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Vermont Health Reform

Georgia J. Maheras*

I. Vermont's Reforming Nature

In 2011, Vermont made headlines for passing Act 48 – comprehensive health care reform legislation.[1] Its major hallmarks are a focus on cost containment, developing a state-based Exchange, and transitioning the system to a single payer.[2] Act 48 states that "[i]t 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, businesses, and members of the public."[3] The creation of new state regulatory bodies is not a silver bullet that changes the cost or outcomes of Vermont's health care system; rather it provides for a new opportunity. The state can share policies, supporting change among Vermonters, their health care providers, health care payers, and government. This change aims to reduce health care cost growth and to improve outcomes in Vermonters. This article

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[1] Act No. 48, 2011 Vt. Acts & Resolves 239; *e.g.*, Abby Goodnough, *Vermont: Governor Signs Health Care Law*, N.Y. TIMES, May 27, 2011, at A16 (noting law "sets Vermont on a path to creating the nation's first publicly financed health care system"); Zach Howard, *New Bill Puts Vermont on Road to Single-Payer Health Care*, REUTERS (May 26, 2011, 1:27 PM), http://www.reuters.com/article/2011/05/26/us-vermont-healthcare-idUSTRE74P61120110526; Adam Clark Estes, *Vermont Becomes First State To Enact Single-Payer Health Care*, ATLANTIC WIRE (May 26, 2011), http://www.theatlanticwire.com/national/2011/05/vermont-becomes-first-state-pass-single-payer-health-care/38207/; Amy Goodman, *Single Payer Healthcare: Vermont's Gentle Revolution*, GUARDIAN (May 25, 2011, 8:00 AM), http://www.guardian.co.uk/commentisfree/cifamerica/2011/may/25/healthcare-vermont.

[2] GREEN MOUNTAIN CARE BD., VERMONT'S HEALTH CARE INNOVATION PLAN 3-4 (2012), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/B%20Vermont_Health_Care_Innovation_Plan%20FINAL.pdf.

[3] Act No. 48 § 1(a), 2011 Vt. Acts & Resolves at 240.

discusses Vermont's latest reform efforts, focusing on the payment and delivery system reforms that will enable the state to achieve the longer term goal of universal access decoupled from employment.

Vermont's latest reforms are built upon a foundation of reform. Beginning with community rating in the early 1990s, Vermont embarked on a series of Medicaid expansions and insurance market reforms that are matched by few states.[4] For example, the majority of the Patient Protection and Affordable Care Act's ("PPACA") insurance market reforms, such as guaranteed issue and elimination of pre-existing condition exclusions,[5] have been in place for nearly two decades in Vermont.[6]

In 1989, Vermont created Dr. Dynasaur – a Medicaid/CHIP program that now covers all children in households with incomes up to 300% of the federal poverty level ("FPL").[7] From the late 1990s until 2007, Vermont expanded coverage to adults with incomes up to 300% FPL through the Vermont Health Access Program ("VHAP") and the Catamount Health Plan.[8] These programs are fully- or partially-subsidized insurance

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[4] Act No. 52 § 1, 1991 Vt. Acts & Resolves 178, 180 (requiring community rating and guaranteed issue in small group market); Vermont Health Care Act of 1992, Act No. 160 § 41, 1992 Vt. Acts & Resolves 85, 107-09 (requiring community rating and guaranteed issue in individual market); MARK A. HALL, WAKE FOREST UNIV. SCHOOL OF MED., AN EVALUATION OF VERMONT'S HEALTH INSURANCE REFORM LAWS (1998), *available at* http://www.phs.wfubmc.edu/public/pub_insurance/PDF/vermont.pdf; Howard M. Leichter, *State Model: Vermont: Health Care Reform in Vermont: A Work in Progress*, HEALTH AFF., May 1993, at 71, 71, *available at* http://content.healthaffairs.org/content/12/2/71.full.pdf; Howard M. Leichter, *Health Care Reform in Vermont: The Next Chapter*, HEALTH AFF., Nov. 1994, at 78, 78.

[5] Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1201(2), 124 Stat. 119, 154-56 (amending 42 U.S.C. §§ 300gg-1, -3, -4), *available at* http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

[6] VT. STAT. ANN. tit. 8, § 4080a(d), (g) (2012) (originally enacted as Act No. 52 § 1, 1991 Vt. Acts & Resolves 178, 180) (requiring guaranteed issue and limiting exclusions for pre-existing conditions in small group market); *id.* § 4080b(d), (g) (2012) (originally enacted as Act No. 160 § 41, 1992 Vt. Acts & Resolves 85, 107-08) (requiring guaranteed issue and limiting exclusions for pre-existing conditions in individual market).

[7] Act No. 94 § 2(a), 1989 Vt. Acts & Resolves 266 (creating program that became known as "Dr. Dynasaur"); Act No. 160 § 54(b), 1992 Vt. Acts & Resolves 85, 114 (appropriating Medicaid funds to Dr. Dynasaur program); 13-170-430 VT. CODE R. § 4312.6 (2012); *see also* AGENCY OF HUMAN SERVS., STATE OF VT., GLOBAL COMMITMENT TO HEALTH 11-W-00194/1: ANNUAL REPORT FOR FFY 07 1 (2008), *available at* http://dvha.vermont.gov/administration/gcannual_reportffy07final.pdf (providing historical overview of Vermont health care reforms beginning in late 1980s).

[8] AGENCY OF HUMAN SERVS., *supra* note 7, at 1; *see also* VT. STAT. ANN. tit. 33, § 1973 (2012) (VHAP); VT. STAT. ANN. tit. 8, § 4080f (2012) (Catamount Health Plan); VT. STAT. ANN. tit. 33, §§ 1981-1985 (2012) (Catamount Health Plan); Act No. 14 § 9, 1995 Vt. Acts & Resolves 44, 48-

products available to income-eligible Vermonters.[9]

In the early 2000s, Vermont's health care landscape saw a new wave of initiatives: creation of a patient-centered medical home initiative, as part of the Blueprint for Health,[10] and execution of "Global Commitment" – a new Medicaid waiver granted

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49 (formerly codified at VT. STAT. ANN. tit. 33, § 1972) (establishing Vermont Health Access Trust Fund) *repealed by* Act No. 93 § 16, 2006 Vt. Acts & Resolves 8, 14-15 (requiring transfer of funds to newly created state health care resources fund and repealing VT. STAT. ANN. tit. 33, § 1972); Act No. 122, § 133, 2004 Vt. Acts & Resolves 353, 416 (codified at VT. STAT. ANN. tit. 33, § 1973) (requiring establishment of "Vermont health access plan (VHAP) pursuant to a waiver of federal Medicaid law"); Act No. 190 § 1, 2006 Vt. Acts & Resolves 453, 453 (codified at VT. STAT. ANN. tit. 8, § 4080f (n)-(o) (2012) (relating to creation of Catamount Health); Act No. 191 §§ 15-16, 2006 Vt. Acts & Resolves 455, 468-76 (codified respectively at VT. STAT. ANN. tit. 8, § 4080f (2012), VT. STAT. ANN. tit. 33, § 1973 (2012)) (establishing Catamount Health).

[9] AGENCY OF HUMAN SERVS., *supra* note 7, at 1; *see also Vermont Health Access Plan (VHAP) Qualifications*, GREENMOUNTAINCARE, http://www.greenmountaincare.org/vermont-health-insurance-plans/vermont-health-access-plan/vhap-qualifications (last visited Apr. 10, 2013); *Vermont Health Access Plan (VHAP)*, GREENMOUNTAINCARE, http://www.greenmountaincare.org/vermont-health-insurance-plans/vermont-health-access-plan (last visited Apr. 10, 2013); *Catamount Health Qualifications*, GREENMOUNTAINCARE, http://www.greenmountaincare.org/vermont-health-insurance-plans/catamount-health/catamount-qualifications (last visited Apr. 10, 2013); *Catamount Health*, GREENMOUNTAINCARE, http://www.greenmountaincare.org/vermont-health-insurance-plans/catamount-health (last visited Apr. 10, 2013).

[10] DEP'T OF VT. HEALTH ACCESS, VERMONT BLUEPRINT FOR HEALTH: 2012 ANNUAL REPORT 2 (2013), *available at* http://hcr.vermont.gov/sites/hcr/files/Blueprint/Blueprint%20for%20Health%202012%20Annual%20Report%20%2002_14_13_FINAL.pdf ;VT. CHILD HEALTH IMPROVEMENT PROGRAM, UNIV. OF VT. COLL. OF MED., WHAT IS THE VERMONT BLUEPRINT FOR HEALTH? (2011), *available at* http://www.uvm.edu/medicine/vchip/documents/2011VCHIPINSERT_BLUEPRINT.pdf. The Blueprint for Health was launched in 2003 as a Governor's Initiative "to address the increasing costs of people with chronic illnesses." DEP'T OF VT. HEALTH ACCESS, *supra*; VT. CHILD HEALTH IMPROVEMENT PROGRAM, UNIV. OF VT. COLL. OF MED., *supra*. Patient-centered medical homes, which "provide well-coordinated and patient-centered care[,]" are part of the Blueprint for Health. VT. CHILD HEALTH IMPROVEMENT PROGRAM, UNIV. OF VT. COLL. OF MED., *supra*; *see also* VT. STAT. ANN. tit. 18, §§ 701-09 (2012) (detailing the Blueprint for Health); Act No. 191 § 5, 2006 Vt. Acts & Resolves 455, 457-60 (codified at VT. STAT. ANN. tit. 18, §§ 701-02 (2012)) (establishing the Blueprint for Health); Christina Bielaszka-DuVernay, *Innovation Profile: Vermont's Blueprint for Medical Homes, Community Health Teams, and Better Health at Lower Cost*, 30 HEALTH AFF. 383 (2011); Mary Takach, *Reinventing Medicaid: State Innovations To Qualify and Pay for Patient-Centered Medical Homes Show Promising Results*, 30 HEALTH AFF. 1325 (2011) (discussing Vermont's et al. experiments with patient-centered medical homes).

by the Centers for Medicare and Medicaid Services ("CMS").[11] The Global Commitment waiver allowed the state to designate the Medicaid agency as a Medicaid Managed Care Entity, which included the ability to make managed care investments around cost containment and other initiatives.[12]

II. Why Health Care Reform Now?

Vermont recognized moral and economic reasons to undertake health care reform. The state's health care cost growth far outpaced inflation and needed to be curtailed. Additionally, while population health outcomes and health care quality are considered high in Vermont, the population is getting less healthy over time.[13] Vermont has a high-quality health care system by many measures.[14] Nevertheless, the growth rate

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[11] JOCELYN GUYER, KAISER COMM'N ON MEDICAID & THE UNINSURED, ISSUE PAPER, VERMONT'S GLOBAL COMMITMENT WAIVER: IMPLICATIONS FOR THE MEDICAID PROGRAM 1 (2006), *available at* http://www.kff.org/medicaid/upload/7493.pdf (noting that new Medicaid waiver would allow Vermont "to fundamentally restructure its Medicaid program"); *see also* Act No. 215 § 308, 2006 Vt. Acts & Resolves 646, 752 (codified at VT. STAT. ANN. tit. 33, § 1901(d)(1)) (authorizing "the office of Vermont health access . . . to serve as a publicly operated managed care organization (MCO)"); Letter from Cindy Mann, Dir. of Ctrs. for Medicare & Medicaid Servs., to Douglas A. Racine, Sec'y of Vt. Agency of Human Servs. (June 27, 2012), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/vt/vt-global-commitment-to-health-ca.pdf (detailing current Medicaid waiver for Global Commitment); *see also Waivers*, MEDICAID.GOV, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html (last visited Apr. 10, 2013) (providing general information on Medicaid waivers and details of current waivers). "Waivers are vehicles states can use to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP)." *Waivers, supra.*

[12] *See* GUYER, *supra* note 11, at 6, 7; AGENCY OF HUMAN SERVS., *supra* note 7, at 1.

> Implemented October 1, 2005, the Global Commitment convert[ed] the Office of Vermont Health Access (OVHA), the state's Medicaid organization, to a public Managed Care Organization (MCO). [The Agency of Human Services pays] the MCO a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

AGENCY OF HUMAN SERVS., *supra* note 7, at 1; *see also* Act No. 215 § 308, 2006 Vt. Acts & Resolves 646, 752 (codified at VT. STAT. ANN. tit. 33, § 1901(d)(1)) (authorizing "the office of Vermont health access . . . to serve as a publicly operated managed care organization (MCO)").

[13] SUSAN BESIO, VT. AGENCY OF ADMIN., OVERVIEW OF VERMONT'S HEALTH CARE REFORM 15, 32 (2008), *available at* http://hcr.vermont.gov/sites/hcr/files/Revised_Vermont_HCR_\Overview_October_08__0_1.pdf.

[14] DOUGLAS MCCARTHY ET AL., COMMONWEALTH FUND, AIMING HIGHER: RESULTS FROM A STATE SCORECARD ON HEALTH SYSTEM PERFORMANCE, 2009 8, 9 (2009), *available at*

of health care costs is unsustainable, and the state generally gets poor returns on its health care expenditures.[15] The health care system in Vermont is broken, with health care cost growth being a main indicator of this issue.[16]

Vermont's health care costs are not in line with state economic growth, as the growth rate of health care costs has been two to three times the rate of inflation.[17]

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http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2009/Oct/1326_McCarthy_aiming_higher_state_scorecard_2009_full_report_FINAL_v2.pdf (analyzing health system performance across multiple dimensions and ranking Vermont first overall in 2009, second in 2007).

[15] GREEN MOUNTAIN CARE BD., ANNUAL REPORT OF THE GREEN MOUNTAIN CARE BOARD TO THE VERMONT GENERAL ASSEMBLY 4 (2013), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/GMCB_AnnualRpt2013_R.pdf; ROBIN J. LUNGE, VT. AGENCY OF ADMIN., STRATEGIC PLAN FOR VERMONT HEALTH REFORM 2012–2014 4-8 (2012), *available at* http://hcr.vermont.gov/sites/hcr/files/Strategic%20plan%201%2016%2012.pdf; *Reduce Health Care Costs and Cost Growth*, VT. AGENCY OF ADMIN., http://hcr.vermont.gov/goals/reduce_costs (last visited Apr. 10, 2013).

[16] *See* LUNGE, *supra* note 15, at 4.

[17] *See* GREEN MOUNTAIN CARE BD. WITH DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., 2010 VERMONT HEALTH CARE EXPENDITURE ANALYSIS 10 (2012), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/2010EA040212.pdf (noting "Vermont health care spending grew an average of 6.3% per year from 2005 to 2010"); *Consumer Price Index: All Urban Consumers (CPI-U)*, BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt (last updated Mar. 15, 2013) (indicating average annual percent change of approximately 2.4% in consumer price index from 2005 to 2010).

> Health care cost growth during the period 1997-2009 greatly outstripped economic growth, in Vermont and nationally. In 2010 and 2011, health care cost increases were closer to (but still exceeded) economic growth, but experts predict that the gap between economic growth and health care cost growth will widen again in 2014 and continue for the years beyond. . . . United States health care cost growth consistently has exceeded inflation by about two percentage points, in good economic times and bad, resulting in higher per capita costs over time, even after adjusting for inflation.
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> . . .
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> This mismatch might not sound significant, but it has resulted in fairly steady growth in the percentage of each dollar we earn that pays for health care. In 2011, Vermont spent an estimated 19.3 percent of gross domestic product on health care, significantly more than the national average of 16.9 percent . . . . Vermont health spending as a percentage of [gross state product (GSP)] was 16 percent in 2005. The percentage of [GSP] dedicated to health care did not grow in Vermont or nationally from 2009-2011, as a result of the recession and

Despite many health care coverage expansion efforts, nearly 7 percent of the population still lacks health coverage and an additional 28 percent of residents under age 65 have inadequate coverage.[18] Without reform, Vermont's health care expenditures are expected to grow to $10 billion a year by 2019, which is more than double the 2010 rate of $4.9 billion.[19] Resident health care spending as a percentage of gross state product is estimated at approximately 19 percent and climbing.[20] The increase in health care costs limits the ability of Vermonters and the state to pay for other things such as education, transportation, and non-medical emergency services.[21]

> reduced government health care spending, but current predictions show health care growth continuing its historical trajectory in 2014 and beyond.

GREEN MOUNTAIN CARE BD., *supra* note 15, at 4-5.

[18] BRIAN ROBERTSON & JASON MAURICE, INS. DIV., VT. DEP'T OF FIN. REGULATION, 2012 VERMONT HOUSEHOLD HEALTH INSURANCE SURVEY: COMPREHENSIVE REPORT 1 (2013), *available at* http://www.dfr.vermont.gov/sites/default/files/VHHIS_2012_Final_Report.pdf (finding 6.8% of Vermont residents uninsured based on 2012 data); BRIAN ROBERTSON ET AL., VT. OFFICE OF HEALTH ACCESS, TASK 7: STUDY OF THE UNINSURED AND UNDERINSURED: PLANNING FOR VERMONT'S HEALTH BENEFITS EXCHANGE 1, 73 (2011), *available at* http://dvha.vermont.gov/administration/hbe-uninsured-underinsured-report-03032011.pdf (finding 27.9% of Vermont residents under age 65 underinsured based on 2009 data).

[19] VT. LEGISLATIVE JOINT FISCAL OFFICE & DEP'T OF BANKING, INS., SEC. & HEALTH CARE ADMIN., COSTS OF VERMONT'S HEALTH CARE SYSTEM COMPARISON OF BASELINE AND REFORMED SYSTEM 3 (2011), *available at* http://www.leg.state.vt.us/jfo/healthcare/November%20Report%20-%20Final.pdf; GREEN MOUNTAIN CARE BD. WITH DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., *supra* note 17, at 8.

[20] *See* DIV. OF HEALTH CARE ADMIN., VT. DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., LEGISLATIVE REPORT: 2009 VERMONT HEALTH CARE EXPENDITURE ANALYSIS & THREE-YEAR FORECAST 4, 5 (2011), *available at* http://www.dfr.vermont.gov/sites/default/files/2009%20EA%20REPORT.pdf. In 2009, resident health care spending totaled $4.7 billion, constituting 18.5% of the gross state product (GSP), and was projected to reach approximately $5.9 billion by 2013. *Id.* at 5, 33. Additional data from 2010 showed resident health care expenditures totaling $5.0 billion and, again, projected the total to reach $5.9 billion in 2013, with an average annual increase in expenditures from 2010 to 2013 of 5.7%. DIV. OF HEALTH CARE ADMIN., VT. DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., LEGISLATIVE REPORT: THREE-YEAR FORECAST OF VERMONT HEALTH CARE EXPENDITURES 2010-2013 6, 8 (2011), *available at* http://www.dfr.vermont.gov/sites/default/files/2009-EA-InForecast-Final.pdf. In 2010, resident health care expenditures accounted for approximately 19.2% of GSP. GREEN MOUNTAIN CARE BD. WITH DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., *supra* note 17, at 13. In 2011, those expenditures accounted for an estimated 19.3% of GSP. GREEN MOUNTAIN CARE BD., *supra* note 15, at 5.

[21] *See* GREEN MOUNTAIN CARE BD. WITH DEP'T OF BANKING, INS., SEC., & HEALTH CARE ADMIN., *supra* note 17, at 8.

In addition to costs, Vermont's current system faces several other challenges. Patient care is "often poorly integrated," "technology does not allow for adequate communication between providers," and "the payment system promotes the use of more health care services, rather than better health."[22] "The [health care] system [overall] is geared toward treating illness rather than preventing it," and "Vermonters do not do all they can to be healthy."[23] The state must spread fixed costs of health care facilities and services over a relatively small population, and new innovations that improve treatment are often very expensive.[24] In state comparisons of health care system quality, Vermont generally receives high ratings for the quality and health outcomes produced by its health system.[25] In certain categories concerning individual health, for example, obesity and deaths from colorectal cancer, the state could improve.[26]

III. What Is Vermont's Health Landscape?

The health care landscape defines how a state can approach health care reforms. Depending on the distribution of payers, providers, and residents, each state has different options. Vermont's approximately 625,000 residents receive care at fourteen hospitals, eight of which are critical access, meaning they have fewer than twenty-five beds.[27] The state has one academic medical center, which, along with Dartmouth-Hitchcock Medical Center in New Hampshire, provides most of the tertiary care services.[28] Eight Federally Qualified Health Centers ("FQHCs") serve approximately 20

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[22] Anya Rader Wallack et al., Opinion, *The Vermont Health Care System Remains Broken*, VTDIGGER.ORG, (Dec. 5, 2012), http://vtdigger.org/2012/12/05/wallack-et-al-the-vermont-health-care-system-remains-broken/.

[23] GREEN MOUNTAIN CARE BD., *supra* note 15, at 4.

[24] *Id.*

[25] *Id.* at 6; MCCARTHY ET AL., *supra* note 14, at 8, 9.

[26] GREEN MOUNTAIN CARE BD., *supra* note 15, at 6. Approximately 25 percent of Vermonters are obese. *Id.*; *see also* UNITED HEALTH FOUND., AMERICA'S HEALTH RANKINGS: A CALL TO ACTION FOR INDIVIDUALS AND THEIR COMMUNITIES 103 (2012), *available at* http://ahrsitefiles.s3.amazonaws.com/SiteFiles/Reports/Americas-Health-Rankings-2012.pdf (estimating 25.4% of state population obese, illustrating general upward trend in obesity since 1990). Although Vermont's deaths from colorectal cancer (15.7 per 100,000) are below the national average (16.4 per 100,000), it constitutes the second leading cause of death in the state. GREEN MOUNTAIN CARE BD., *supra* note 15, at 7 (citing 2008 CDC data).

[27] *State & County QuickFacts: Vermont*, U.S. CENSUS BUREAU, http://quickfacts.census.gov/qfd/states/50000.html (last visited Apr. 10, 2013); GREEN MOUNTAIN CARE BD., *supra* note 15, at 1.

[28] GREEN MOUNTAIN CARE BD., *supra* note 15, at 1.

percent of the state's residents.[29] Together, the hospitals and FQHCs employ more than half of the 2,000 licensed physicians providing salary, benefits and IT support.[30] The state's private insurance market is dominated by three insurance carriers, only two of which offer individual (non-group) or small group insurance.[31] Both the providers and the insurance companies have been highly regulated since the late 1980s.[32] This regulation and the Medicaid expansions discussed above have resulted in a 6.8 percent uninsurance rate.[33]

These facts and statistics do not convey Vermont's greatest strengths: its history of bold reforms and its size. The past reforms make the latest reform effort the next in a series and something to be expected by stakeholders. The state's relatively small size

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[29] *Id.* (noting that more than 120,000 Vermonters are served by eight FQHCs); *see also State & County QuickFacts*, *supra* note 27 (estimating Vermont's population at approximately 625,000); *What Are Federally Qualified Health Centers (FQHCs)?*, HRSA, http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html (last visited Apr. 10, 2013).

[30] GREEN MOUNTAIN CARE BD., *supra* note 15, at 1.

[31] BAILIT HEALTH PURCHASING, LLC, THE CURRENT VERMONT HEALTH INSURANCE MARKET 4, 6, 20 (2011), *available at* http://dvha.vermont.gov/administration/hbe-insurance-market-report-revised-10-10-11.pdf; VT. HEALTH CONNECT, PLANNING REVIEW: VERMONT HEALTH BENEFIT EXCHANGE, 97 (2012), *available at* http://healthconnect.vermont.gov/sites/hcexchange/files/Planning_Research_Documents/hbe-powerpoint-presentation-for-vermonts-planning-review-with-hhs-05-2012.pdf. The three dominant carriers are BlueCross BlueShield of Vermont (including BCBSVT and TVHP), MVP Healthcare, and CIGNA. BAILIT HEALTH PURCHASING, *supra*, at 4, 6. In 2009, 98.5% of Vermonters with private individual or group insurance were covered by these three companies. *Id.* at 4. Only BlueCross BlueShield of Vermont and MVP Healthcare offered non-group insurance. *Id.* at 20. Similarly, only BlueCross BlueShield of Vermont and MVP Healthcare offer plans in the small group insurance market. VT. HEALTH CONNECT, *supra*, at 97.

[32] *See* VT. STAT. ANN. tit. 26, §§ 1351-61 (2012) (outlining statutory regulation of Vermont's Board of Medical Practice); *Vermont Board of Medical Practice*, VT. DEP'T OF HEALTH, http://healthvermont.gov/hc/med_board/bmp.aspx (last visited Apr. 10, 2013) (providing information and resources on the Vermont Board of Medical Practice); HALL, *supra* note 4; Bulletin No. 95 from Gretchen Babcock, Commissioner, Vt. Dep't of Banking and Ins. (Sept. 20, 1989), *available at* http://www.dfr.vermont.gov/sites/default/files/insurance-bulletin-95.pdf (outlining recent statutory and regulatory changes in Vermont health insurance in 1989); Sharon Willcox, *Consumer Protection in Private Health Insurance: The Role of Consumer Complaints*, U.S. DEP'T OF HEALTH & HUMAN SERVS., June 2000, http://aspe.hhs.gov/health/reports/consumer/phi/vermont.htm (detailing Vermont's regulatory oversight of health insurance).

[33] *See generally* ROBERTSON & MAURICE, *supra* note 18 (analyzing uninsurance rates); *id.* at 1. "In late 2012, 6.8% of Vermont residents (42,760) were uninsured. This was down slightly since 2009, when 7.6% of Vermont residents were uninsured, and represented a significant decline from the rate observed in 2005 when 9.8% (61,057) were uninsured." *Id.* at 10.

makes it possible to get all of the critical people in a room to address issues that arise.

IV. Health Care Reform Goals

The latest step in Vermont's bold health care reform agenda was the passage of Act 48 in 2011.[34] This law builds on the earlier reforms, specifically endorsing and expanding the patient-centered primary care medical home initiative and the Blueprint for Health.[35] The law also lays out four interrelated goals:

- Ensure access to and coverage for high quality care for all Vermonters;
- Reduce health care costs and cost growth;
- Improve Vermonters' overall health; and
- Ensure greater equity and fairness in health care payments.[36]

Health care reform will only be successful if all four goals are achieved.[37] These health care reform goals are consistent with the Commonwealth Fund's 2006 report, *Framework for a High Performance Health System in the United States*, which found that "a high performance health system is designed to achieve four core goals: 1) high quality, safe care; 2) access to care for all people; 3) efficient, high value care; and 4) system capacity to improve."[38]

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[34] Act No. 48, 2011 Vt. Acts & Resolves 239.

[35] *E.g.*, *id.* §§ 3c, 4, 12a; *see also* Claire K. Ankuda, *Vermont's Single-Payer Health Care System: An Interview with Allan Ramsay*, 14 VIRTUAL MENTOR 567, 568 (2012), *available at* http://virtualmentor.ama-assn.org/2012/07/pdf/pfor1-1207.pdf (referring to patient-centered medical homes and Blueprint for Health as "foundation" of Vermont's health care system).

[36] *Vermont Reforms*, VT. HEALTH CONNECT, http://healthconnect.vermont.gov/healthcare_reform/vermont_reforms (last visited Apr. 10, 2013); *see* Act No. 48 §3, 2011 Vermont Acts & Resolves at 244-45 (codified at VT. STAT. ANN. tit. 18, §§ 9371-72 (2012)) (providing principles and purposes of health care reform).

[37] *See* LUNGE, *supra* note 15, at 5-6 (explaining four goals function together to create infrastructure of health care system).

[38] *See* COMM'N ON A HIGH PERFORMANCE HEALTH SYSTEM, COMMONWEALTH FUND, FRAMEWORK FOR A HIGH PERFORMANCE HEALTH SYSTEM IN THE UNITED STATES 4-6 (2006), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2006/Aug/Framework%20for%20a%20High%20Performance%20Health%20System%20for%20the%20United%20States/Commission_framework_high_performance_943%20pdf.pdf. The

Vermont's strategy is to integrate within and between provider organizations, while at the same time, moving away from fee-for-service payments, towards payment methods that pay providers for quality performance.[39] Additionally, Vermont seeks comprehensive reform with universal coverage for services that are decoupled from employment.[40] Vermont's goals appear achievable because of intense and well-coordinated work – both within and outside of government.[41] Those involved in implementation also see public engagement as critical to success; Vermonters need to understand the coming changes and to help inform the policy decisions being made.[42]

V. Health Reform's Three Parts

Vermont's health reform seeks to achieve its goals through three major areas of work: 1) comprehensive cost containment and reform of payment and delivery systems;

Commonwealth Fund also found that to achieve a high performance health care system the system must "[c]ommit to a clear national strategy for achieving the mission and establish a process to implement and refine that strategy;" "[d]eliver care through models that emphasize coordination and integration;" and "[e]stablish and track metrics for health outcomes, quality of care, access to care, population-based disparities, and efficiency." *Id.* at 3.

[39] LUNGE, *supra* note 15, at 6, 11.

[40] *Id.* at 7, 9. Vermont already has initiatives underway "to develop operational and financial plans to cover all Vermonters through a unified system, not linked to employment, with equitable financing that reduces complexity in the system." *Id.* at 7. Vermont's Director of Health Care Reform in the Agency of Administration intends to "[g]ain passage of legislation and approval of a federal waiver for public financing that is divorced from employment and sensitive to the ability of individuals and businesses to pay for coverage and [that] is more sustainable." *Id.* at 9.

[41] *See* LUNGE, *supra* note 15, at 7, 10 (noting Vermont's reform will require participation and cooperation from those inside and outside of the government). Specific "primary responsibilities" have been assigned to certain agencies, complete with tasks and deadlines. *Id.* at 10.

[42] *Id.* at 6. "Engagement from the public is essential, too, to ensure that efforts to improve our health care system are understood, reflect the values of Vermonters, encourage Vermonters to be and stay healthy[,] and support strong relationships between Vermonters and their health care practitioners." *Id.*; *see also* JEB SPAULDING & ROBIN LUNGE, AGENCY OF ADMIN., HEALTH CARE REFORM FINANCING PLAN 2, 16-17 (2013), *available at* http://hcr.vermont.gov/sites/hcr/files/2013/Health%20Care%20Reform%20Financing%20Plan_typos%26formatting%20corrected_012913.pdf (noting crucial for Vermonters to understand reforms); VERMONT HEALTH BENEFIT EXCHANGE, OUTREACH AND EDUCATION PLAN 3-4, 7, 9, 39 (2012) *available at* http://dvha.vermont.gov/administration/vermont-health-connect-outreach-and-education-plan.pdf (identifying importance of teaching Vermonters about Exchange and health reform). *See generally* ADAM RAMSEY, GREEN MOUNTAIN CARE BD., HEALTH CARE REFORM AND ACCOUNTABLE CARE: THINGS WE AND OUR RESIDENTS NEED TO KNOW (2012), *available at* http://chmfamilymedicine.msu.edu/sites/familymed/files/docs/2012-fm-residency-retreat-ramsay.pdf.

2) establishment of a health benefits exchange and expansion of the patient-centered medical home initiative; and 3) creation of a universal coverage system that is decoupled from employment.[43] Each of these major areas is housed in a different part of state government,[44] as depicted below in Figure 1, and the first two areas of work are precursors to implementing the third, as shown below in Timeline 1.

Vermont has taken advantage of several opportunities to receive federal funding in support of its reforms and has been granted two rate review enhancement grants, two exchange grants, and, most recently, a State Innovation Models grant.[45] This funding allows Vermont to acquire the staffing and analyses necessary to support the pace and breadth of reform.[46] The federal funding also supports two of the aforementioned three major areas of health reform: building the health benefits exchange and constraining health care cost growth.[47]

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[43] RAMSEY, *supra* note 42, at 6-7 (explaining core goals); LUNGE, *supra* note 15, at 5-7 (identifying goals of Vermont's health care reform); SPAULDING & LUNGE, *supra* note 42, at 5, 17 (providing overview of key goals of reform).

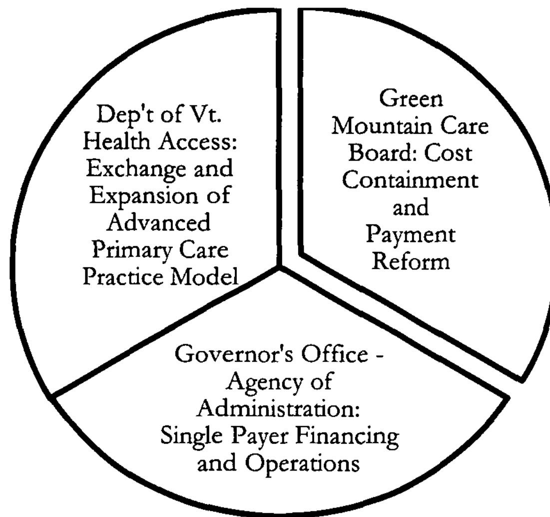
[44] *See* LUNGE, *supra* note 15, at 10-18 (identifying agencies' and departments' responsibilities in relation to goals of reform).

[45] *Vermont Health Reform*, STATEHEALTHFACTS.ORG, http://www.statehealthfacts.org/profileind.jsp?cat=17&rgn=47 (last visited Apr. 10, 2013) (indicating rate review grants totaled $1 million and $3.8 million, exchange grants totaled $1 million and $124.4 million); *State Innovation Models Initiative: Model Testing Awards*, CTR. FOR MEDICARE & MEDICAID SERVS., http://innovation.cms.gov/initiatives/State-Innovations-Model-Testing/index.html (last visited Apr. 10, 2013) (indicating award of up to $45 million to implement and test State Health Care Innovation Plan).

[46] SPAULDING & LUNGE, *supra* note 42, at 19.

[47] *Id.* at 1-2.

Figure 1: Health Reform's Division of Tasks



A. Department of Vermont Health Access

The Department of Vermont Health Access ("DVHA") serves as Vermont's Medicaid Managed Care Entity.[48] DVHA also administers the state's PPACA-compliant Exchange, as well as the Blueprint for Health ("Blueprint"), which is the patient-centered medical home initiative.[49] DVHA's Division of Health Reform serves as the state's health information technology hub.[50]

As Vermont's Medicaid Managed Care Entity, DVHA acts as any private managed care entity would – engaging in provider contracting, setting payment reimbursement rates, providing care management, and enrolling Medicaid-eligible

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[48] *See supra* notes 11-12 and accompanying text; *see also* DEP'T OF VT. HEALTH ACCESS (DVHA), http://ovha.vermont.gov/ (last modified Mar. 6, 2013); Act No. 48 § 401, 2011 Vt. Acts & Resolves 239, 273 (2011) (directing DVHA to include a division to manage Medicaid "policy, fiscal, and support services").

[49] *See* DEP'T OF VT. HEALTH ACCESS, BUDGET DOCUMENT: STATE FISCAL YEAR 2014 5 (2013), *available at* www.leg.state.vt.us/reports/2013ExternalReports/286704.pdf; Act No. 48 § 401, 2011 Vt. Acts & Resolves 239, 273 (2011) (designating DVHA as responsible for establishing Vermont's health benefit exchange); *see also supra* note 10 and accompanying text.

[50] *Division of Health Reform*, DEP'T OF VT. HEALTH ACCESS, http://dvha.vermont.gov/administration/division-of-health-reform (last modified Dec. 3, 2012); *see also* DIVISION OF HEALTH REFORM, DEP'T OF HEALTH ACCESS, VT. STATE AGENCY OF HUMAN SERVS., VERMONT HEALTH INFORMATION TECHNOLOGY PLAN (VHITP) (2010), *available at* http://hcr.vermont.gov/sites/hcr/files/Vermont_HIT_Plan_4_6__10-26-10__0.pdf.

Vermonters in various programs.[51]

The Blueprint, which began in 2006, is expanding across the state, and, by the end of 2013, approximately 500,000 Vermonters will be served by patient-centered medical homes.[52] The Blueprint initiative requires primary care practices to be certified as medical homes by the National Committee for Quality Assurance and provides assistance to enable them to achieve this.[53] One of the keys to the Blueprint's success is the development of Community Health Teams.[54] These are teams of clinicians from within each community who work together across primary care practices, providing services such as mental health and nutrition.[55] The community health teams serve as extensions of the primary care practices and enable patients to receive needed services within their community.[56]

Vermont Health Connect is the state's health benefits exchange.[57] It will serve the functions required by PPACA,[58] providing seamless eligibility and enrollment, allowing for online comparison and purchase of insurance products, and enabling consumer choice.[59] In 2012, Vermont enacted Act 171, which set the parameters for

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[51] *See* DEP'T OF VT. HEALTH ACCESS, *supra* note 49, at 15.

[52] *Id.* at 23. The Blueprint has the stated additional goals of creating an "environment where all Vermonters have access to seamless effective and preventive health services[,]" as well as the goal of streamlining and aligning the health system to encourage independent providers to work together. *Id.*

[53] *See id.* The "model" of the Blueprint initiative seeks to have all primary practices recognized by National Committee for Quality Assurance. *Id.*

[54] *See* DEP'T OF VT. HEALTH ACCESS, *supra* note 49, at 8-9; Bielaszka-DuVernay, *supra* note 10, at 384-85; *see also* VT. STAT. ANN. tit. 18, § 705 (2012) (detailing community health teams as part of Blueprint for Health).

[55] DEP'T OF VT. HEALTH ACCESS, *supra* note 10, at 8.

[56] *Id.*

[57] VERMONT HEALTH CONNECT, http://healthconnect.vermont.gov/ (last visited Apr. 10, 2013); VERMONT HEALTH CONNECT, VERMONT HEALTH CONNECT: FIND THE PLAN THAT'S RIGHT FOR YOU (2012), *available at* http://healthconnect.vermont.gov/sites/hcexchange/files/VT%20VHC%20Basics%20Handout.pdf.

[58] Letter from Peter Shumlin, Governor of Vermont, to Steve Larsen, Deputy Adm'r & Dir., Ctr. for Consumer Information & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs. (July 9, 2012), *available at* http://healthconnect.vermont.gov/sites/hcexchange/files/Planning_Research_Documents/vermont-declaration-letter.pdf (declaring Vermont's intention to establish a state-based exchange in accordance with PPACA).

[59] *See* sources cited *supra* note 57; *see also* *Health Care Reform: Affordable Care Act*, VERMONT HEALTH CONNECT, http://healthconnect.vermont.gov/healthcare_reform/aca (detailing Vermont's Exchange).

the state exchange.[60] Vermont's exchange is an "active purchaser" exchange in which the state solicits plans and will select from among the carriers submitting plans.[61] Act 171 also requires all plans in the individual and small group markets to be sold on the exchange, meaning that Vermonters in that insurance market cannot purchase insurance directly from the insurance carriers.[62] The exchange mirrors the current private insurance market in that, as of March 2013, two insurance carriers intend to offer products on the exchange and the state is in complete PPACA compliance.[63]

Vermont's "essential health benefits" have been designed to emphasize value-based insurance design.[64] Value-based insurance design is when costs for preventive care and chronic disease treatment are lower than other costs.[65] Conceptually, consumers' out-of-pocket medical costs should be based on the value of a medical service in relation to their health rather than its intrinsic price.[66] As with many state-

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[60] *See generally* Act No. 171, 2012 Vt. Acts & Resolves 753.
[61] *Id.* § 2c at 755 (detailing requirements for exchange options); *see also* Rosemarie Day & Pamela Nadash, Analysis & Commentary, *New State Insurance Exchanges Should Follow the Example of Massachusetts by Simplifying Choices Among Health Plans*, 31 HEALTH AFF. 982 (2012) (discussing and comparing types of health insurance exchanges); *State Decisions for Creating Health Insurance Exchanges*, STATEHEALTHFACTS.ORG, Mar. 21, 2013, http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17 (providing overview of state exchange decisions).
[62] Act No. 171 § 3, 2012 Vt. Acts & Resolves at 758 (codified at Vt. Stat. Ann. tit. 33, § 1811(b)). "No person may provide a health benefit plan to an individual or small employer unless the plan is offered through the Vermont health benefit exchange and complies with the provisions of this subchapter." *Id.*
[63] *State Exchange Profiles: Vermont*, HENRY J. KAISER FAMILY FOUND. HEALTH REFORM SOURCE, Feb. 11, 2013, http://healthreform.kff.org/State-Exchange-Profiles/vermont; *see also supra* note 31 and accompanying text (discussing current private insurance market).
[64] *See Essential Health Benefits*, VT. HEALTH CONNECT, http://healthconnect.vermont.gov/information/essentials (last visited Apr. 10, 2013); *Vermont EHB Benchmark Plan*, CMS, http://cciio.cms.gov/resources/EHBBenchmark/vermont-ehb-benchmark-plan.pdf (last visited Apr. 10, 2013); *see also* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, §§ 1301-02, 124 Stat. 119, 162-68 (to be codified at 42 U.S.C. §§ 18021-22) (detailing requirements for essential health benefits required for "qualified health plans"). In October 2012, the Green Mountain Care Board approved as Vermont's Benchmark Plan "the largest small-employer plan, offered by Blue Cross Blue Shield of Vermont, with the state CHIP plan for pediatric oral care and the FEDVIP plan for pediatric vision." *Essential Health Benefits, supra.*
[65] *See* Michael E. Chernew et al., *Value-Based Insurance Design*, 26 HEALTH AFF. w195, w195 (2007). "Value-Based Insurance Design (VBID) explicitly acknowledges and responds to patient heterogeneity. It encourages the use of services when the clinical benefits exceed the cost and likewise discourages the use of services when the benefits do not justify the cost." *Id.*
[66] *Id.* at w195-w203; *see also* Michelle Andrews, *In New Insurance Model, Costs Are Based on Value of*

based exchanges, there is a need for the agency developing the exchange to coordinate with the insurance department that is responsible for licensure and regulation of insurance companies.[67] In Vermont, the Department of Financial Regulation ("DFR") is the insurance regulator, and it collaborates with the exchange team to make sure the carriers meet all of the PPACA and state requirements.[68]

B. Agency of Administration

Recognizing the need for coordination among multiple state agencies, Vermont's reforms placed a Director of Health Care Reform in the state's Agency of Administration ("AOA").[69] The AOA is responsible for the overall budget and operations of the state government and directs key administration initiatives.[70] The Director of Health Care Reform is responsible for coordinating reform efforts across state agencies.[71] The AOA is also tasked with developing the operational and financing plans for the state's transition away from employer-dependent insurance coverage to a single pipe or payer model.[72]

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the Treatment, KAISER HEALTH NEWS, http://www.kaiserhealthnews.org/features/insuring-your-health/pegging-price-to-value.aspx (Nov. 29, 2010) (identifying Value-Based Model as "[t]he idea that consumers' out-of-pocket medical costs should be based on the value of a medical service to their health rather than its price"); Kasia Moreno, *Value-Based Health Care: Fad or Future?*, FORBES, http://www.forbes.com/sites/forbesinsights/2012/06/11/value-based-health-care-fad-or-future/ (June 11, 2012) (providing the statistical probability that value-based model of health insurance will become mainstream).

[67] *See generally Initial Guidance to States on Exchanges*, HEALTHCARE.GOV, http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html (last visited Apr. 10, 2013) (detailing PPACA's Exchange requirements that may implicate state insurance regulation). *See also* TIMOTHY STOLTZFUS JOST, COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: EIGHT DIFFICULT ISSUES (2010), *available at* http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Sep/1444_Jost_hlt_ins_exchanges_ACA_eight_difficult_issues_v2.pdf.

[68] *See generally* ROBIN LUNGE, AGENCY OF ADMIN., REPORT TO THE VERMONT LEGISLATURE: CONSUMER PROTECTION REPORT (IN ACCORDANCE WITH ACT 171 (2012), SECTION 26A) (2013), *available at* http://www.leg.state.vt.us/reports/2013ExternalReports/285691.pdf (detailing roles of DFR and GMCB vis-à-vis the Exchange and PPACA compliance).

[69] Act No. 48 §1b, 2011 Vt. Acts & Resolves 239, 241 (amending VT. STAT. ANN. tit. 3, § 2222a(a), (b)).

[70] *Welcome to the Agency of Administration*, VT. AGENCY OF ADMIN., http://aoa.vermont.gov/ (last visited Apr. 10, 2013).

[71] Act No. 48 §1b, 2011 Vt. Acts & Resolves, 239, 241 (codified at VT. STAT. ANN. tit. 3 § 2222a (2012)).

[72] *Id.* (codified at VT. STAT. ANN. tit. 3, § 2222a(c)(8), (11)); *id.* § 2(a)(1),(6), at 242-43, 244.

Transition to this new model depends on the success of the state's efforts in achieving all four health care reform goals.[73] The transition leverages infrastructure built for the health benefits exchange and policy implemented with the intent to bend the cost curve.[74] Act 48 explicitly states that the state will not transition to a new model of coverage, known as Green Mountain Care, until the following criteria have been met:

> (A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.
> (B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy.
> (C) The financing for Green Mountain Care is sustainable.
> (D) Administrative expenses will be reduced.
> (E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending.
> (F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.[75]

The state will also need to apply for and receive approval of a waiver from PPACA, which is currently not allowed until 2017.[76]

Bending the cost curve means that the state needs to have made sufficient payment and delivery system reforms so that the rate of growth in health care costs is in line with the state's, and Vermonters', ability to pay for that growth.[77] Over the past 10 years, the rate of growth in health care costs has been between 5 percent and 6 percent a

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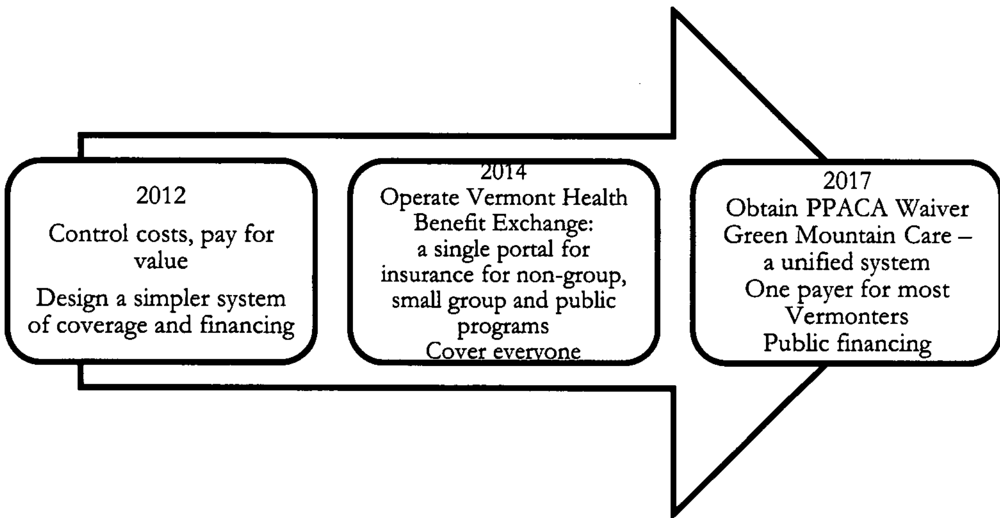
[73] *See supra* notes 36-37 and accompanying text.
[74] For a general discussion of health care reform options to bend the cost curve, including through exchanges, see ENGELBERG CTR. FOR HEALTH CARE REFORM, BROOKINGS INST., BENDING THE CURVE THROUGH HEALTH REFORM IMPLEMENTATION (2010), *available at* http://www.brookings.edu/~/media/research/files/reports/2010/10/btc%20ii/final%20bending%20the%20curve%20102010.
[75] Act No. 48 § 4, 2011 Vt. Acts & Resolves at 266 (codified at VT. STAT. ANN. tit. 33, § 1822 (2012)); *see also infra* notes 104-106 and accompanying (discussing Green Mountain Care).
[76] *See* Act No. 48 § 2, 2011 Vt. Acts & Resolves at 242 (noting availability of PPACA waivers for state Exchange requirements beginning in 2017); *see also* Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 203 (to be codified at 42 U.S.C. § 18052) (detailing waivers for Exchanges available beginning in 2017).
[77] *See* Hamilton Davis, *The Single-Payer Framework: Cost Containment Is the Shumlin Administration's Biggest Conundrum*, VTDIGGER.ORG, June 6, 2012, http://vtdigger.org/2012/06/06/the-single-payer-framework-cost-containment-is-the-shumlin-administrations-biggest-conundrum/ (analyzing feasibility of cost containment strategies).

year, while the rate of gross state product ("GSP") growth has been around 2 percent.[78] Health care costs are outpacing all other costs and limiting the ability to pay for services such as education and transportation.[79]

The AOA recently submitted a financing plan to the legislature for the single-payer model of coverage.[80] The financing plan is a conversation starter, as the state will work over the next two years to narrow down the mechanisms and amounts – to shift from a predominately employer/employee-paid financing structure to one that is paid through the state's annual budgeting structure.[81]

Timeline 1: Stages of Vermont Health Care Reform



C. Green Mountain Care Board

Vermont's efforts to contain health care costs and to implement payment and delivery system reforms are unique in the nation.[82] Vermont's health landscape, described above, indicates a health care market that is dominated by few payers and

[78] *See supra* notes 17, 20.
[79] *See supra* note 20.
[80] SPAULDING & LUNGE, *supra* note 42, at 1.
[81] *See generally* SPAULDING & LUNGE, *supra* note 42.
[82] Jessica Marcy, *Vermont Edges Toward Single Payer Health Care*, KAISER HEALTH NEWS, Oct. 2, 2011, http://www.kaiserhealthnews.org/stories/2011/october/02/vermont-single-payer-health-care.aspx (noting Vermont is only state to consider single payer health care).

providers with little to no competition. Because of this, Vermont's policy has been historically to manage this market though significant regulatory oversight.[83] Building on this history, Act 48 vested significant authority in a new, independent state agency: the Green Mountain Care Board ("GMCB" or "Board").[84] Act 48 gives the Board broad authority over health care policy-making.[85] This is intended to bring together previously separate regulatory and policymaking elements, to support a higher level of accountability for health care outcomes,[86] and to improve transparency in regulatory processes and policymaking.[87] According to the Board's enabling statute:

> It is the intent of the general assembly to create an independent board to promote the general good of the state by:
> 1. improving the health of the population;
> 2. reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;
> 3. enhancing the patient and health care professional experience of care;
> 4. recruiting and retaining high-quality health care professionals; and
> 5. achieving administrative simplification in health care financing and delivery.[88]

The five-member, governor-appointed Board acts as decision-maker in Vermont's health care reform scheme and is responsible for payment reform program implementation.[89] The Board is also a public board, discussing policy and making decisions in weekly public hearings.[90] The Board's major responsibilities involve a

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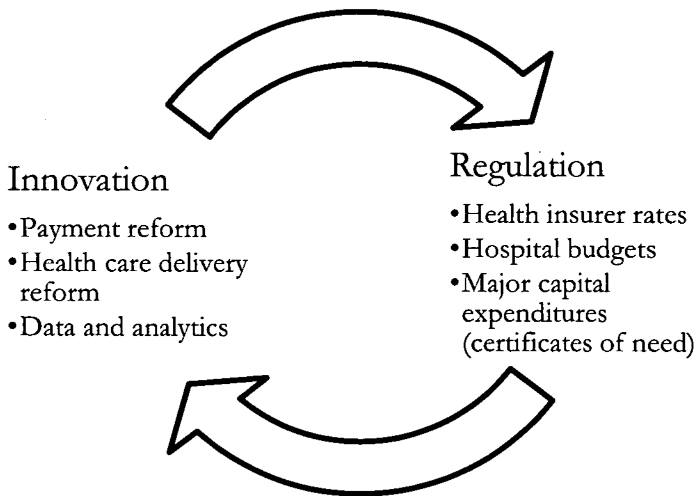
[83] GREEN MOUNTAIN CARE BD., *supra* note 15, at 1.
[84] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 247 (codified at VT. STAT. ANN. tit. 18, § 9374(a)(1) (2012)).
[85] *Id.* at 248 (codified at VT. STAT. ANN. tit. 18, § 9374(e)-(f) (2012)); Act No. 171 § 5, 2012 Vt. Acts & Resolves 753, 767-68 (codified at VT. STAT. ANN. tit. 18, § 9374(g)-(j) (2012)).
[86] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 248-50 *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, § 9375(b) – (e) (2012)).
[87] Act No. 48 § 3, 2011 Vt. Acts & Resolves at 244 (codified at VT. STAT. ANN. tit. 18, § 9371(3)).
[88] *Id.*, 2011 Vt. Acts & Resolves at 245 (codified at VT. STAT. ANN. tit. 18, § 9372).
[89] *Id.*, 2011 Vt. Acts & Resolves at 247 (codified at VT. STAT. ANN. tit. 18, § 9374(a)(1)-(b)(4)); Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 248-50, *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, § 9375 (2012)).
[90] *See* Act No. 48 § 3, 2011 Vt. Acts & Resolves 247, 252 (codified at VT. STAT. ANN. tit. 18, § 9378 (2012)) (characterizing input solicitation as a public process); *Board Meetings*, GMCBOARD.VERMONT.GOV, http://gmcboard.vermont.gov/meetings (last visited Apr. 10, 2013) (providing information about weekly Board meetings). "The Green Mountain Care Board

constant cycle of innovation and regulation informing each other,[91] as discussed below in more detail.

Figure 2: Green Mountain Care Board's Regulatory and Innovation Cycle



The Board's powers and duties,[92] include:

- Health care payment and delivery system reform through development, implementation, and evaluation of payment and delivery models;[93]

encourages Vermonters to comment on health system reform." *Public Comment*, GMCBOARD.VERMONT.GOV, http://gmcboard.vermont.gov/publiccomments (last visited Mar. 29, 2013).

[91] *See* Act No. 48 § 3, 2011 Vt. Acts & Resolves at 245 (codified at VT. STAT. ANN. tit. 18, § 9372) (stating purposes for which general assembly created independent board).

[92] *See* Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 248-50, *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, § 9375 (2012)) (outlining Green Mountain Care Board's duties); *see also* Act No. 48 § 3, 2011 Vt. Acts & Resolves at 244 (codified at VT. STAT. ANN. tit. 18, § 9371) (delineating principles for health care reform).

[93] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 248-49 *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(1) (2012)). The Board must develop, implement and evaluate the effectiveness of "health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont." *Id.*

- Approval, modification, and disapproval of health insurance rates;[94]

- Annual approval of hospital budgets;[95]

- Approval, conditional approval, and disapproval of major health care capital expenditures based on certificates of need;[96]

- Approval of the state's Exchange benefit package(s) for qualified health benefit plans in compliance with PPACA;[97]

- Development of the Vermont health system "Dashboard" to assess the system's quality and performance under standardized criteria;[98]

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[94] *Id.* (codified at VT. STAT. ANN. tit. 18, § 9375(b)(6)). The Board must

> [a]pprove, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board.

Id.

[95] *Id.* (codified at VT. STAT. ANN. tit. 18, § 9375(b)(7); *see also* VT. STAT. ANN. tit. 18, § 9456 (outlining hospital budget review process). The Board must "[r]eview and establish hospital budgets" annually. *Id.*

[96] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 249 *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(8)); *see also* VT. STAT. ANN. tit. 18, § 9434 (listing general certificate of need requirements). Beginning in January 2013, the Board is required to "[r]eview and approve, approve with conditions, or deny applications for certificates of need." VT. STAT. ANN. tit. 18, § 9375(b)(8).

[97] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 249-50 *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, §§ 9375(b)(9), (c) (2012)); Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1311(b)(1), 124 Stat. 119, 173 (to be codified at 42 U.S.C. § 18031(b)(1)) (requiring each state to establish a health insurance exchange). The Board is required to "review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans" to be offered in Vermont's Health Benefit Exchange in accordance with PPACA. VT. STAT. ANN. tit. 18, §§ 9375(b)(9), (c).

[98] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 249 *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(10) (2012)). The Board must "[d]evelop and maintain a method for evaluating" the Vermont health system's "performance and quality." *Id.*; *see also GMCB's Vermont Health Dashboard of Key Indicators*, GREEN MOUNTAIN CARE BD., http://www.gmcboard.vermont.gov/dashboardproject (last visited Apr. 13, 2013).

- Development of a unified health care budget;[99]

- Approval of the state's health information technology plan to ensure infrastructure keeps pace with the state's health care reform goals;[100]

- State health care workforce policy approval and strategic plan development;[101]

- Health planning through review of the state's "health resource allocation plan;"[102] and

- Health care provider rate-setting.[103]

In addition, the Board has some specific duties related to the development of Green Mountain Care, a program of publicly-financed universal coverage under development for Vermont.[104] These duties include:

- "[C]onsidering recommendations from the agency of human services, and defin[ing] the Green Mountain Care benefit package . . . ."[105]

- "[R]ecommending to the general assembly and the governor a three-year Green Mountain Care budget . . . to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended

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[99] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 249 *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves 753, 776 (codified at § 9375(b)(11)) (designating budget review duty to Board); Act No. 171 § 11, 2012 Vt. Acts & Resolves 753, 770-71 (codified at VT. STAT. ANN. tit. 18, § 9375a) (providing requirements for annual unified health care budget review process). The Board is expected to guide allocation and growth of health care spending through the unified health care budget. *See* VT. STAT. ANN. tit. 18, § 9375a.
[100] Act No. 48 §3, 2011 Vt. Acts & Resolves 239, 250 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(2)). The Board is required to "[r]eview and approve Vermont's statewide health information technology plan . . . to ensure that the necessary infrastructure is in place to enable the state to achieve" its health reform goals. *Id.*
[101] *Id.* at 249 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(3)).
[102] *Id.* (codified at VT. STAT. ANN. tit. 18, § 9375(b)(4)).
[103] Act No. 48 §3, 2011 Vt. Acts & Resolves 239, 250 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(5)). The Board must "[s]et rates for health care professionals . . . to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed." *Id.*
[104] *Id.* (codified at VT. STAT. ANN. tit. 18, § 9375(c)).
[105] *Id.* (codified at VT. STAT. ANN. tit. 18, § 9375(c)(1)).

> appropriations, revenue estimates, and necessary modifications to tax rates and other assessments."[106]

One of the Board's most important activities is to develop and implement payment and delivery system reforms.[107] Act 48 explicitly states that health care reform should contain health care costs through the implementation of these payment and delivery system reforms.[108] Vermont is doing this by shifting payments away from fee-for-service and towards alternative payment reimbursement methodologies.[109] This transition is a work in progress and includes the following activities: 1) designing and implementing payment reform pilots;[110] 2) developing a better financial forecasting model;[111] 3) developing better analytic capabilities;[112] 4) identifying the appropriate rate of cost growth;[113] and 5) involving all payers in the reforms.[114] Figure 3 below

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[106] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 250 (codified at VT. STAT. ANN. tit. 18, § 9375(c)(3) (2012)).

[107] Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 251-52 *amended by* Act No. 171 § 27, 2012 Vt. Acts & Resolves 753, 795-96 (codified at VT. STAT. ANN. tit. 18, § 9377 (2012)).

[108] Act No. 48 § 3 2011 Vt. Acts & Resolves 239, 251 (codified at VT. STAT. ANN. tit. 18, § 9377(a) (2012)); *see also id.* at 244-45 (codified at VT. STAT. ANN. tit. 18, § 9371) (identifying principles of health care reform); *id.* at 246-47 (codified at VT. STAT. ANN. tit. 18, § 9373(12) (defining "payment reform").

[109] *See* GREEN MOUNTAIN BD., *supra* note 15, at 8-9.

> "Payment reform" means modifying the method of payment from a fee-for-service basis to one or more alternative methods for compensating health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, integrated delivery systems, and other health care professional arrangements, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies for the provision of high-quality and efficient health services, products, and supplies while measuring quality and efficiency. The term may include shared savings agreements, bundled payments, episode-based payments, and global payments.

Act No. 48 § 3, 2011 Vt. Acts & Resolves 239, 246-47 (codified at VT. STAT. ANN. tit. 18, § 9373(12) (2012)); *see also id.* at 251-52, *amended by* Act No. 171 § 27, 2012 Vt. Acts & Resolves 753, 795-96 (codified at VT. STAT. ANN. tit. 18, § 9377 (2012)) (detailing payment reform).

[110] Act No. 48 § 3, 2011 Vt. Acts & Resolves at 251-52, *amended by* Act No. 171 § 27, 2012 Vt. Acts & Resolves at 795-96 (codified at VT. STAT. ANN. tit. 18, § 9377).

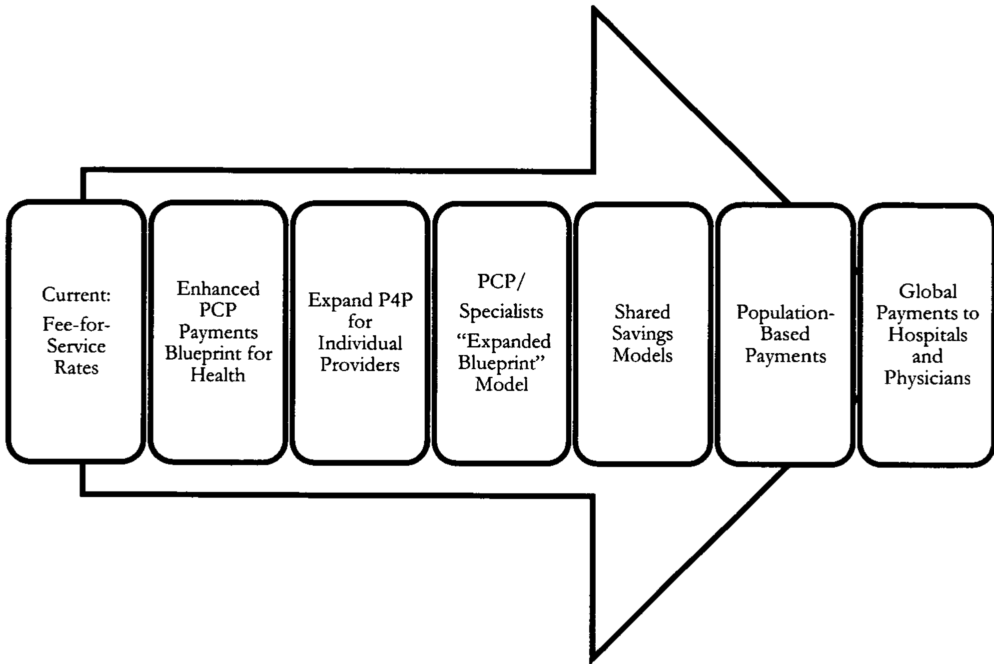
[111] Act No. 48 § 3, 2011 Vt. Acts & Resolves at 248 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(1)(A)).

[112] *Id.*, *amended by* Act No. 171 § 12, 2012 Vt. Acts & Resolves at 776 (codified at VT. STAT. ANN. tit. 18, § 9375(b)(1)).

[113] *Id.* (codified at VT. STAT. ANN. tit. 18, § 9375(b)(1), (10)(D)).

demonstrates the progression from the current reimbursement structure to one that is more accountable and value-based.

Figure 3: Reimbursement Progression



Vermont is testing three alternative payment models – the last three in the progression depicted above in Figure 3,[115] and it has developed a robust pilot application process for providers engaged in these new models.[116] The testing process includes an evaluation of financial implications, specifically, whether the model will save money.[117]

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[114] *See* Act No. 48 § 3, 2011 Vt. Acts & Resolves at 251-52, *amended by* Act No. 171 § 27, 2012 Vt. Acts & Resolves at 795-96 (codified at VT. STAT. ANN. tit. 18, § 9377) (detailing payment reform); *see also* Act No. 48 § 3, 2011 Vt. Acts & Resolves at 244-45 (codified at VT. STAT. ANN. tit. 18, §§ 9371-72) (providing health care reform principles and purposes).

[115] *Payment Reform*, GREEN MOUNTAIN CARE BD., http://gmcboard.vermont.gov/PaymentReform (last visited Apr. 13, 2013); *Model Testing Application: Project Narrative*, GREEN MOUNTAIN CARE BD., http://www.gmcboard.vermont.gov/sites/gmcboard/files/Project%20Narrative.pdf (last visited Apr. 10, 2013).

[116] *See Payment Reform Pilot Application*, GREEN MOUNTAIN CARE BD., http://gmcboard.vermont.gov/sites/gmcboard/files/PR_Application.pdf (last visited Apr. 10, 2013).

[117] *Model Testing Application: Project Narrative*, *supra* note 115, at 1-6.

The testing process also evaluates patient access to care and patient satisfaction.[118] The Board will evaluate all models to determine if the cost is moderated and if the quality of care being delivered improves.[119]

As noted, the alternative payment models being tested include a Shared Savings Model, a Population-Based Payments Model, and a Global Payment Model for Hospitals and Physicians.[120] The Shared Savings Model provides bundled, or lump-sum, payments to a group of providers for a patient's surgical procedure or treatment for a specific medical condition.[121] The Population-Based Payments Model provides global payments to fully integrated health care systems consisting of facilities, physicians, and other

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[118] *Id.* at 33.

[119] *Id.* at 35. The three models to be tested each have four aims:

> I. Increase both organizational coordination and financial alignment between Blueprint advanced primary care practices and specialty care, including mental health and substance abuse services, long term services and supports, and care for Vermonters living with chronic conditions;
>
> II. Implement and evaluate the impact of value-based payment methodologies that encourage delivery system changes, improvements in care coordination and quality, and better management of costs;
>
> III. Coordinate a financing and delivery model for enhanced care management and new service options for Vermonters dually-eligible for Medicare and Medicaid with additional Medicare shared savings models, a Medicaid shared savings model and other models of population-based payment being tested in Vermont; and,
>
> IV. Accelerate development of a Learning Health System infrastructure, including: a reliable repository for clinical and claims data populated by a statewide digital infrastructure; statewide assessments of patient experience and team based services; ready access to comparative reporting and modeling; teams of skilled facilitators to support transformation; and an array of activities to support ongoing improvement. This infrastructure will be designed to meet the needs of providers engaged in delivery system reform and the state's needs for ongoing evaluation of the impact of reforms on health care quality, costs, patient experience and population health.

Id. at 5-6; *see also* GREEN MOUNTAIN CARE BD., VERMONT'S HEALTH CARE INNOVATION PLAN 27-34 (2012), *available at* http://gmcboard.vermont.gov/sites/gmcboard/files/B%20Vermont_Health_Care_Innovation_Plan%20FINAL.pdf (detailing four aims and each model to be tested).

[120] *Payment Reform*, *supra* note 115.

[121] *Id.*

providers that are designed to meet the diverse health care needs of a designated population.[122] Finally, the Global Payment Model for Hospitals and Physicians provides the participating hospital with a total budget payment, including payment for the hospital's physician employees.[123] These models all seek to promote coordinated care and infrastructure improvements, while evaluating value-based payment methodologies to determine cost-effectiveness.[124]

As of March 2013, the Board approved two payment reform pilots and is working with ACOs, hospitals, FQHCs, and physicians to test the models.[125] The Board anticipates that the majority of providers in the state will each be participating in at least one model over the next three years.[126]

VI. Next Steps

Vermont's timeline is aggressive and requires active participation by several state agencies and health care stakeholders.[127] It also presents an unprecedented level of transparency and engagement of all parties affected under health care reform.[128] The Board and the Administration will continue working together to implement short-term policies and to articulate a long-term vision and strategies to succeed in health care reform.

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[122] *Id.*
[123] *Id.*
[124] *See supra* note 119.
[125] *See Model Testing Application: Project Narrative*, *supra* note 115, at 4; GREEN MOUNTAIN CARE BD., *supra* note 119, at 27.
[126] *Model Testing Application: Project Narrative*, *supra* note 115, at 37.
[127] *See id.* at 3; GREEN MOUNTAIN CARE BD., *supra* note 119, at 34.
[128] *See* GREEN MOUNTAIN CARE BD., *supra* note 119, at 15-24 (providing historical overview of health care reform efforts in Vermont).