

Vermont Health Care Reform Aims for More Coverage, Less Expense, and Better Care

For 2 decades, political leaders in Vermont attempted to pass comprehensive health care reform before Governor Jim Douglas (R) finally signed legislation presented by the Democratic-controlled legislature on 25 May 2006. The Health Care Affordability Act (Act 191) integrated the aim of universal access to health insurance with other initiatives centered on comprehensive coordinated care (especially for people with chronic diseases) and payment reform. "I think that it is the most innovative and important reform that any state has ever passed," said Kenneth E. Thorpe, PhD, professor of health policy and management at Emory University.

Thorpe, who worked as a health care consultant for the Vermont legislature and helped design the reform effort, said that for years, legislators were focused on solving the problem of uninsured residents. He encouraged them also to focus on making coverage more affordable and of better quality for those who already had insurance. Thorpe pointed out that patients with chronic diseases were the key driver of health care spending, consuming about 70% of the \$3.3 billion spent each year. "This really focused the attention onto re-designing the system and promoting prevention, issues that are nonpartisan," he said.

Still, coming to an agreement on this novel reform was not easy, and not everyone is happy with the result. Many people in the state still strive for more sweeping reform. Gov. Douglas, who earlier vetoed a single-payer plan, has talked about the difficult compromises that were needed before he reached agreement with the legislature. He has also spoken about the need to balance health reform goals with other priorities, such as economic development and education (1).

In 2007, the legislature supplemented Act 191 with follow-up legislation (Acts 70, 71) that enacted chronic disease care pilots, benchmarks, and an electronic medical record pilot. On 1 October 2007, the newly formed Catamount Health, a health insurance plan for uninsured Vermonters, started enrolling eligible residents for coverage.

By the end of February 2008, about 2800 people had signed up for coverage through Catamount Health. Most had qualified for coverage at subsidized rates because their family incomes were below 300% of the federal poverty level (\$30 630 as an individual or \$61 950 as a family of 4). Although enrollment numbers are low, due in part to the time it takes to complete the enrollment process, they are steadily increasing and are expected to rise to at least 8800 by the end of the 2008 fiscal year. In addition, the state is implementing a premium assistance program for uninsured Vermonters who have access to, but cannot afford, employer-sponsored insurance. The state is also aggressively marketing the premium assistance plan to the estimated 50% of uninsured Vermonters who are eligible for the existing Medicaid programs but are not enrolled. Together, these efforts are expected to insure about 20 000 by 2010, a meaningful proportion of the state's 65 000 uninsured population.

With an eye on affordability, the state designed Catamount Health so that those covered by it would have limited out-of-pocket costs beyond the premium. Enrollees pay premiums that vary according to income level, and the state has mandated that the maximum individual in-network deductible be no more than \$250 (see the **Appendix**, available at www.annals.org). Coverage is comprehensive, inclusive of physician, inpatient, outpatient, emergency department,

ambulance, mental health, substance abuse, and maternity care, as well as medical equipment, supplies, and prescription drugs.

For now, participation in the new coverage program is voluntary for individuals who are uninsured, unlike Massachusetts, which requires uninsured residents to enroll. If fewer than 96% of all state residents have coverage by 2010, however, the state legislature will decide whether to implement a coverage mandate.

Total spending is estimated to be \$59.1 million in 2010, which would be used primarily to support the new Catamount Health and employer-sponsored insurance premium assistance programs, along with their associated administrative costs. Over 47% of the revenue for Catamount Health comes from tobacco tax increases, about 7% from the global commitment Medicaid waiver, 6% from redirected state revenues, and almost 40% from an employer assessment. Employers with 9 or more employees (dropping to 5 or more over the next few years) are now required to help finance coverage for their workers and are charged \$365 per full-time equivalent, uninsured employee who was not offered—or who did not take the offer of—health care coverage. The assessment is scheduled to increase annually by an amount indexed on the Catamount Health rate of premium cost increase.

Notably, 10% of the Catamount Health budget is being allocated to accomplish the initiatives on improved care delivery, including Vermont Blueprint for Health and a statewide immunization program. Vermont launched Blueprint in 2003 to promote healthy behaviors and shape a statewide system of care for people with chronic conditions. Blueprint was initially poorly funded and was slow to get started, but the program has since received a growing

portion of general funds from the Vermont Legislature; the budget has increased from \$145 000 in 2004 to \$1.2 million in 2005, \$5.2 million in 2006, and \$4.8 million in 2007. Blueprint has gained momentum as the other aspects of health reform have taken shape, in effect becoming the heart of the state's effort. "All of the coverage initiatives are linked with the Blueprint principles in terms of changing the way that we deliver health care," said Susan Besio, PhD, director of Vermont health care reform implementation.

A comprehensive health care reform effort is more likely to succeed in Vermont for many reasons. First, the population is small at 623 000, and the uninsured population is relatively also small at approximately 10%. The population is racially and economically homogeneous and is one of the healthiest in the country. Second, statewide frameworks and a real tradition of collaboration are already in place. Third, Vermont has only 13 hospital service areas, and all of the hospitals are owned by one of 2 essentially noncompeting, nonprofit health systems: Dartmouth–Hitchcock Alliance and Fletcher Allen. Vermont has just 3 major health plans—Blue Cross-Blue Shield, MVP Health Care, and Cigna. "Vermont offers a unique opportunity to test out real innovations for health care delivery and payment. We're probably one of the few states that could actually implement such programs on a statewide basis and lay the groundwork for reform which could be reproducible in other places," said James A. Hester, PhD, director of the Health Care Reform Commission for the Vermont Legislature.

For Vermont's health care reform to become sustainable, however, it must succeed in blunting the state's sharp trend upward in health care spending. For instance, health care expenditures grew an average of 10.8% annually from 1998 to 2002, and the trend upward has continued. An economic recession might lead to

shrinking available health care dollars, as well as a growing number of unemployed people who would need subsidized insurance, which would strain Catamount's budget. "This reform is on track. The technology is there, as are the models for restructuring the payment system and the delivery system. The only reason why it won't work is if they don't fund it adequately," Thorpe said.

KEY COMPONENTS OF REFORM

Long-Term Care

Now that Catamount Health is in place, Besio and her colleagues at Blueprint carry the responsibility of achieving the other changes necessary for the state to meet its health and budgetary goals. They are focusing on improving long-term care because so much of the state's health care dollars are spent on managing patients with chronic conditions. Data show that care for people with chronic conditions accounts for 78% of health care spending, 76% of hospital admissions, 72% of all physician visits, and 88% of all prescriptions filled.

Improving long-term care should lead to fewer complications for patients with chronic conditions and, as a result, fewer health care dollars spent. For guidance, the state has turned to the well-regarded chronic care model, developed by Edward H. Wagner, MD, MPH, director of the Institute for Healthcare Innovation at Group Health Cooperative of Puget Sound in Seattle. This model delineates 6 health care delivery system features that improve chronic disease management (2): decision making guided by the best clinical evidence; delivery system design that emphasizes the practice of planned, team-based care and follow-up; health care organization that provides the motivation, incentives, and resources to improve long-term care; clinical information systems that track individual patients and specific populations of patients; community linkages that provide patients with

access to valued services and resources; and self-management guidance that encourages and supports patient responsibility for their own health.

Changing long-practiced health care delivery patterns is not easy. "The chronic care model is a major undertaking, requiring practices to redesign how they deliver medical care. But mounting evidence indicates that this model hits the critical elements that are associated with improved care," said Wagner. According to research from RAND, interventions that contain at least 1 element of the chronic care model improve clinical outcomes and processes, and, to a lesser extent, quality of life.

To further the benefits of the chronic care model, Blueprint has added an emphasis on prevention and public health by collaborating with public health and disease prevention programs in diabetes, tobacco control, asthma, arthritis, cancer, injury prevention, and women's health. It is looking to obesity prevention, in particular, as a way to reduce growth in health care spending in the future.

Health education programs are already fostering improvements in long-term care. Primary care providers throughout the state have been attending workshops based on the clinical microsystems approach, which is based on the idea of small, interdependent groups working together regularly to improve care for specific groups of patients. According to Lisa Dulsky Watkins, MD, assistant director of Blueprint for Health, these workshops have helped doctors in small or solo practices to connect with peers in their community, especially in rural areas.

Meanwhile, members of the community have been attending healthy living workshops that provide 15 hours of instruction over 6 weeks on ways to reduce risk for chronic diseases and improve overall fitness and well-being. So far, about 500 Vermonters have attended the workshops, and evaluation indicates

that their attendance resulted in fewer acute visits to doctors and the emergency department during the following year.

Implementation of the chronic care model in Vermont is not happening all at once. Blueprint started with 2 pilot hospital service areas in 2005 and added 4 more in 2006 so that it now covers about half of the hospital service areas in the state. Currently, these pilots are centered individually on local hospitals and focused specifically on the delivery of long-term care for diabetes. Blueprint has a new legislative mandate to expand the program by developing 2 to 4 more pilots in the next 18 months that use the medical home concept and care coordination teams along with the other Blueprint elements to focus on prevention and intervention for all chronic conditions. The overall goal is to have the program implemented statewide by 2012.

Payment Changes

Practices are more likely to go to the trouble of redesigning themselves to fulfill the chronic care model if the financial incentives change, according to Wagner. Vermont is changing the financial incentives to better align payment with health care goals.

The state aims for payment reform that supports care coordination and chronic disease management. "Many of the deficiencies in U.S. health care are reflections of the disjointed and poorly coordinated care that patients receive as they move across settings and among providers. This kind of care results in more frequent and flawed care transitions, failures of communication, and errors," said Elliot S. Fisher, MD, MPH, professor of medicine and community and family medicine at Dartmouth Medical School.

Vermont is exploring use of the accountable care organization (ACO) model developed by Fisher and colleagues, which depends on one key observation: Most patients receive care within the context of a local delivery system that comprises physi-

cians and the hospital where they work. The hospital and its extended medical staff provide a natural organizational setting within which to improve the overall experience of care (3). The focus of care would shift from individual providers to a local hospital and the physicians who work within and around it.

The ACO model would allow the payers and providers in a region to develop a prospective budget for all services, which they would then be allotted. "It is important to provide physicians and hospitals a budget that will allow them to be confident that they will meet revenue needs, so that they can more clearly work in ways that allow them to consider the needs of the population they serve rather than how do they simply meet their bottom line," Fisher said. Any savings within the allotted budget would be shared, allowing for additional incomes that could be used, among other ways, to bolster physician incomes, reinforce primary care, increase hospital revenue, and protect profit margins, according to Fisher. He noted a 2006 Institute of Medicine report that called for more shared accountability among providers to improve health care. This kind of medicine emphasizes primary care and the medical home, as well as the reduced use of procedures, hospitalizations, and nursing home stays that are not clearly indicated (4).

Vermont is already organized by individual hospitals that serve as the hub for local physician practices, and hospital loyalties run strong. The geography of Vermont promotes regional self-sufficiency: Lots of hills and valleys tend to confine people to their own region. The ACO model provides a way to build on that organization and Vermont's resources. Now, pilot projects are in the works to test out the medical home model—based on a coordinated, primary care-directed, team approach to health care—through the Blueprint program. Later, the ACO model would extend this plan to a much broader scope.

Health Care Technology

Vermont also plans to extend health information technology initiatives broadly. As of July 2007, the state has a Health Information Technology Plan that was developed and is now being implemented by Vermont Information Technology Leaders (VITL), a nonprofit, public-private partnership. The partnership has already launched the 2-hospital pilot phase of the Electronic Medication History Service, which, with patient consent, provides doctors and nurses with an on-demand electronic record of all of a patient's medications that insurers have paid for in the past year. This information helps avoid medication interactions and unnecessary changes in medications and, in turn, helps increase patient safety. "It's so much better than the lists that patients come in with, if they come in with one at all. It also helps because it provides a quick longitudinal picture of any medication changes or past treatment for various conditions," said Harry L. Chen, MD, a Democratic representative for the Vermont Legislature and emergency medicine physician who helped design the program. The program can retrieve data on about 75% of patients visiting the emergency department, regardless of whether they previously visited the hospital, because payers have allowed access to pharmacy claims data.

Blueprint is also implementing a long-term tracking information system to monitor doctor visits, laboratory test results, and hospitalizations among people with chronic conditions and make this information available in a centralized, organized, and up-to-date health record. It is currently in a pilot phase for diabetes and hypertension at a single hospital. Blueprint plans to use this new tool within the next 12 to 18 months for new integrated medical home pilot projects, which will include a list of all chronic diseases. Eventually, Blueprint hopes to make the tool available to other providers throughout the state.

Another VITL effort, the Electronic Health Record Pilot Project, helps primary care physicians purchase electronic health records systems. It is funded by a range of stakeholders, including private health insurance providers. Five Vermont primary care practices were recently awarded grants under the pilot project to help pay for the purchase and implementation of an electronic health record system. The effort is scheduled to expand to more practices.

GAINING MOMENTUM

With its broad scope, Vermont health care reform effort has taken longer to gain momentum than many physicians and policymakers in the state expected. But with various pilot projects and educational efforts now under way through Blueprint and with Catamount slowly but steadily growing in enrollment, people are starting to appreciate that the state's health care is undergoing systemwide changes. Should the state succeed in its many endeavors, it will transform from its current fragmented, individually provided, fee-for-service health care system to a more collaborative, community-oriented system. "The emphasis on coordination of care, chronic care, and information technology differentiates us from all other health reform efforts. We are at the cutting edge of U.S. health care," said Hester, the director of the Health Care Reform Commission for the state.

Many other states are not far behind. Maine, Pennsylvania, Wisconsin, and Maryland, among others, are also working on comprehensive health care reform, and they are watching Vermont to see how new health care models can be applied statewide, according to Thorpe. "The health care reform debate has, until

recently, been narrowly defined as a financing discussion for the uninsured. But there's growing recognition that broader reform—that looks at where we spend our money and what accounts for the growth in spending and that also targets interventions much more appropriately—is what is really needed," Thorpe said.

Meanwhile, financing remains both an important and controversial aspect of the reform. Catamount health plans will enroll only people who have been without health care for at least 1 year, although there are exceptions to this waiting period, and preexisting conditions, including pregnancy, are not covered. These provisions are unpopular but necessary. "We can't afford to drop them. Sustainability is a huge issue," Besio said. In passing the Health Care Affordability Act, one of the governor's key concerns was to make sure that the reform did not lead to any increases in the state's tax burden. The state increased the tobacco tax and required the employer's contribution system only because they are directed specifically at bringing down the state's health care costs through discouraging unhealthy behavior (tobacco taxes) and sharing the burden of the cost-shift due to the uninsured (employer contribution).

However, a vocal group of doctors has pushed Catamount Health to drop the provisions that require enrollees to be uninsured for a full year and those that block coverage of preexisting conditions. Some have supported the Vermont Hospital Security Bill (H304) that would publicly fund hospital care or the continuing effort to expand health care reform to a single-payer system. "The problem is that we still don't have a health care system that makes sure everyone has adequate coverage for

their needs," said Deborah Richter, MD, a family practitioner in Cambridge, Vermont, and active member of Health Care for All, an organization that supports single-payer, universal health care.

The effort to publicly fund hospital care is not likely to become a reality this year in Vermont, but it is noteworthy because it highlights just how seriously many Vermonters take this issue, and it provides yet another reason why this might be the best state to test innovative health care reforms. Residents, as well policymakers and politicians, are truly engaged in improving health care. This effort has already resulted in laws that increase the availability of coverage for the uninsured and change health care delivery in ways more revolutionary than those of any other state. "We're excited about the future ahead," Besio said. "Now we're hoping to get everyone in the state excited and on board about moving forward with this reform."

—Jennifer Fisher Wilson

Science Reporter, *Annals of Internal Medicine*

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None disclosed.

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APPENDIX

Green Mountain Care

Health care coverage for uninsured Vermont residents is inclusive of Dr. Dynosaur (for people age <18 years); traditional Medicaid (for those with income <100% federal poverty level [FPL] plus other criteria); Vermont Health Access Plan (VHAP), an insurance program for adults and covers a wide range of services including hospital care and doctor visits (income up to 150% to 185% FPL); and Catamount Health (income >185% FPL). Within VHAP and Catamount, there are levels for premium assistance.

Catamount premiums depend on individual or household income. The monthly premium costs in 2007 for individual coverage with premium assistance by FPL were (costs for 2-person coverage are double these amounts):

Below 200% (\$20 420): \$60
 200–225% (\$20 421–22 973): \$90
 225–250% (\$22 974–25 525): \$110
 250–275% (\$25 526–28 077): \$125
 275–300% (\$28 078–30 630): \$135

Full-cost monthly premiums for individuals and households >300% FPL:

Single (>\$30 630): \$393
 2-Person (>\$41 070): \$786
 Family (>\$61 950): \$1100

Catamount Health Eligibility

Catamount Health is available to uninsured Vermont residents who are at least 18 years old and are ineligible for an employer-

sponsored insurance (ESI) plan*. People who meet the definition of “uninsured”:

- Have not had private insurance for the past 12 months
- Had VHAP or Medicaid but became ineligible for those programs
- Had private insurance but lost it because he or she lost a job; got divorced; had insurance through someone else who died; is no longer dependent on a parent’s insurance; graduated, took a leave of absence, or finished college or university and got insurance through school; or no longer had COBRA coverage.

*People can purchase Catamount Health even if they are eligible for an ESI plan if their income is less than 300% FPL and:

Their ESI plan is not approved by the state as comprehensive and affordable (with state assistance).

or

It is more cost-effective for the state to provide premium assistance for them to enroll in a Catamount Health plan than providing premium assistance for them to enroll in their ESI.

or

It is more cost-effective for the state to provide premium assistance for them to enroll in their ESI than providing premium assistance for them to enroll in Catamount Health, but they must wait until the next open enrollment period for their ESI (at which point they must switch to their ESI to receive premium assistance).

Source: Susan Besio, PhD, director of Vermont health care reform implementation.