the insurance market in Vermont including allowing non-group carriers to cede 5% of claims to a reinsurance pool as a way of lowering non-group costs (however as of this writing no funds have been appropriated for this purpose) and giving insurers the option of applying a health promotion/ disease prevention discount of up to 20%.

Financing

The law is financed through a number of revenue sources. The tobacco tax is increased by 60 cents (followed by another 20 cents in 2008), Employers must pay $365 per uninsured worker with the amount of the employer assessment rising over time in step with premiums for Catamount Health. Initially, the first 8 FTEs are exempt from the assessment. This exemption declines to 4 FTEs by 2010. In contrast to the Massachusetts law, the Vermont statute is much clearer about which employers pay the assessment. In Massachusetts, the definition of who pays the employer fee is left to regulation. Recently promulgated regulations provide that only those employers who do not either cover 25% of their workforce or offer to pay 33% of premiums are subject to the fee. In Vermont payment is tied to whether an employee actually *takes up* insurance, not whether there is an offer. As in Massachusetts, the employer assessment is only a small fraction of the amount of a typical insurance policy. There is no individual mandate in the law although the issue could be revisited if the coverage target is not reached. A commission will review the individual mandate question in several years.

Other

There are many other provisions in the law including creation of an administrative simplification work group; improved reporting of price and quality data; a study to create uniform uncompensated care policies (due January 07); and support for VHAP and Catamount outreach.

Anticipated effect

Overall, between expanded enrollment in existing programs and new coverage in Catamount Health, the law is expected to extend health insurance coverage to twenty five thousand people.[11] This may seem like a small number in some states but it represents over one third of the uninsured in Vermont. Overall, the proportion of the non-elderly who have insurance would rise from 87% to 92%.

Issues to watch going forward

There are numerous implementation issues that will bear close watching as the Vermont reform unfolds. Perhaps foremost among them is the adequacy of financing for the Catamount subsidies over time. Closely related is the issue of providing adequate financing to the existing Medicaid program which underpins Catamount. The cost of the program could increase, depending on how employers and individuals respond to the new incentives. Over time it is likely that there would be a decline in the percentage of employers offering and workers taking employer-sponsored insurance, especially as new employers weigh making insurance an employee benefit versus relying on state programs. Other unresolved issues include Catamount's interaction with the non-group market (e.g. will there be selection bias) and the fact that people in similar

[11] Details About the 2006 Health Care Affordability Act; http://www.leg.state.vt.us/HealthCare/2006_HC_Affordability_Act_Details_Leddy.htm

financial circumstances continue to have very different options with respect to the cost of health coverage depending on their eligibility for employer sponsored insurance or Catamount.

Another critical question is whether the subsidized premium schedule really makes health care affordable for low and moderate income households. While a low take-up rate will reduce cost pressure, it will also mean that the legislation has failed to achieve its primary purpose.

The program financing assumes that the complex and somewhat disjointed chronic disease initiatives will successfully moderate the rate of health insurance premium growth, and also that there will be sufficient funds under Vermont's capped federal Medicaid allotment so that the state will not have to pay for Catamount or Medicaid with 100% state dollars.

Conclusions and Lessons Drawn from the Vermont Experience

What does the recent Vermont reform (along with other reform efforts in New England and across the country) say about the prospects, problems and limitations of state-based reform? What are the themes and lessons for other states?

Building on a strong foundation

One of the key similarities between Vermont and Massachusetts is that both states had a long history of health policy reform initiatives. The success (albeit partial) of prior initiatives addressing both public and private insurance created an important base on which additional reform could build.

The growing pressure for employer accountability

Like Massachusetts, Vermont includes an employer responsibility provision as part of its reform. This seems to be a reflection of a growing sentiment that states cannot keep picking up the tab for a declining base of employer-sponsored insurance without capturing a financial contribution from employers who do not offer coverage. Recent action in Maryland and California as well as in a number of states that have moved to identify the employers with the largest number of workers enrolled in Medicaid are all part of this trend.

Individual responsibility

The notion of "individual responsibility" is also one that is gaining prominence. The question of an individual mandate was on the table in both Vermont and Massachusetts although Vermont deferred a decision. The individual responsibility idea is also reflected in Vermont in the idea of a wellness discount. Several states have attempted to incorporate "individual responsibility" components into their Medicaid programs, and the growth of high-deductible health plans couple with health savings accounts is also part of this trend.

Medicaid challenges

Medicaid remains the base of any conceivable state-based reform initiative. At the same time, states continue to struggle with maintaining their programs. As in Maine, the Vermont reform was passed without addressing some of the underlying financing issues

in the Medicaid program. Both of these Northern New England states are facing challenges with respect to funding their existing programs even as they move to expand coverage. Both Vermont and Massachusetts (but not Maine) did attempt to address the issue of provider rates, although this puts additional cost pressure on the program.

Political lessons

On the political side, the Vermont success reinforces many of the basic lessons of the Massachusetts effort. The legislation was a function of a broad-based agreement to address problem of uninsured. There was a widespread perception that health reform was a must-do issue, fueled in the Vermont case by the campaign promises of both parties and the near miss of 2005. In both states, political entrepreneurs in senior leadership positions were key champions of reform. In both states, significant compromises were necessary between a Republican executive and a Democratic legislature to get legislation enacted.

Finally, Vermont and Massachusetts also show that while bipartisan compromise can be reached and significant reform enacted, creating long-term stable financing for expanding health coverage at the state level remains elusive. Perhaps grappling with both the coverage expansion and long-term financing issues is too much change for state policymakers to bite off at one time. Maybe building the road as we drive is the only available option in the current political environment-although one that ensures more bumps along the way.