

S.88 as passed out of Senate Health and Welfare Committee March 12, 2010.
(Currently in Senate Appropriations Committee.)

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S. 88.

An act relating to health care financing and universal access to health care in Vermont.

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Reported favorably with recommendation of amendment by Senator Racine for the Committee on Health and Welfare.

The Committee recommends that the bill be amended by striking out all after the enacting clause and inserting in lieu thereof the following:

Sec. 1. FINDINGS

The general assembly finds that:

- (1) The escalating costs of health care in the United States and in Vermont are not sustainable.
- (2) Health care costs are hurting Vermont's families, employers, local governments, nonprofit organizations and the state budget, with serious economic problems as the consequence.
- (3) The cost of health care in Vermont is estimated to increase by \$1 billion, from \$4.9 billion to \$5.9 billion, by 2012.
- (4) Vermont's per-capita health care expenditures are estimated to be \$9,463.00 in 2012, compared to \$7,414.00 per capita in 2008.
- (5) The average annual increase in Vermont per-capita health care expenditures from 2009 to 2012 is expected to be 6.3 percent. National per-capita health care spending is projected to grow at an average annual rate of 4.8 percent during the same period.
- (6) From 2004 to 2008, Vermont's per-capita health care expenditures grew at an average annual rate of eight percent compared to five percent for the United States.
- (7) At the national level, health care expenses are estimated at 18

percent of GDP and are estimated to rise to 34 percent by 2040.

(8) Vermont's health care system covers a larger percentage of the population than that of most other states, but still about seven percent of Vermonters lack health insurance coverage.

(9) In 2008, 15.4 percent of Vermonters with private insurance were underinsured, meaning that the out-of-pocket health insurance expenses exceeded five to 10 percent of a family's annual income depending on income level or that the annual deductible for the health insurance plan exceeded five percent of a family's annual income. Out-of-pocket expenses do not include the cost of insurance premiums. Most Vermonters are a job loss away from being uninsured.

(10) Vermont's health care reform efforts to date, including Dr. Dynasaur, VHAP, Catamount, the Blueprint for Health, health information

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technology, and the department of health's wellness and prevention initiatives have been beneficial to thousands of Vermonters, and hold promise for helping to provide access and to control costs in the future.

(11) Testimony received by the senate committee on health and welfare and the house committee on health care makes it clear that the current best efforts described in subdivision (10) of this section will neither provide insurance coverage for all Vermonters nor significantly reduce the escalation of health care costs.

(12) It is clear that only structural reform will provide all Vermonters with access to affordable, high quality health care as a human right.

(13) As this state has done before in so many areas of public policy, Vermont must show leadership on health care reform.

* * * HEALTH CARE SYSTEM DESIGN * * *

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 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.

(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) Vermont's health delivery system must model continuous improvement of health care quality and safety and, therefore, the system must be accountable in access, cost, quality, and reliability.

(5) A system for eliminating unnecessary expenditures; reducing administrative costs; reducing costs that do not contribute to efficient, quality health services; and containing all system costs must be implemented so that health care spending does not bankrupt the Vermont economy.

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(6) The financing of health care in Vermont must be sufficient, fair, sustainable, and shared equitably.

(7) 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 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 and preferably to reducing health care costs below today's amounts.

(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;

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- (C) reducing of 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 their 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, the values and priorities of Vermonters, and federal health care reform if enacted.

(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.

Sec. 4. VERMONT HEALTH CARE BOARD

(a) Definitions. As used in this act:

(1) "Health care professional" means an individual, partnership, corporation, facility, or institution licensed or certified or authorized by law to provide professional health care services.

(2) "Health service" means any medically necessary treatment or procedure to maintain, diagnose, or treat an individual's physical or mental condition, including services provided pursuant to a health care professional's

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order, services to assist in activities of daily living, services for mental health conditions, drug and alcohol abuse treatment, and prescription drugs.

(3) "Hospital" shall have the same meaning as in 18 V.S.A. § 1902 and may include a hospital located outside Vermont.

(4) "Hospital service" means any health service received in a hospital and any associated costs for professional services.

(5) "Preventive care" means screening, counseling, treatment, or medication determined by scientific evidence to be effective in preventing or detecting disease.

(6) "Primary care" means health services provided by health care professionals specifically trained for and skilled in first-contact and continuing

care for individuals with signs, symptoms, or health concerns, not limited by problem origin, organ system, or diagnosis. Primary care services include health promotion, preventive care, health maintenance, counseling, patient education, case management, and the diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.

(7) “Vermont resident” means an individual domiciled in Vermont as evidenced by an intent to maintain a principal dwelling place in Vermont indefinitely and to return to Vermont if temporarily absent, coupled with an act or acts consistent with that intent. The health care board shall establish specific criteria to demonstrate residency.

(b) Vermont health care board.

(1) Within 30 days of enactment, the Vermont health care board is created and shall have the powers and duties established by this section. The board shall consist of five members who have demonstrated expertise in health care systems or health care system design. The governor shall appoint two members of the board. The speaker of the house, and the president pro tempore of the senate shall each appoint one member. The fifth member shall be chosen by a majority of the appointed members. All appointments shall be completed no later than 30 days after enactment.

(2) A person in the employ of or holding any official relation to any health care provider or insurer, or engaged in the management of a health care provider or insurer, or owning stock, bonds, or other securities thereof, or who is, in any manner, connected with the operation of a health care provider or insurer shall not be a member of the board. In addition, no board member shall render professional health care services or make or perform any business contract with any health care provider or insurer if such service or contract relates to the business of the health care provider or insurer, except contracts

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made as an individual or family in the regular course of obtaining health care services.

(3) The office of legislative council shall provide the board with administrative support, including technical support for budget management, payroll and fiscal matters, clerical staff, and office space. The board shall

contract with outside consultants to provide expertise necessary to do the analysis and design required by this act. The legislative council and joint fiscal office shall provide the board with legal and fiscal support.

(4) The board shall be considered a public body pursuant to 1 V.S.A. § 310 and shall be subject to the access to public records requirements in 1 V.S.A. §§ 315–320. After the public oversight panel publicly reports its proposals to the general assembly as required in Sec. 5 of this act, the board may be subject to public access requests for material relied upon in making its proposals with redactions of proprietary or confidential information as needed.

(5) The board shall cease to exist on June 30, 2011.

(c) The Vermont health care board is authorized to seek matching funds to assist with carrying out the purposes of this act. In addition, it may accept any and all donations, gifts, and grants of money, equipment, supplies, materials, and services from the federal or any local government, or any agency thereof and from any person, firm, or corporation for any of its purposes and functions under this act and may receive and use the same subject to the terms, conditions, and regulations governing such donations, gifts, and grants.

Sec. 5. HEALTH CARE SYSTEM DESIGN AND IMPLEMENTATION PLAN

(a)(1) By January 1, 2011, the Vermont health care board shall propose to the general assembly and the governor at least three design options and an implementation plan for creating and integrating a health care system that meets the principles and goals outlined in Secs. 2 and 3 of this act. One option shall include the design of a government-administered and -financed health benefits system decoupled from employment, which prohibits insurance coverage for the health services provided by this system and allows for private insurance coverage of supplemental health services only. 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 achieve implementation of the new system no later than July 1, 2012.

(2) The board shall review and consider 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
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by the Lewin Group; and studies and reports provided to the joint legislative commission on health care reform. In addition, the board shall consider existing health care systems in other states or countries as models.

(3) The board, the agency of human services, and the department of banking, insurance, securities, and health care administration shall collaborate to ensure the board and its employees or consultants have the information necessary to create the design options. The board shall 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.

(4) By December 1, 2010, the board 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 board 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 governor.

(b) Each of the design options shall include the following components as further described in Sec. 6 of this act:

- (1) general administration of services;
- (2) packages of health services, including cost-sharing;
- (3) coordinated local delivery system;
- (4) health system planning and public health;
- (5) budgets;
- (6) payment methods;
- (7) process for payment amounts;
- (8) financing;
- (9) Medicaid and Medicare waiver proposals;
- (10) a method to address compliance of the proposed design options with the Employee Retirement Income Security Act (ERISA), if necessary; and
- (11) redesign of state agencies administering or regulating health care, health care professionals and providers, and other health-related services, if necessary to implement the efficient administration or oversight of the health

care system.

(c) The Vermont health care board shall include in the proposal an analysis of each design option as compared to the current state of health care in Vermont, including the costs of providing health care to the uninsured and

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underinsured in Vermont, any potential savings from creating an integrated system of health care, the impacts on the current private and public insurance system, potential fiscal impacts to individuals and businesses, impacts on the state's economy, and the pros and cons of each design option and of no changes.

Sec. 6. HEALTH CARE SYSTEM DESIGN COMPONENTS

In creating the design options, the Vermont health board shall consider the following components for each option:

(1) General administration of services. The board shall make a recommendation, where appropriate to the design option, on:

(A) the overall administrative design to insure all Vermonters have access to and coverage for affordable, quality health services through a public or private, single-payer, or multi-payer system;

(B) methods 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.

(C) enrollment processes.

(D) the application of the standards and procedures in 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.

(E) appeals processes for decisions made by entities or agencies administering coverage for health services.

(2) Packages of Health services.

(A) Covered services. Each of the design options shall include access to and coverage for primary care, preventive care, chronic care, acute

episodic care, and hospital services. A design option may include more than one package of health services with the associated cost of each package and may include coverage for additional health services, such as home- and community-based services, services in nursing homes, or dental or vision services.

(B) Cost-sharing. Each of the design options shall consider options to provide for affordable, income-sensitive cost-sharing.

(3) Coordinated, local delivery systems.

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(A) The design options shall ensure that the delivery of health care in Vermont is coordinated in order to provide health services to the citizens of Vermont, to improve health outcomes, and to improve the efficiency of the health care system by ensuring that health care professionals, hospitals, health care facilities and home- and community-based providers offer patient care in an integrated manner designed to optimize patient care at a lower cost and to reduce redundancies in the health care delivery system as a whole. The design options shall consider and include building on the delivery system initiatives that are part of the Blueprint for Health, such as the medical home pilot projects.

(B) The Vermont health care board shall include in each design option a recommendation for the improvement of the organization of the health care delivery system, including:

(i) mechanisms in each region of the state to solicit public input; conduct a community needs assessment for incorporation into the health resources allocation plan; plan for community health needs based on the community needs assessment; develop budget recommendations and resource allocations for the region; provide oversight and evaluation regarding the delivery of care in its region; and other functions determined to be necessary in managing of the region's health care delivery system or furthering cost-containment.

(ii) a regional entity organized by health care professionals and providers to coordinate health services for that region's population, including developing payment methodologies and budgeting, incentive payments, and

other functions determined to be necessary in managing the region's health care delivery system or furthering cost-containment.

(4) Health system planning and public health.

(A) The Vermont health care board shall include in each of the design options an evaluation of the existing mechanisms for health system and facility planning and assessing quality indicators and outcomes, and of 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.

(B) The board shall include recommendations for changes to existing mechanisms to ensure compatibility with the design options.

(5) Budgets. The Vermont health care board shall include in each option a recommendation for amending the unified health care budget as provided for in subdivision (A) of this subdivision (5) and to develop a global

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budget for a facility, provider, or part of the health care system as appropriate to that option and as provided for in subdivision (B).

(A) Unified health care budgets.

(i) The purpose of the unified health care budget is to establish a statewide spending target within which costs are controlled, resources directed, and quality and access assured.

(ii) The Vermont health care board shall propose recommendations to revise the unified health care budget provided for in 18 V.S.A. § 9406, including consideration of cost-containment mechanisms or targets, anticipated revenues available to support the expenditures, and other appropriate considerations.

(iii) The board shall also propose recommendations on 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.

(B) Global budgets. The board shall recommend whether a global

budget is appropriate to ensure cost-containment by a health care facility, health care provider, a group of health care professionals, or a combination as appropriate to that option. The board shall also recommend the appropriate process and considerations 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.

(6) Payment methods.

(A) The Vermont health care board shall include a recommendation for the payment methods to be used for each health care sector which provides health services under each design option. The payment methods shall be aligned with the goals of this act and shall provide for cost-containment, provision of high quality, evidence-based health services in a coordinated setting, patient self-management, and healthy lifestyles.

(B) The board shall consider the following payment methods:

(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

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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.

(7) Process for determining payment amounts.

(A) The Vermont health care board shall recommend a process 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 provide reasonable access to health services, provide sufficient uniform payment to health care professionals, reduce unnecessary care, and encourage the financial stability of health care professionals.

(B) When considering the payment methods in subdivision (6)(A) of this section, the Vermont health care board shall make recommendations for the appropriate process for each of the design options, including:

- (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 board 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

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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.

(C) To facilitate negotiation of payment amounts, the board may recommend the utilization of 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. In authorizing the activities provided for in this section, the intent of the general assembly is to displace state and federal antitrust laws by granting state action immunity for actions that might otherwise be considered to be in violation of state or federal antitrust laws.

(8) Financing. The board shall include an estimate of any additional costs for providing access to and coverage for health services to the uninsured and underinsured, any estimated savings from streamlining the administration of health care, and financing proposals for sustainable revenue necessary for funding the system.

(9) Medicaid and Medicare waiver proposals. The board shall propose how to redesign the Global Commitment to Health Medicaid Section 1115 and the Choices for Care Long-Term Care waiver to be consistent with each design option in order to maximize federal participation and funding in the health care system. The board shall also include a proposal for a Medicare waiver where appropriate to the design option to ensure the participation of Medicare in all or part of the system proposed by that option.

(10) Employee Retirement Income Security Act (ERISA). The board shall propose a strategy to seek an ERISA exemption from Congress if necessary for one of the design options. In addition, assuming the absence of an ERISA exemption, the board shall consider how to design each option in compliance with ERISA.

(11) Evaluation of state agencies. The board shall evaluate redesigning the structure of state agencies administering or regulating health care, health care professionals, health care providers, or health insurers, or involved in other health-related services, such as public health or health resource planning.

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The purpose of the evaluation shall be to ensure the appropriate and efficient

operation of state government and to ensure a single locus of responsibility for the health care system and for health care reform.

Sec. 7. APPROPRIATIONS

The amount of \$300,000 is appropriated from the general fund to the office of legislative council in fiscal year 2011 for the health care board to accomplish the purposes of this act.

Sec. 8. EFFECTIVE DATE

This act shall take effect upon passage.

(Committee vote: 6-0-0)