VERMONT

WRITTEN TESTIMONY

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On Behalf of

THE STATE OF VERMONT

For the

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on

"Learning from the States: Individual State Experiences with Health Care Reform Coverage Initiatives in the Context of National Reform"

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INTRODUCTION

My name is Susan Besio. I am the Director of Health Care Reform for the state of Vermont, and also was recently appointed Director of the state's Medicaid Program. With me today is Dr. Harry Chen, who is a practicing emergency room physician and board member of Vermont Program for Quality in Health Care, and former Vice-Chair of the Vermont Legislative Committee on Health Care. We would like to thank Senator Kennedy, Senator Enzi, Senator Bingaman, Senator Sanders, and the rest of the members of the Committee for giving us the opportunity to speak today about our state's experiences with health care reform related to coverage and how they can inform national reform efforts.

VERMONT HEALTH CARE REFORM CONTEXT

Per capita health care costs are lower in Vermont when compared to the U.S., but the spending gap has been narrowing since 1999. Health care spending growth rates in Vermont have exceeded national averages for each of the last four years, and health care costs were 17.1% of Vermont's gross state product in 2007. We cannot afford our current health care system.

Universal health care coverage is a key mechanism to help bring down the costs of health care. Covering the uninsured will help lower uncompensated care costs, which affect premiums paid by the insured. In addition, people who do not have *affordable, comprehensive* coverage do not access preventive or primary care, and instead use costly emergency room services; they also develop more significant illnesses which require more costly services. For example, data from the Vermont 2005 Family Health Insurance Survey [1] showed that 45% of uninsured children did not see a physician for routine care (compared to 7% of insured children); this has significant implications for both short-term and long-term wellness, and health care expenditures.

In 2005, before our reforms began, Vermont had an uninsured rate of 9.8% (61,056) compared with a national rate of 15.7%, and an uninsured rate for children of 4.9%.[1] This relatively low uninsured rate is partially due to Vermont use of its Medicaid 1115 waiver authority to expand coverage for the uninsured. The Dr. Dynasaur program provides Medicaid coverage to all children with household incomes under 300% FPL, to pregnant women with household incomes under 200% FPL, and to parents and caretakers with household incomes under 185% FPL. The Vermont Health Access Plan (VHAP) provides coverage for uninsured adults with household income under 150% FPL and adults with children on Dr. Dynasaur who have income under 185%. Approximately 19% of Vermonters (125,000) have health insurance provided by the state through these programs.

Regarding private insurance, Vermont is one of a handful of states that requires guaranteed issue and community rating – reflecting the state's values of wanting to provide affordable, comprehensive health coverage regardless of age or health status (matters largely outside the individual's control). However, affordable coverage is becoming more difficult, especially in the individual market, where enrollment has decreased 44% from 2000 to 2007. And while Vermont employers appear to be maintaining coverage for their employees, the cost-sharing within the

[1] *Vermont Family Health Insurance Survey, 2005. The survey report can be found at http://www.bishca.state.vt.us/HcaDiv/Data_Reports/healthinsurmarket/2005_VHHIS_Final_080706.pdf*

plans is increasing each year, making it more difficult for Vermonters to get the care they need, when they need it.

VERMONT HEALTH CARE REFORM LEGISLATION

On May 25, 2006, Vermont Governor James Douglas signed into law Acts 190 and 191 (Acts Relating to Health Care Affordability for Vermonters). These Acts, augmented by portions of the State Fiscal Year 2007 Appropriations Act and Act 153 (Safe Staffing and Quality Patient Care), along with Acts 70 and 71 in 2007 and Acts 203 and 204 in 2008 provide the foundation for Vermont's Health Care Reform Plan.

Vermont's comprehensive package of health care reform legislation is based on the following reform design principles:

- It is the policy of the state of Vermont to ensure universal access to and coverage for essential health care services for all Vermonters.
- Health care coverage needs to be comprehensive and continuous.
- Vermont's health delivery system must model continuous improvement of health care quality and safety.
- The financing of health care in Vermont must be sufficient, equitable, fair, and sustainable.
- Built-in accountability for quality, cost, access, and participation must be the hallmark of Vermont's health care system.
- Vermonters must be engaged, to the best of their ability, to pursue healthy lifestyles, to focus on preventive care and wellness efforts, and to make informed use of all health care services throughout their lives.

Using these principles as a framework, Vermont's health care reform legislation contains over 50 separate initiatives designed to simultaneously achieve the following three goals:

- Increase access to affordable health insurance for all Vermonters
- Improve quality of care across the lifespan
- Contain health care costs

It is significant that Vermont's landmark 2006 Health Care Reform legislation was the product of extensive negotiation and collaboration by the Douglas Administration, legislative leaders of the Vermont General Assembly, and the private sector participants – including providers and payors - in Vermont's health care system. While there were multiple ideas and political agendas as part of the discussions, there is agreement that the final legislation was comprehensive in its breadth and significant in its potential impact on health care in Vermont. There also was a commitment to move forward with implementation in a collaborative, non-partisan manner to maximize its success, as evidenced by the subsequent, collaborative work embodied in additional legislation passed in 2007 and 2008 and under development in the current legislative session.

VERMONT COVERAGE REFORMS

These reforms are making a real difference. In contrast to many other states where the number of uninsured is increasing, Vermont's coverage reforms instituted in the past two years have

reduced the number of uninsured from 9.8% in 2005 to 7.6% in 2008, and the uninsured rate for children has fallen from 4.9% in 2005 to 2.9% in 2008.

Data from the 2005 Vermont Family Health Insurance Survey on the demographics of the uninsured in Vermont helped focus the design of our coverage reforms. According to the survey, fifty-one percent (51%) of the uninsured in Vermont were estimated to be eligible for a Medicaid program but not enrolled in the program; twenty-seven percent (27%) of the uninsured in Vermont had household income under 300% FPL but were not eligible for a Medicaid program; and twenty-two percent (22%) of the uninsured in Vermont had household income greater than 300% of FPL. Over three-quarters of Vermonters indicated that cost was the major reason for being uninsured.

In response, Vermont's coverage reforms:

- designed and implemented the new Catamount Health insurance plan,
- developed income sensitive premium assistance programs for Catamount Health and for employer-sponsored insurance,
- developed the new brand name "Green Mountain Care" to include the state's Medicaid and Medicaid expansion coverage programs, Catamount and the new premium assistance programs under a single umbrella, and
- implemented mechanisms to assist with comprehensive outreach to every uninsured Vermonter that is matched with application assistance, tracking, follow-up, and referral.

Mandated in statute, the new coverage initiatives were designed with very specific underlying values. These included ensuring *comprehensive* coverage and *affordable* coverage; (premiums and out-of-pocket); promoting preventive care and chronic care management; augmenting, not supplanting, employer-based coverage; and avoiding contributing to the cost shift via inadequate provider payments in any new coverage plans.

CATAMOUNT HEALTH PLAN: Act 191 of 2006 created a separate insurance pool in the individual market for the purpose of offering a lower cost comprehensive health insurance product for uninsured[2] Vermonters. The Catamount Health Plan is modeled after a preferred provider organization plan with a $250 in-network deductible and $800 out of pocket maximum for individual coverage. Cost sharing is prescribed in statute, and includes a waiver of all cost-sharing for chronic care management and services for subscribers who agree to participate in a defined chronic care management program offered through the carrier, and a zero deductible for prescription drug coverage. Lower premium costs as compared to equivalent benefit plans on the individual market were achieved due to estimates concerning the claims costs of the uninsured relative to the claims costs of the general population, and based on provider reimbursement rates established in the law that are lower than commercial rates (but 10% higher

[2] *Uninsured means: 1) you have insurance which only covers hospital care OR doctor's visits (but not both); 2) you have not had private insurance for the past 12 months; 3) you had private insurance but lost it because you lost your job or your hours were reduced; got divorced; have or are finishing COBRA coverage; had insurance through someone else who died; are no longer a dependent on your parent's insurance; or graduated, took a leave of absence, or finished college or university and got your insurance through school; 4) you had VHAP or Medicaid but became ineligible for those programs; (5) you have been enrolled for at least six months in an individual health insurance plan with an annual deductible of $10,000 or more for single coverage or $20,000 or more for two-person or family coverage; or (6) you lost health insurance as a result of domestic violence.*

than Medicare rates). Catamount Health policies began being offered by Blue Cross Blue Shield of Vermont and MVP Health Care on October 1, 2007. As of the end of March 2009, over 8,200 people have enrolled in Catamount Health Plans, and enrollment continues to increase by several hundred each month.

CATAMOUNT HEALTH PREMIUM ASSISTANCE PROGRAM: Of the 8,200 beneficiaries covered by Catamount Health Plans, 85% are receiving premium assistance, which is available to Vermont residents who have been uninsured for at least 12 months (with exceptions) and who are not eligible for a public insurance program such as Medicaid. Premium assistance is based on household income, and eligible individuals are able to purchase a Catamount Health policy at the following rates, with the remainder paid by the state:

Up to 200% FPL:	$60 per month
200-225% FPL:	$110 per month
225-250% FPL:	$135 per month
250-275% FPL:	$160 per month
275-300% FPL:	$185 per month
Over 300% FPL:	Full cost of the Catamount Health individual policy ($393 / month)

EMPLOYER SPONSORED INSURANCE (ESI) PREMIUM ASSISTANCE PROGRAMS: Vermont's health care reform is designed to support and build on our nation's current health care system that primarily relies on employer-based coverage. As such, the new Catamount Health Plan and the associated premium assistance programs were constructed to minimize "crowd-out" from employer coverage, and the funding of the reforms include an assessment on employers that do not offer insurance.

The ESI Premium Assistance Program also makes health coverage more affordable for uninsured Vermonters who have incomes under 300 percent FPL and have access to approved employer-sponsored coverage.[3] If cost-effective for the state, adults currently enrolled in the Medicaid VHAP program and new VHAP applicants who have access to an approved employer-sponsored insurance (ESI) plan are required to enroll in their employer-sponsored plan as a condition of continued coverage under VHAP. The premium assistance program provides a subsidy of premiums or cost-sharing amounts based on the household income of the eligible individual to ensure that the individual's out-of-pocket obligations for premiums and cost-sharing amounts are substantially equivalent to or less than the annual premium and cost-sharing obligations under VHAP (ranging from $7 to $49 per month). In addition, supplemental benefits or "wrap-around" coverage is offered to ensure VHAP-eligible enrollees continue to receive the full scope of benefits available under VHAP.

Catamount Health Premium assistance applicants who have access to an approved employer-sponsored insurance (ESI) plan are required to enroll in their employer-sponsored plan as a

[3] *ESI plans must be comprehensive and affordable. Affordable is defined as a maximum individual in-network deductible of $500. Comprehensive is defined as including coverage for physician care, inpatient care, outpatient, for prescription drugs, emergency room, ambulance, mental health, substance abuse, medical equipment/supplies, and maternity care. Employers do not have to contribute to the plan for it to qualify.*

condition of receiving premium assistance. Their cost sharing for their employer's plan is identical to those enrolled in the Catamount Health Premium Assistance program.

As of the end of March 2009, over 1,450 Vermonters were receiving premium assistance from the state to enroll in their employer's plan.

SEAMLESS TRANSITIONS: The statutes and state regulations governing the premium assistance programs and the already existing Medicaid-related programs are designed to create an integrated system of state assistance to better assure the continuity of health care to covered beneficiaries, so that individuals who fall out of one assistance category may transition into another when financial eligibility requirements are met.

COMPREHENSIVE, INTEGRATED MARKETING AND OUTREACH: The state has worked with the private carriers offering Catamount Health Plans and other Vermont stakeholders to develop a comprehensive marketing strategy across all the coverage and affordability initiatives. Through a contract with a national marketing firm, the state has implemented an aggressive outreach campaign, including television, radio, Internet, and print advertising; developed a new Green Mountain Care web-site with a high level screening tool; augmented an existing toll-free help-line to inform people about and assist them to enroll in Green Mountain Care programs; and conducted trainings around the state with over 2,500 participants. The state also works with the Department of Labor to conduct outreach to employers, including targeted efforts to companies following a layoff; has implemented targeted outreach to 18-34 year olds where they live, work and play; and has recently gotten sponsorship by a major bank to promote Green Mountain care.

PRIVATE INSURANCE MARKET REFORM: A viable non-group market (where premiums are perceived as affordable and where enrollment is stable for all demographic groups without access to employer-sponsored insurance) is an essential component of a well-functioning, all-lines health insurance market. Like many other states, the Vermont non-group market is characterized by declining enrollment, adverse selection, increasing prices, enrollment in high deductible plans, and limited carrier participation. Act 191 of 2006 directed BISHCA to establish a non-group market security trust to reduce premiums in the non-group market by a minimum of 5% to make non-group products more affordable for individual Vermonters. Unfortunately, limited state funds have resulted in a lack of progress to lower the costs for Vermonters enrolled in these products.

Act 191 of 2006 also directed the state to study the non-group market and make recommendations to the General Assembly to improve this option for Vermonters. While the state has contracted with a national expert to conduct studies and make recommendations for reforms to this market the complexity of this type of reform has prohibited significant changes.

HEALTHY LIFESTYLES INSURANCE DISCOUNTS: Vermont is a community-rated state, and therefore costs variations within a specific insurance product are not generally allowed for different populations. However, beginning in 2006, health care reform legislation has authorized the state to adopt regulations permitting health insurers to establish premium discounts (up to 15% of premiums) or other economic rewards for subscribers in Vermont's community rated non-group and small group markets, and to allow insurers in the small and large group markets

to offer split benefit design plans, which would allow a healthy lifestyle differential in cost sharing for the same premium cost. Any discounts offered through these programs must be offered in a non-discriminatory manner and may not be limited by health status. Individuals committing to improve health through healthier lifestyle choices must be offered the discount. It is hoped that these new options will provide an incentive for choosing healthier lifestyles, help make insurance more affordable for individuals and businesses, improve the health of Vermonters enrolled in these plans, and thereby affect the overall growth in our health care costs in the long run**.**

POSSIBLE INDIVIDUAL INSURANCE MANDATE: In 2006, Vermont made a conscious decision to not require an individual mandate such as the Massachusetts approach. However, Act 191 of 2006 does require that if less than 96% of Vermont's population is insured by 2010, the legislature must "determine the needed analysis and criteria for implementing a health insurance requirement by January 1, 2011 … including methods of enforcement, providing proof of insurance to individuals, and any other criteria necessary for the requirement to be effective in achieving universal health care coverage." Actuaries for the Vermont Department of Banking Insurance and Health Care Administration have opined that an individual mandate can be an effective way of addressing adverse selection and pre-existing condition coverage challenges. However, learning from Massachusetts, it is clear that an individual mandate requires significant state investments to make affordable coverage available so residents can meet the mandate. Given the current economic environment, an individual mandate does not seem fiscally feasible for Vermont in the near future.

FINANCING FOR VERMONT'S COVERAGE REFORMS

Funding for the programs within Vermont's Health Care Reform is based on the principle that everybody is covered and everybody pays.

***CATAMOUNT HEALTH FUND*:** Vermont's health care reform established a new fund in Fiscal Year 2007 primarily as a source of funding for the Catamount Health and ESI premium assistance programs. Sources of revenue include 17.5 % of the new cigarette taxes (see below), the Employers' Health Care Premium Contribution (see below), Catamount Health premium assistance amounts paid by individuals to the State, and other revenues established by the General Assembly.

***INCREASES IN TOBACCO PRODUCT TAXES*:** The health care reform legislation included a $.60 per pack increase in the cigarette tax beginning July 1, 2006 and an additional $.20 per pack increase beginning July 1, 2008; a new tax on "little cigars" and roll-your-own tobacco as cigarettes; and changed the method of taxing moist snuff to a per-ounce basis and increases tax on July 1, 2008 by 17 cents.

EMPLOYERS' HEALTH CARE CONTRIBUTION FUND: Act 191 of 2006 established an Employer Health Care Contribution Fund to contribute to the Catamount Fund.[4] Employers pay an assessment based on their number of "uncovered" employees, using the following guidelines:

[4] *More information can be found at: www.labor.vermont.gov/Default.aspx?tabid=1164*

- Employers without a plan that pays some part of the cost of heath insurance of its workers must pay the health care assessment on all their employees.
- Employers who offer health insurance coverage must pay the assessment on workers who are ineligible to participate in the health care plan (unless the plan is offered to all full-time employees, and the employee is a seasonal or part time worker with coverage elsewhere), and on workers who refuse the employer's health care coverage and do not have coverage from some other source.

The assessment is based on full-time equivalents at the rate of $91.25 per quarter ($365 per year), exempting eight FTEs in fiscal years 2007 and 2008, six FTEs in 2009, and four FTEs in and after 2010. The assessment rate increases annually indexed to Catamount Health Plan premium growth.

MEDICAID GLOBAL COMMITMENT TO HEALTH 1115 DEMONSTRATION WAIVER: In 2005, Vermont entered into a new five year comprehensive 1115 federal Medicaid demonstration waiver designed to: 1) provide the state with financial and programmatic flexibility to help Vermont maintain its broad public health care coverage and provide more effective services; 2) continue to lead the nation in exploring new ways to reduce the number of uninsured citizens; and 3) foster innovation in health care by focusing on health care outcomes. The Waiver program consolidates funding for all of the state's Medicaid programs, except for the new Choices for Care (long-term care) waiver and several small programs (SCHIP and DSH payments for hospitals). It also converts the state's Medicaid organization to a public Managed Care Organization (MCO). Under this new waiver, the MCO can invest in health services that typically would not be covered in our Medicaid program, and Vermont's Medicaid program has programmatic flexibility to implement creative programs and reimbursement mechanisms to help curb our health care costs.

In 2007, the state requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of this waiver. However, CMS only approved use of Medicaid funds up to 200% of FPL. The Governor and the Legislature agreed to use state General Fund to subsidize the premium assistance for individual within the 200% to 300% FPL range, recognizing that many of these individuals cannot afford to purchase full cost insurance on their own.

STATE FISCAL OBLIGATIONS PROTECTED: The health care reform legislation enables the state Emergency Board to establish caps on enrollment in the Premium Assistance Programs if sufficient funds are not available to sustain the programs. This has not been employed to date.

KEY LESSONS LEARNED AND HOW THEY INFORM NATIONAL COVERAGE REFORM

PLAN AFFORDABILITY: Access to affordable health care plans is key to universal coverage. This is very evident in Vermont's reforms, as only 15% of the people who have enrolled in the new Catamount Health Plans have bought the plans at full cost ($393 per month for an individual). The remaining have enrolled with premium assistance, and 75% of those are individuals below 200% FPL who only pay $60 per month.

Any national coverage option must be made affordable to people in all income ranges, without compromising the comprehensiveness of benefits and without further shifting costs of care to the private sector or providers. Vermont tried to achieve this in the Catamount Plans by requiring the providers be reimbursed at Medicare rates plus 10% rather then the estimated 130% currently paid by private insurers. This would not be an option for a national plan, as providers could not absorb such a massive shift in their payer mix. Therefore, options for a federally-offered plan must provide premium assistance based on income and have mechanisms such as a risk pool to cover the costs for the most high needs beneficiaries. These provisions will have significant costs that cannot be absorbed by the states.

COLLABORATION: Vermont's progress on health care reform has not come easily. Choosing a public-private partnership model for expanding coverage requires close collaboration amongst insurers, providers and government. Non-profit agencies have also contributed time and money to the effort to achieve universal access. At times, this degree of collaboration may seem duplicative, but is essential to success in the absence of an individual mandate.

FLEXIBILITY: Even in a small state like Vermont it is clear that one size doesn't fit all. What works well in Burlington with its academic medical center may be very different than what will work in a rural community in the Northeast Kingdom. Reform efforts must allow for such grassroots change, building on existing local successes. The dictum of *primum non nocere* applies to reform as well as it does to health care itself.

VERMONT ELEMENTS THAT ARE CRITICAL TO NATIONAL REFORM

BENEFIT DESIGN: As previously mentioned, Vermont's Catamount Health plans offer very comprehensive coverage and low out-of-pocket costs. Vermont believes that providing comprehensive, affordable coverage with an emphasis on primary and preventive care, is key to successful reforms of our health care system. Coverage with high deductibles, high cost-sharing and / or minimal coverage does not promote accessing early and preventive care, which in turn, will not achieve the long-term goal of decreasing our system's health care costs. Vermont also believes that ensuring community rating and guaranteed issue is paramount for ensuring that all eligible people can access the coverage they need at an affordable and fair price.

CROWD-OUT PROTECTIONS: Vermont's reforms included several mechanisms that were designed to support the existing employer-sponsored insurance system, through which 56% of Vermonters get their primary health care coverage. Catamount Health Plans and the premium assistance programs require that individuals must be uninsured for 12 months before becoming eligible (with exceptions due to life-changing events). In addition, Vermont provides premium assistance for people to enroll in their employer's plan (if it is affordable and comprehensive). Finally, employers who do not offer coverage to their employees must pay into the Employer Health Care Contribution Fund to help support the state-sponsored programs. As such, over the past three years, Vermont has not seen a large drop in the number of insured Vermonters who have employer-sponsored insurance even in times of economic downturn (decrease of only .5%). Any national reform efforts built on the employer-based health care system will need to include similar provisions that protect from its erosion.

Connector Mechanisms and Insurance Regulation: Vermont did not use the Massachusetts Connector approach, but instead developed a unified marketing and enrollment process between state government and the private insurers offering the new Catamount Plan. While national reforms that involve a coverage mandate or new federal coverage options may necessitate formal mechanisms to connect individuals with their coverage options, federal legislation should allow for program design and implementation at the state level. Most states have specific rules and regulations in place to regulate coverage and provide consumer protections based on state values, such as community rating and guaranteed issue provisions enacted in Vermont. Unless the national reform includes standards that adhere to this level of access, a national connector will not meet states' needs.

Establishing a national floor with flexibility for a state-based approach would allow states to preserve consumer protections valued by their citizens and implement innovative strategies to contain costs while improving access and quality. States would also greatly benefit from the creation of multi-state pooling of risk (information only exchanges are not as useful), as long as minimum standards are applicable. Benefit plans should be comprehensive in services covered including mental health parity; should be subject to state consumer appeals and remedies; and should be subject to state system reform initiatives such as chronic care management and treatment standards. Utilized in this way, national standards establishing a floor may be an effective way to establish minimum coverage requirements while maintaining state-based regulation and preventing a set-back for state reform efforts already underway.

SYSTEM DELIVERY REFORM: Although not the specific focus of this Roundtable, strong evidence is emerging that coverage expansions will not be successful if there are not simultaneous and significant efforts to reform the care delivery system. Lack of access to primary care physicians is a major concern as many existing physicians are reaching retirement age and fewer medical school graduates are going into this field. Better support (such as multi-payer payment reforms, electronic information systems, and additional care condition staff) must be provided to primary care providers to enable them to deliver evidence-based preventive care and to attend to patients with chronic conditions. Incentives to attract and retain primary care providers and other needed allied health care providers should include educational scholarships, loan forgiveness and reformed payment systems. Additional improvements in administrative systems such as common formularies, pre-authorization requirements, and common claims systems would help to secure a primary care base and necessary access for patients. These supports may also help turn the tide on waning interest in this type of practice. Vermont has put significant efforts into transforming its care delivery system though the Blueprint for Health multi-payer integrated medical home and community care team projects, along with the development of a statewide health information exchange. National emphasis on these types of initiatives will be key to controlling the cost of health care in the long-run and making coverage both affordable and accessible.

MOST DIFFICULT ASPECTS OF VERMONT'S COVERAGE REFORMS AND EFFORTS TO ADDRESS THEM

BALANCING FISCAL RESOURCES: Even though Vermont currently offers premium assistance for people up to 300% FPL, it has done so without full federal assistance that was initially expected

when the reforms were designed. As noted above, Vermont requested an amendment from CMS to include Catamount Health and the employer-sponsored insurance premium assistance programs under the financial umbrella of its 1115 demonstration waiver, which operates under a negotiated cap for total state and federal expenditures. However, CMS only approved use of Medicaid funds up to 200% of FPL, necessitating that state funds be used over he past two years to support premium assistance programs between 200 and 300% FPL. This has been a significant drain on state resources, and as the economy continues to decline, this may put the program in jeopardy. In order to help reforms succeed, the federal government must support states that believe they can fiscally support expansions under already existing federal spending agreements.

Vermont, like other states, is facing large budget deficits over the next few years, even after factoring in the assistance provided in the American Recovery and Reinvestment Act. Just this past Friday, Vermont's revenues were down-graded another 1.3% for this state fiscal year ending on June 30, and by 4.1% for state fiscal year 2010. This is the third revenue downgrade in the past 6 months. As such, Vermont is now experiencing significant pressures on its budget to support the already existing Medicaid programs.

MEDICARE: The fiscal resource dilemma faced by Vermont and other states is compounded by the fact that state Medicaid programs are being required to cover growing percentages of the costs for long-term care and people who are dual-eligibles for Medicaid and Medicare. These budgetary pressures are putting our coverage initiatives at risk, thereby possibly undermining our successes to date and into the future. Any new requirements within national reform for Medicaid expansions and / or mandated coverages will need full federal financial support, and federal payment changes for Medicare must be a part of the fiscal plan.

The fact that Medicare is an isolated federally-administered program that often has conflicting payment structures and benefit design elements with Medicaid also impedes states' ability to deliver coordinated and effective care for its citizens who have dual coverages. In addition, the lack of state-level flexibility to integrate Medicare with state reforms significantly impedes reform efforts. While federal policymakers have rightly focused on how Medicare can drive change in the health care system, valuable partnerships can be formed between Medicare and states that have already been leading the way in reform. However, this requires the federal government transform the Medicare program to permit such collaboration and partnerships with states. One possible solution would be to allow CMS to establish a system where state led reform efforts could be considered outside of the current Medicare demonstration project methodology (e.g., CMS set up a review panel to consider state led proposals *as they are developed).* This approach is well established in other federal agencies, such as the National Institutes for Health.

COMPLEXITY OF MEDICAID RULES: Vermont has tried to develop a seamless system of state-sponsored coverage options. However, the complexity of Medicaid rules and eligibility categories has made this extremely difficult to design and administer. Medicaid rule simplification and the latitude to better align eligibility categories and rules across programs (e.g., food stamps) would be extremely helpful.

OLD ELIGIBILITY AND IT SYSTEMS: Many states, including Vermont, are relying on antiquated eligibility systems that are difficult to program and make it hard to access data and reports for

guiding policy and budgetary decisions. Vermont's eligibility determination system was put in place in 1983. There has been recognition for a number of years that system replacement is important; however, this requires considerable state fiscal investments which have been prioritized for beneficiary coverage instead. As such, it has taken significant staff and fiscal resources to implement all of the eligibility changes created with the addition of the Catamount and ESI premium assistance programs. In addition, in some cases new policies that would benefit beneficiaries or create fiscal savings have not been implemented due to eligibility system capacities. The American Recovery and Reinvestment Act contains significant funds for health information technology, but these funds cannot be used to assist states to replace their eligibility systems. Since these systems will be key to any new coverage expansions, this decision should be revisited at the national level.

ERISA: The Employee Retirement Income Security Act (ERISA) has been a problem for Vermont's reform efforts in several ways. For example, the inability to gather data on self-insured benefit plans limits targeted outreach to uninsureds and the ability to monitor employer-based benefit changes over time. In addition, Vermont has had to work around the fact that self insured employers do not have to be at the table for state reforms, whether focused on health care quality, cost containment, or improving access. The ERISA also poses implementation dilemmas for ESI premium assistance programs. A possible federal solution would be to write an exemption to allow states to apply for a waiver of ERISA preemption, provided the state reform effort is aimed at reducing the uninsured or achieving other federally approved policy goals.

CONCLUSION

A key to Vermont's health reform has been the inclusion of all stakeholders all the time – in development, design and implementation. As we move forward with national reform, individuals, providers, the private sector and government -- at the state and federal levels – must work collaboratively to realize our shared goals of improving access and quality and containing costs.

Many states have taken the lead and have implemented incremental and comprehensive reforms that can and should inform national health care reform, but these state reforms also should not be dismantled in the process. There are a range of issues where state variability matters, especially given the unique conditions of state and local insurance markets, different perspectives on health care services, and options for creating effective health care delivery systems.

States strongly support services that provide for the health and well-being of their citizens. While there is a very important role for the federal government in paying for and shaping the type of health coverage available, overly proscriptive requirements will impede states' ability to design programs, benefit packages, and coordinate services in a way that meets the needs of our citizens.

In conclusion, we want to express our appreciation for the leadership by your committee to move forward on the national agenda for health care reform. We in Vermont believe it is essential to the overall physical and fiscal health of our state and our nation, and we look forward to partnering with you in this crucial and exciting endeavor.