

**A Summary of the
2006 Health Care Affordability Act
State of Vermont**



Presented by Representative Harry Chen
House Health Care Committee

For more information go to:

<http://www.leg.state.vt.us/HealthCare/catamount.htm>

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2006 HEALTH CARE AFFORDABILITY ACT SUMMARY

The legislation reins in health care costs by offering affordable coverage to all Vermonters and establishing an outstanding chronic care system

The 2006 Health Care Affordability Act is a first step toward achieving the goal of quality, affordable health care for all Vermonters. This legislation has one overriding goal: controlling the steeply rising costs of health care. It accomplishes this in two ways: by better managing chronic care and making health care affordable and accessible for all Vermonters.

MAKING HEALTH INSURANCE AFFORDABLE AND ACCESSIBLE TO THE UNINSURED

- The act establishes a health insurance program called Catamount Health. Under this plan, everyone who is uninsured for 12 months will have access to - and will help pay for - a comprehensive health insurance package. The benefits will be administered through the private market and premiums will be based on income. Under the plan, everyone pays their fair share through an affordable premium structure. In addition, employers will pay an assessment based on the number of their employees who are uninsured. We estimate that at least 25,000 Vermonters who are now uninsured will obtain health coverage.
- Benefits of Catamount Health include:
 - Primary care, preventive and chronic care, acute episodic care, and hospital services.
 - Reimbursement for medical services equal to ten percent above cost.
 - 25,000 estimated to enroll, including new Medicaid enrollment.
 - Chronic care management.
- The financing of Catamount Health is fair and fiscally responsible.
 - Based on the principle that everybody is covered and everybody pays
 - Individuals pay sliding scale premiums based on income
 - Employers pay an assessment based on the number of their employees (measured as full time equivalents) who are uninsured, exempting the first eight FTEs in fiscal years 2007 and 2008, six FTES in 2009, and four FTES in and after 2010
 - Other revenues from increases in tobacco taxes and through matching federal dollars
 - State fiscal obligations protected through caps on enrollment

IMPROVING HOW WE DELIVER HEALTH CARE

- The act helps deliver the right care at the right time to the most expensive health care consumers – those with chronic conditions. It makes chronic care management available to every Vermonter, whether privately insured, covered under a public program, or currently uninsured. Chronic conditions consume 70 percent of the cost of health care in Vermont. Chronic conditions are what Vermonters worry about most.
- The plan will establish an outstanding system of chronic care management. This system - available to all Vermonters - will provide:
 - Early and coordinated screening for chronic conditions like diabetes or asthma.
 - Better management of chronic care.

- Emphasis on patient self-management.
- Payment to providers that rewards quality and disease management, not just quantity. The system will reimburse providers for doing what we want them to do for those with chronic conditions -- manage their care. For example, calling patients and reminding them to come in for regular check-ups, visiting patients in their home, and doing the necessary follow up.
- The act also codifies the Vermont “Blueprint for Health” prevention and chronic disease management plan and directs chronic care management in Medicaid and Catamount Health that will save an estimated 5-10 percent in health care costs.

EMPLOYER SPONSORED INSURANCE INITIATIVE

- Uninsured Vermonters will receive assistance to purchase the health insurance plan offered by their employer.
- Individuals currently eligible for or enrolled in the Vermont Health Access Plan will be eligible for the new ESI initiative as will uninsured Vermonters who are eligible for Catamount Health Assistance
- The state will do a cost-benefit analysis to ensure that it is cost-effective to provide help to an individual through this program and will protect individuals through a minimum standard for employer plans.

IMMUNIZATIONS –Every Vermonter will be able to receive CDC recommended immunizations for free after October 1, 2007.

MEDICAID INITIATIVES

- The act reduced premiums for low-income individuals and families receiving health care coverage through the Vermont Health Access Plan (VHAP) by 35% and through Dr. Dynasaur by 50%.
- A chronic care management program will be instituted in the Medicaid programs to ensure that low-income Vermonters receive the best quality care when they need it.

COMMON SENSE INITIATIVES

- Community Wellness Grant Program
- Information Technology Coordination
- Loan Repayment for Health Care Professionals
- Healthy Lifestyles Insurance Discount
- Common claims, procedures and credentialing administrative simplification
- Multi-payer Database and Consumer Price and Quality Information
- Medical Event Reporting and Hospital Infection Reporting program
- Safe Apology program

2006 HEALTH CARE REFORM INITIATIVES—THE DETAILS

The 2006 Health Care Affordability Act is a first step toward achieving the goal of quality, affordable health care for all Vermonters. This legislation has one overriding goal: controlling the steeply rising costs of health care. It accomplishes this in two ways: by better managing chronic care and making health care affordable and accessible for all Vermonters.

Catamount Health will be offered to eligible Vermonters October 2007.

- **Catamount Health**
 - Private insurers in the small group market (MVP Health Care, Blue Cross Blue Shield) will offer Catamount Health, a comprehensive insurance package covering primary care, chronic care, and hospital services. Individuals may choose which insurer they would like to use.

| WHO CAN PURCHASE CATAMOUNT HEALTH? |
|--|
| You may purchase Catamount Health if you are an uninsured Vermont resident and do not have insurance through an employer. |
| Uninsured means: <ul style="list-style-type: none"> ➤ You have insurance which only covers hospital care OR doctor's visits (but not both) ➤ You have not had private insurance for the past 12 months ➤ You had private insurance but lost it because you: <ul style="list-style-type: none"> ○ Lost your job ○ Got divorced ○ Finished with COBRA coverage ○ Had insurance through someone else who died ○ Are no longer a dependent on your parent's insurance ○ Graduated, took a leave of absence, or finished college or university and got your insurance through school ➤ You had VHAP or Medicaid but became ineligible for those programs |

How much will Catamount Health cost?

The cost of Catamount Health will depend on your income and which insurer you sign up with. For the least expensive plan, Catamount Health will cost:

| Income by federal poverty level <i>(1 person/annual in 2006)</i> | Monthly premium cost |
|--|-----------------------------|
| Below 200% FPL (<i>\$19,600</i>) | \$60.00 |
| 200-225% (<i>\$19,600 – 22,050</i>) | \$90.00 |
| 225-250% (<i>\$22,050 – 24,500</i>) | \$110.00 |
| 250-275% (<i>\$24,500 – 26,950</i>) | \$125.00 |

| | |
|------------------------------|----------------------------------|
| 275-300% (\$26,950 – 29,400) | \$135.00 |
| Over 300% (\$29,400) | Full cost, estimated at \$340.00 |

| Cost-Sharing Information | |
|--|--|
| Deductibles | <i>In-Network:</i> \$250.00/individual \$500.00/family <i>Out-of-Network:</i> \$500.00/individual \$1,000.00/family |
| Co-insurance | 20% |
| Co-payment | \$10.00 office visit |
| Prescription Drug Coverage | No deductible <i>Co-payments:</i> \$10.00 generic drugs \$30.00 drugs on the preferred drug list \$50.00 non-preferred drugs |
| Out-of-pocket Maximum (does not include premium payments; includes deductibles, co-insurance, and co-payments) | <i>In-Network:</i> \$800.00/individual \$1,600.00/family <i>Out-of-Network:</i> \$1,500.00/individual \$3,000.00/family |
| Preventive Care | \$0. Not subject to deductible, co-insurance, and co-payments. |
| Chronic Care | \$0 for individuals enrolled in the chronic care management program; otherwise, subject to the above amounts. |

- Premium rates
 - Actuarially determined
 - Standard to ensure affordability and financial stability of insurers
- Reimbursements
 - Health care professionals: Medicare +10% in 2006 increasing as per Medicare reimbursement methodology
 - Hospitals: cost +10% increasing as per Medicare economic index
- Oversight
 - Insurers go through the usual rate-setting process at the Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

- BISHCA will require Blue Cross Blue Shield or MVP Health Care to offer Catamount Health, if not done voluntarily
- Emergency Board will suspend enrollment in Catamount Health if there is not enough money to support premium assistance
- Commission on Health Care Reform to review October 1, 2009 for cost-effectiveness & may trigger a self-insured plan if current structure is not cost-effective

Help for the Underinsured; Cost Shift

- If you have insurance covering only hospital services OR only doctors visits, you will be eligible for Catamount Health without a wait.
- People who buy health insurance in the individual market, not through an employer, are paying very high prices for insurance, and their costs go up every year. On July 1, 2007, the state will begin to cover 5% of the claims costs of this kind of insurance. While this may not reduce the premium, it will lower the increase in the premium and provide some relief to these individuals.
- The act also contains several changes that should help what is called the “cost shift.” The cost shift results when uninsured or underinsured people need health care and cannot afford the bill or when the state or federal government does not pay the full cost of a service. These costs are “shifted” to people with private insurance. By reducing the number of uninsured and underinsured people and by increasing the rates paid by public health insurance programs, the cost shift will be reduced, which in turn will reduce the increases in health care premiums.

• Chronic Care Initiatives

- *Blueprint for Health* – an initiative to create a chronic care infrastructure and uniform model for providing chronic care in Vermont.
 - Pilot projects underway
 - Goal of statewide implementation by 2009
- *Medicaid chronic care management program* for individuals enrolled in Medicaid, Dr. Dynasaur and VHAP
 - Program will be provided by a private company through a contract with the state
 - Begins October 1, 2007
- The Agency of Administration will ensure coordination between the Blueprint and other initiatives around chronic care in state government, including any initiatives in the Agency of Human Services.
- The Commissioner of Human Resources and the Vermont State Employees Association will look at the chronic care program offered to state employees to determine if it meets the Blueprint model and if not, how to coordinate.

- **Immunizations**
 - Starting October 1, 2007, clinically recommended immunizations are provided to all Vermonters at no cost.
 - A study will determine appropriate administration through the Department of Health.
- **Employer-Sponsored Insurance – Premium Assistance Program**
 - Uninsured Vermonters can receive help with the cost of an employer-sponsored health insurance plan.

| WHO CAN RECEIVE FINANCIAL ASSISTANCE FOR EMPLOYER-SPONSORED INSURANCE? | |
|--|---|
| <p>Individuals enrolled in or eligible for the Vermont Health Access Plan (VHAP).</p> <p>You are eligible for VHAP if you are an uninsured Vermonter with income under 150% of the federal poverty level.</p> <p><i>150% FPL:</i> \$14,700 annual income for an individual</p> | <p>Uninsured Vermonters with income under 300% of the federal poverty level.</p> <p><i>300% FPL:</i> \$29,400 annual income for an individual</p> |
| <p>Uninsured means:</p> <ul style="list-style-type: none"> ➤ You have insurance which only covers hospital care OR doctor's visits (but not both) ➤ You have not had private insurance for the past 12 months ➤ You had private insurance but lost it because you: <ul style="list-style-type: none"> ○ Lost your job ○ Got divorced ○ Finished with COBRA coverage ○ Had insurance through someone else who died ○ Are no longer a dependent on your parent's insurance ○ Graduated, took a leave of absence, or finished college or university, and got your insurance through school ➤ You had VHAP or Medicaid but became ineligible for those programs | |

- Individuals enrolled in or applying for VHAP will be required to purchase their employer-sponsored insurance plan if the plan meets certain criteria:
 - The employer's plan is as good as the typical plan of four largest insurers in the small group and association market
 - The state will review the plan to see if enrolling the individual in employer-sponsored insurance—rather than VHAP—is cost-effective to the state
 - The state will provide secondary benefit coverage, so the coverage will not change

- Individuals who are otherwise eligible for Catamount Health may get assistance for purchasing an employer-sponsored plan if the employer's plan is:
 - Equivalent to Catamount Health, although there is more flexibility on coverage for chronic care by the plan before January 1, 2009
 - The state will review the plan to see if enrolling the individual in ESI (rather than Catamount Health) is cost-effective to the state

| How much will I pay for my employer's plan? | |
|--|--|
| There will be co-payment amounts for emergency room visits as well. | |
| Income by federal poverty level <i>(One person/annual in 2006)</i> | Monthly premium cost (approximate) |
| Below 50% FPL (\$4,900) | \$0.00 |
| 50-75% (\$4,900 - 7,350) | \$7.00 |
| 75-100% (\$7,350 – 9,800) | \$25.00 |
| 100-150% (\$9,800 – 14,700) | \$33.00 |
| 150-185% (\$14,700 – 18,130) | \$49.00 |
| Over 185% (\$18,138) | Premiums and cost-sharing to be determined |

- The Emergency Board will suspend enrollment in this program if there is not enough money to support premium assistance. Individuals will remain eligible for VHAP or Catamount Health if this happens.
- The Health Access Oversight Committee and the Joint Fiscal Committee will review the details of the plan in order to approve spending an amount over \$250,000 for implementation costs. Prior to the review, the administration will report on:
 - How the appropriation will be spent
 - Results of a survey to determine VHAP enrollees with access to employer-sponsored insurance
 - Proposal for the sliding-scale assistance amounts
 - What benefits under VHAP will need to be provided as secondary coverage
 - How children will be treated through this program
 - The budgetary impacts of the program
- **Medicaid Initiatives**
 - Medicaid will create a chronic care management program through a contract with a private company for individuals enrolled in Medicaid, Dr. Dynasaur and VHAP
 - Medicaid will also determine how to restructure payment to health care professionals for chronic care to pay doctors to provide the right care at the right time
 - Reduces VHAP premiums by 35% starting July 1, 2007
 - Reduces Dr. Dynasaur premiums by 50% starting July 1, 2007

- Increases reimbursements for doctors and hospitals starting January 1, 2007
- Medicaid Outreach
 - The Bi-State Primary Care Association, in consultation with the Medical Care Advisory Committee, will research successful Medicaid enrollment efforts in Vermont and other states and report its findings and recommendations to the legislature and Agency of Human Services by 11/15/06
 - The Office of Vermont Health Access (OVHA) may access funds to implement upon approval of the Health Access Oversight Committee
- **Financing**
 - **Employers' Health Care Premium Contribution**
 - Employers will pay a quarterly assessment equaling \$1 per day per total number of full-time equivalent (FTE) employees, if the employer:
 - does not offer health insurance
 - only offers health insurance to some employees (assessment is on those who are not eligible for an employer's insurance)
 - has uninsured employees
 - The employer may exempt a maximum of eight FTEs from the assessment in fiscal years (FY) 2007 & 2008; six in FY 2009; and four in FY 2010
 - FTE is defined as the number of employee hours worked during a calendar quarter divided by 520
 - Starts April 1, 2007, to be paid at the end of that quarter (June 30, 2007)
 - Establishes a study on the best method of accounting for seasonal employees
 - **Cigarette and Tobacco Taxes**
 - Increases the cigarette tax by 60 cents on July 1, 2006 and an additional 20 cents on July 1, 2008
 - Taxes "little cigars" and roll-your-own tobacco as cigarettes
 - Changes method of taxing moist snuff to a per-ounce basis and increases tax on July 1, 2008 by 17 cents
 - **Global Commitment** - Requires the Agency of Human Services to seek a global commitment waiver to include Catamount Health assistance and the employer-sponsored insurance premium assistance program in the Medicaid waiver.

ADDITIONAL INITIATIVES

- **Individual Insurance Mandate** –if Vermont has less than 96% of the population insured in 2010, the legislature will consider implementing a requirement that every Vermonter have health insurance. The Commission on Health Care Reform will study the issue to determine how it would be implemented.
- **Individual Health Insurance Market Reform**
 - Provides assistance to carriers in the individual market of 5% in order to reduce premiums by 5%
 - Study to determine feasibility of merging the individual and small group markets
- **Cost Shift Review**
 - Expands hospital reporting on cost shift
 - Creates a cost shift task force to determine methods of accounting for the cost shift and ensuring that reductions in the cost shift are passed on to private insurance consumers
 - Establishes a process to create a uniform, statewide uncompensated care policy or set of policies for all hospitals
- **Healthy Lifestyles Insurance Discounts** – allows discounts of up to 15% of premium for compliance with health promotion program and limits total deviation from community rate to 30% (including these discounts) in the individual and small group insurance markets
- **Common claims and procedures** – establishes a work group to make recommendations
- **Common Credentialing for Providers** – The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) will require use of single, standard form for multiple credentialing applications
- **Multi-payer Database & Consumer Price and Quality Information** - requires insurers and third party administrators to report data in order for BISHCA to provide price and quality information to consumers
- **Master Provider Index** – A work group of the Area Health Education Centers Program of the University of Vermont College of Medicine (AHEC) will recommend whether and how to create a master provider index for information technology referencing purposes

- **Community Grants**
 - The Department of Health will award grants to communities employing a comprehensive approach and promoting wellness across community and lifespan
 - Funding can also come from federal government and private funds
- **Health Program Inventory** – The Agency of Human Services will provide to the legislature by December 15, 2006 an inventory of existing state programs or initiatives that promote or fund health, recreation, wellness, or like efforts, including funding sources and conditions
- **Medical Event Reporting**
 - The Department of Health will establish a program for the purpose of improving patient safety, eliminating adverse events in hospitals, and supporting hospital quality improvement efforts
 - Hospitals must track adverse events and analyze the causes
 - Rulemaking will define events hospitals must report to the Department of Health, which must include the National Quality Forum 27 “never events”
 - Hospitals must report to patients or family when an adverse event causes death or serious bodily injury
 - Hospitals must give the Department of Health access necessary to evaluate compliance
 - Patient confidentiality and peer review protections are maintained
 - Infection rate reporting is added to hospital community reports
- **Information Technology Coordination**
 - Consolidates authority for coordinating and supervising health reform initiatives in the Secretary of Administration’s office; also directs agencies to coordinate efforts
 - Requires the statewide plan to address issues relating to data ownership, governance, and confidentiality and security of patient information
 - Extends the deadline for the statewide plan by six months
- **Loan Repayment for Health Care Professionals**
 - Authorizes awards to Vermont health care providers and educators with outstanding loans who are serving Vermonters
 - Designed to attract and retain providers in underserved specialties and geographic areas
 - Recipients must serve patients with Medicare, Medicaid, or state health benefit coverage
 - Guidelines will specify who and what is eligible
- **Advance Directives**
 - Applies law to “procurement organizations” as appropriate

- Requires a health care provider to notify the registry and submit a copy of any amendments, suspensions, and revocations about which it knows
 - Clarifies that advance directive can specify who can and cannot bring probate court action and that probate court will honor this
 - Extends rulemaking deadlines by four to six months
 - Adds to the top of the list for authorizing anatomical gifts a person identified in an advance directive as having such authority
- **Federally Qualified Health Centers (FQHCs)** - appropriates general funds for the development of uncompensated care pool funds for an income-sensitized sliding scale fee schedule for patients at FQHC look-alikes. The Department of Health must provide equal geographic distribution of funds, with the goal of ensuring an FQHC look-alike in every county
- **Sorry Works!**
 - Oral apology or explanation of how medical error occurred, made within 30 days, may not be used to prove liability, is not admissible, and cannot serve as the subject of questioning in administrative or civil proceedings
 - Information obtained through other channels is not barred from use
 - Establishes a voluntary, pilot Sorry Works! program run by the Department of Banking, Insurance, Securities & Health Care Administration (BISHCA) in which physicians and hospitals promptly acknowledge and apologize for mistakes in patient care that result in harm and promptly offer fair settlements
 - Negotiations under Sorry Works! are confidential, and the statute of limitations is tolled during negotiations. Settlement bars further litigation; if settlement is not reached, the patient may bring a civil action
 - Hospitals will report medical malpractice costs to BISHCA for the department to analyze any cost savings resulting from use of Sorry Works!
 - BISHCA will report to the general assembly by January 15, 2009
 - Pilot program until sunset on June 30, 2009; applies only to medical errors occurring after July 1, 2006
- **Executive Branch Reform Coordination** – The Secretary of Administration will coordinate the health care reform initiatives, including Blueprint for Health; information technology – VITL, multi-payer database, common claims and credentialing forms; public health initiatives, Medicaid, VHAP, Dr. Dynasaur, and Catamount Health.
- **Legislative Oversight and Next Steps**
 - The Commission on Health Care Reform is charged with monitoring health care reform and will report on a plan to increase health care coverage to ensure universal access no later than 2011.
 - The commission is codified and remains in existence until 2011
 - The duties are to:

- Monitor the development, implementation and operation of the health care reform initiatives
- Study areas as directed
- Receive input and make recommendations to the relevant standing committees of the legislature on health care reform issues
- The summer charge for the commission is to oversee the study of macroeconomic impacts of health care reform on Vermont
- The commission will review the Catamount Health insurance plans and the Catamount Health Assistance by October 1, 2009 to determine the cost-effectiveness of the program, and may trigger an alternative, self-insured approach if necessary
- The Health Access Oversight Committee continues its charge to oversee Medicaid initiatives, including the employer-sponsored insurance program.