Muskie School of Public Service

HEALTH POLICY COLLOQUIUM BRIEF

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Global Budgets, Payment Reform and Single Payer: Understanding Vermont's Health Reform

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Background: How Did Our Health Financing System Develop?

America's health care system includes much that is excellent and innovative yet it also suffers from inefficiencies and escalating costs. While other developed nations launched efforts to establish universal health coverage in the late 19th and early 20th centuries, the American health system evolved incrementally and that has led to a complex and largely uncoordinated system of care and coverage.

Our modern health financing system is rooted in the 1920's when Baylor Hospital offered an insurance plan for teachers in Dallas – all teachers had to join for a modest premium – and from that grew Blue Cross plans across the country. Private insurance plans soon joined the market, but often set rates based on health status, not at a fixed rate as the Blues had done. By the 1940's employers were engaged in offering health insurance, an approach fueled by wage and price controls during WWII. Employers were prohibited from raising wages but could recruit workers by providing health benefits. Provisions added after the war made employer sponsored health insurance a tax free expenditure which further spurred their growth. By the 1960's most people with health insurance got it through the workplace. The Congress created health insurance for the military and its veterans and in 1965 enacted two entitlement programs – Medicare to cover the elderly and some persons with disabilities – and Medicaid, a program whose financing and administration is shared by the federal and state governments to provide coverage for some, but not all, people with low incomes. In 1997, the Congress created the Children's Health Insurance Program (CHIP) which, while not an entitlement program, is also administered jointly by the federal and state governments.

Over time employers, health plans and the government advanced different approaches to health coverage. Many experimented with managed care, cost sharing, and high deductibles, resulting in an array of products with differing benefits, provider payments and costs. Oversight for health coverage grew as a shared responsibility. Generally, states are responsible for the regulation of health insurance, but the enactment of the Employee Retirement Income Security Act (ERISA) exempted self-funded employer sponsored health plans from state rules. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) created additional protections for those with insurance who change or lose jobs and added requirements about data and privacy. Medicare is administered by the federal government that also sets the general rules for Medicaid, leaving the states considerable discretion about how to mange that program within those rules.

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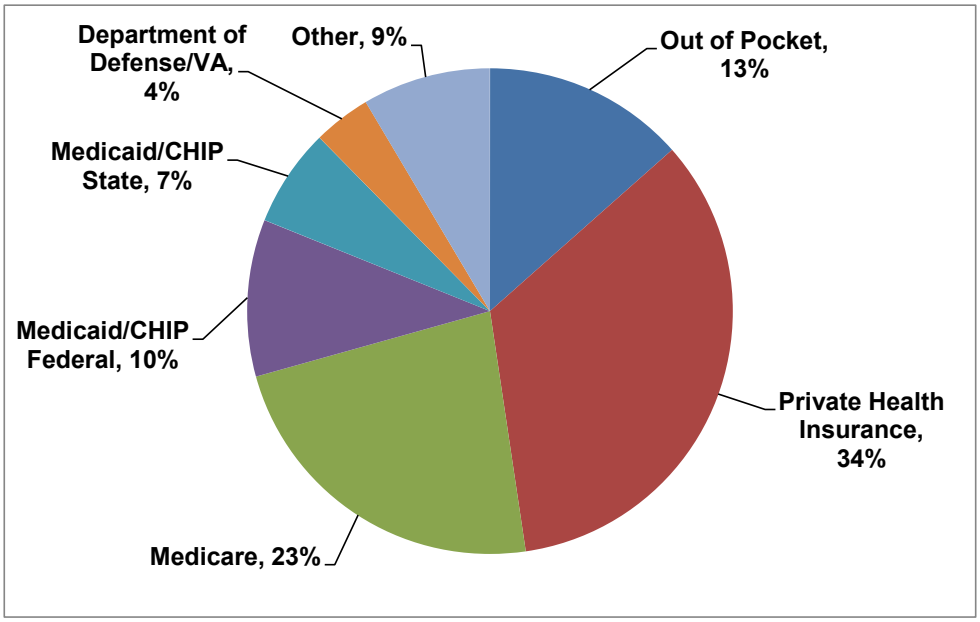
Figure 1: Personal Health Care Expenditures in the U.S., by Payer (2011)



Source: National Health Expenditure Accounts, Centers for Medicare and Medicaid Services (CMS)

Where are we today?

The American health system evolved incrementally and that has led to a complex and largely uncoordinated system of care and coverage

The result of this incremental growth has led to a patchwork quilt in which who is covered, what services they receive, and how they are delivered and paid for varies significantly by payer, health plan and in the case of Medicaid and CHIP, by state.

Complexity has been a major factor in producing the health system we have today. Today, the United States spends twice what other developed nations spend on health care yet we do not always achieve better health outcomes for that expenditure and we leave large numbers uninsured. Health reform, then, needs to be comprehensive to address access, cost and quality and needs to address a deeply imbedded and complex constellation of payers, payment rates, benefits and coverage.

The Affordable Care Act (ACA) of 2010 was enacted as a comprehensive approach to health reform. It increases access through mandates for coverage and subsidies to make that coverage affordable, an optional expansion of Medicaid, and through insurance regulation and transparency. It creates new marketplaces available in every state to help both those without affordable workplace coverage and small businesses to access health insurance. The ACA further aims to improve the health of the American people through new investments in public health, health care data, and quality; and to increase efficiencies through grants and other efforts to support payment and service delivery reforms. The ACA remains controversial and its critics argue that it is too complicated, that it has inadequate cost control provisions and that it relies too much on government intervention. Others argue that it does not go far enough and relies too much on the existing system.

A key feature of the ACA is that, although it builds on the current employer-based system and Medicaid, it provides support and incentives for states, health

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care providers, and payers to test innovations in how we pay for and deliver care, including investing in public health. Recognizing that reforming a system that has developed over a century will require a gradual approach, implementation of the law has been designed to occur over time. The ACA further recognizes that states may benefit from more tailored reforms and allows states to go further and opt out of the ACA in 2017. One state, Vermont, is on the path to do so.

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Why Vermont?

States have long been the "laboratories of democracy", testing new approaches to health care. In the early 1970's Hawaii required most employers to provide coverage to their workers and since then many states, including Maine, have experimented with Medicaid expansions, state based programs of subsidized insurance, rate regulation, insurance reforms, cost containment and comprehensive reforms. Vermont has been actively engaged in health reform, launching voluntary hospital budget review, insurance reforms, population health and prevention strategies and expanded coverage, especially for children so that today Vermont has one of the lowest rates of uninsured children in the nation.[1]

Vermont is not just a neighbor, but as Figure 2 demonstrates, it is a state with considerable similarity to Maine. As a result, Vermont may serve as a laboratory of innovation that both reflects reforms undertaken and underway in Maine and that can inform our work by its trailblazing efforts.

In 2011, Vermont enacted a major health reform to contain costs and to provide as a public good, comprehensive, affordable, publicly financed health care coverage.

What is Vermont's Reform?

In 2011, Vermont enacted a major health reform stating that: "It is the intent of the General Assembly to create Green Mountain Care to contain costs and to provide as a public good, comprehensive, affordable, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage. It is the intent of the General Assembly to achieve health care reform through the coordinated efforts of an independent board, state government, and the citizens of Vermont with input from health care professionals, business and members of the public".[2]

The law established the five member Green Mountain Care Board (GMCB) with broad authorities to implement the law, building on Vermont's long history of reform. The reform moves toward more consistent policy by consolidating and coordinating health policy functions now dispersed across state government under the aegis of the Board. Those functions include certificate of need review to authorize new capital expenditures in health care; the review of hospital budgets and setting annual revenue limits to constrain costs; and health insurance rate review in the individual and small group markets.

Vermont is a leader in initiatives to reform how we pay for care and how it is delivered; similar initiatives are underway in Maine and other states. With its "Blueprint for Health", Vermont has developed new systems for delivering primary care, supported by Community Health Teams, to manage chronic illness

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and improve health. All-payer pilot programs are underway across the State to test bundled payments for oncology, care of opiate addiction, and knee and hip replacement, while a shared savings pilot is in place to reduce inappropriate emergency department use.

Figure 2: Demographic and Health System Indicators

Measure	Maine	Vermont
Total population	1,329,192	626,011
Total area (square miles)	30,843	9,217
Persons per square mile	43.1	67.9
Median household income	$46,160	$52,033
Median Age	43.2	41.9
Health Coverage, Ages 0-64		
Employer	57%	57%
Non-group	5%	6%
Medicaid/CHIP	23%	26%
Other Public	4%	2%
Uninsured	11%	10%
Per Capita Health Expenditures	$8,521	$7,635
Health Care Providers & Use		
Number of Hospitals	37	14
Hospital admissions per 1,000 residents	110	79
Hospital beds per 1,000 residents	2.7	2.1
Inpatient days per 1,000 residents	609	488
Outpatient visits per 1,000 residents	4,493	5,356
Physicians per 10,000 residents	28.2	33.3
Health Status		
% of Adults in Fair or Poor Health	13%	11%
Life Expectancy at Birth	78.7 years	79.7 years

Sources: The Kaiser Family Foundation, *statehealthfacts.org*. Available at http://www.statehealthfacts.org/index.jsp
Robert Wood Johnson Foundation, County Health Rankings & Roadmaps. Available at http://www.countyhealthrankings.org/
U.S. Census Bureau, State and County QuickFacts. Available at http://quickfacts.census.gov/qfd/index.html
U.S. Census Bureau, Population Estimates, Median Age and Age by Sex. Available at http://www.census.gov/popest/data/state/asrh/2011/SC-EST2011-02.html

The federal government granted Vermont a Global Commitment Waiver in its Medicaid program, providing fixed funding in exchange for new flexibility, allowing the state to assure broad public health coverage and more efficient service delivery, including a move to comprehensive managed care. The State is now developing a transition plan because the waiver expires at the end of 2013 when the Affordable Care Act is fully implemented.

The GMCB is also charged with assuring better use of health information technology, building a workforce to recruit and retain high quality health professionals, creating administrative simplification and undertaking comprehensive

health planning. Vermont, like Maine, has an operational All Payer Claims Database. The state has expanded its work in data and transparency by establishing a Health System Dashboard to evaluate the state's health system quality and performance in a way that is easily understood by the public, reflecting the GMCB's commitment to public engagement.

Vermont providers have created a state wide Accountable Care Organization (ACO), "One Care".

The most cutting edge aspects of Vermont's reforms relate to cost containment and efforts to establish a single payer plan, Green Mountain Care. As it pursues these strategies, Vermont is fully engaged in implementing the ACA. The State is on track to launch Vermont Health Connect, a health insurance exchange, or "Marketplace", and was the first in the nation to post premium rates for insurance products sold in the Marketplace.

Like Maine, Vermont has seen significant consolidation and little competition among providers and insurers. To better coordinate care and achieve payment approaches that reward health outcomes and create a more efficient health care delivery system, Vermont providers have created a state wide Accountable Care Organization (ACO), "OneCare", comprised of 13 of the state's 14 hospitals, plus Dartmouth-Hitchcock Medical Center in New Hampshire and about 2000 physicians. OneCare is a participant in the Medicare shared savings ACO payment reform demonstration. The state recently received a $45 million federal State Innovation Model (SIM) grant that will, in part, support expansion of this model to Medicaid and commercial payers. Maine has also received a SIM grant to support reforms underway here.

Moving from the current multipayer financing system that is largely paid by employers and Medicaid and Medicare to a single public system is a complex task.

Coupled with this significant delivery system reform, Vermont's health reform charges the GMCB to conduct all-payer provider rate setting and achieve a unified health care budget – a global budget including all payers and all services. The state is at work to determine how best to establish population based rates that can support delivery system reform and achieve reductions in cost growth and improved health outcomes.

In noting the progress of Vermont's ambitious plan, Governor Shumlin recently remarked that the work underway is a pathway to broader reform noting, "the progress we have made moving even further toward a higher value single payer healthcare system that offers better care to all Vermonters by 2017".[3]

Green Mountain Care is designed to be a publicly financed health plan for all Vermonters. However, the ACA prohibits states from seeking such a reform until 2017, and Vermont's law creating the program did not include a means to finance it. The Governor and legislative leaders have appointed a Finance Commission charged with developing proposals to fund the single payer system and making recommendations in 2015. Vermont is taking innovative steps to restructure its health care system, but challenges lie ahead as it moves to develop a single payer approach. Moving from the current multi payer financing system that is largely paid by employers and Medicaid and Medicare to a single public system is a complex task. The federal Employee Retirement Income Security Act (ERISA) currently prohibits states from requiring self-insured businesses to participate in state-based reforms. In Vermont, about 20% of covered lives are in self insured companies, including one of

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its largest employers, IBM. While the challenges are real, Vermont's progress to date puts the State on a path to become a model for the nation.

In this Colloquium we will explore in depth the Vermont approach, its challenges and opportunities, and discuss what Maine might learn from Vermont's experience.

Possible Colloquium Questions:

- What did Vermont's Medicaid Global Commitment Waiver achieve? What happens when it expires in 2013? Are there lessons for Maine as DHHS considers this approach?
- How is the statewide ACO, OneCare, administered and governed? What is the role for insurance companies? What incentives does OneCare have to reduce costs? How will costs and quality be managed and assured?
- Vermont seems to be close to a single system of health care delivery and accountability. How is that different from single payer?
- ERISA prohibits states from regulating self insured plans and the federal government sets the rules for Medicare – how can a state achieve single payer if it can't require those two big payers to participate?
- When Green Mountain Care is fully implemented, what will it look like? How will coverage, costs and quality be different in Vermont?

References

1 The Kaiser Family Foundation,statehealthfacts.org: Health Insurance Coverage of Children 0-18, states (2010-2011), U.S. (2011)

2 Vermont General Assembly Act 48 of 2011

3 Press Release. Office of the Governor, March 27,2013

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