**Testimony of Anya Rader Wallack, Ph.D.**
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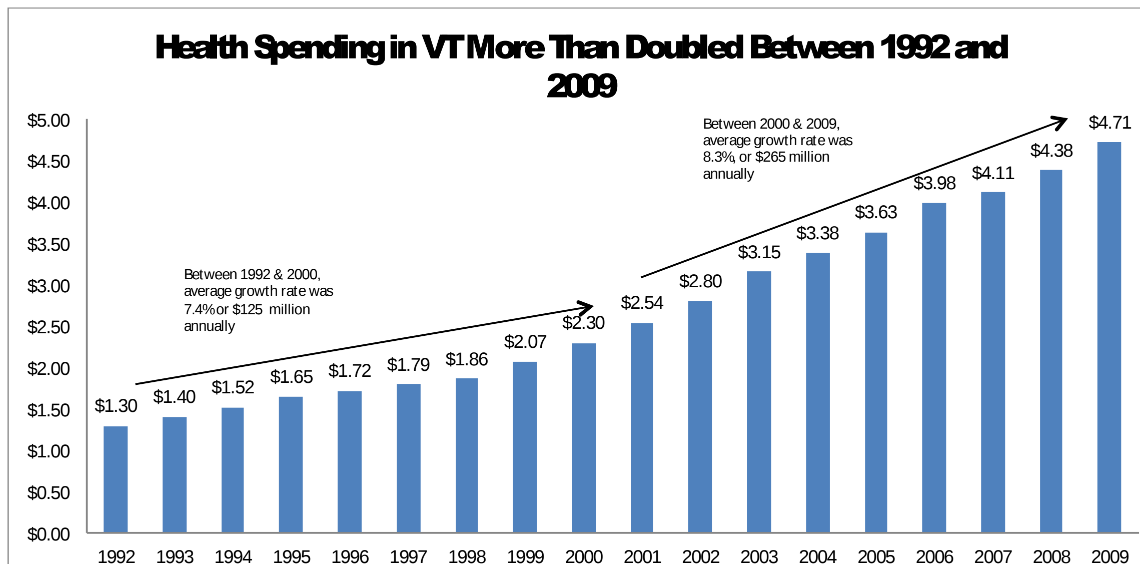
**Joint Meeting of the Senate Health & Welfare**
**and House Health Care Committees**
**on Governor Shumlin's Health Reform Proposal**
**February 8, 2011**

I testified before you about two weeks ago and talked about the reasons we need health reform. Those reasons are compelling. There is a crisis in our health care system:

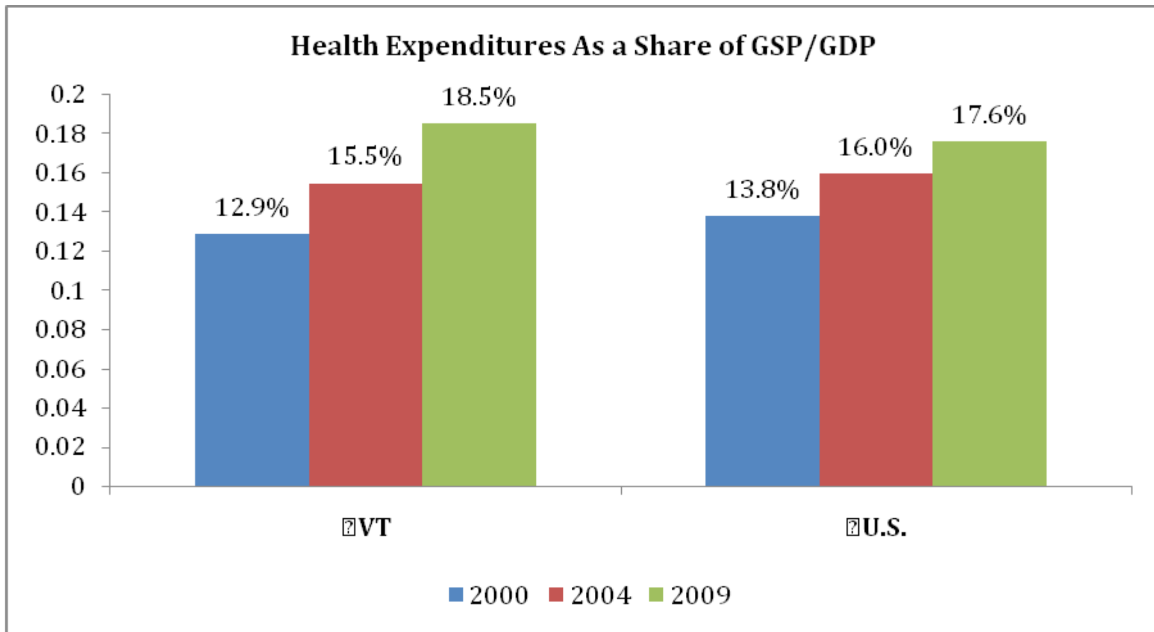
1. It costs too much;
2. Costs are not distributed equitably;
3. We don't get the highest possible value for our money; and
4. People are left out.

Health care costs more than doubled in Vermont between 1992 and 2009.



Source: VT Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)

Health care costs grew, on average, at more than 12 times the rate of growth of the Vermont economy in recent years. This is simply astounding and clearly not sustainable. Health care spending now accounts for 18.5 percent of our gross state product, and clearly is squeezing out other priorities.



Source: BISHCA

Moreover, health care costs are not distributed fairly. There is cost shifting from Medicaid and Medicare to private payers. Within the commercial insurance market, there is cost shifting between market segments and groups, leaving some of our most vulnerable businesses and individuals paying the highest rates of increase. And Medicaid bears nearly the entire burden of long-term care. We need a system where we live within a budget, and everyone pays their fair share of cost increases.

We are wasting money. Too much of the enormous amount we pay goes to administration, duplication, unnecessary or unproven care and inefficient care delivery.

Economist Henry Aaron of the Brookings Institution once described the health care system as " . . . an administrative monstrosity, a truly bizarre mélange of thousands of payers with payment systems that differ for no socially beneficial reason, as well as staggeringly complex public systems with mind‑boggling administered prices and other rules expressing distinctions that can only be regarded as weird.[1]"

Vermont is somewhat simpler, but still way too complex and misguided. We have three commercial carriers, plus two public payers, plus numerous workers' compensation carriers. Each has their own system of doing things and each tries, in its own ineffective way, to control health care costs. This craziness must stop. We have to get insurers out of managing medicine and allow providers to use technology and appropriate quality oversight to get waste out of the system.

Lastly, despite the staggering cost of health care, more than 47,000 Vermonters were uninsured when the state last did a survey on this issue in 2009. Another 28,000 had insurance at that point in time but had been uninsured at some point during the previous year. As many as 90,000 additional Vermonters are considered "underinsured," meaning the costs they pay out of pocket for their health care are unaffordable relative to their

[1]Aaron HJ, "The Costs of Health Care Administration in the United States and Canada—Questionable Answers to a Questionable Question," *New England Journal of Medicine*, Vol. 349, No. 8, August 21, 2003, pp. 801‑803.

income[2]. That's more than a quarter of the state's population potentially facing health care bills that send them to bankruptcy, while the rest of us simply pay a hidden "tax" to cover the costs that are not covered by the uninsured and underinsured.

Today we are giving you the Shumlin administration's recommendations for addressing these problems. I know you have been anxious to receive this proposal and get to work on the details. I also know you will find flaws in it. That is fine. We don't think we have all the answers, but we think we are putting in front of you a solid proposal for moving forward with major, meaningful health reform.

This proposal will not satisfy those who take a narrow perspective.

We certainly will disappoint those who say we should delay containing health care costs until we have the perfect answer for how that can be done. We understand that real cost control will involve tremendous shifts in how providers are organized and paid. This is complex work and makes providers nervous, but we believe we must begin to put Vermont on a health care budget now.

We will disappoint those who want to see a publicly financed single payer immediately. We propose taking full advantage of federal funding to cover uninsured Vermonters. That money begins to flow in 2014. We also propose a more thorough analysis of costs, likely savings and potential financing mechanisms before we ask you to endorse a specific financing plan. However, regardless of the financing mechanism chosen, we recommend including in planning for the exchange the development of a single channel of payment for all health insurance claims, a central component of a single payer system.

Our proposal also may scare some people who have defined roles in the current system and may see those roles change or disappear. Change and dislocation are scary and we will be mindful of that as we move forward. But the prospect of continuing on our current path of an unaffordable, fragmented system that does not treat all Vermonters fairly is far worse.

We also will disappoint those who are hoping that the complexities of real health reform will cause us to propose something less ambitious than a single payer. But make no mistake – we are committing to reforms that get us as many of the benefits of a single payer as possible under current federal law, *and* to asking for a waiver from federal law so that we can gain the full benefits of a single payer when that option is available. We are committed to this goal, and we are giving you a plan for how we will reach it.

We are asking everyone involved in this discussion to step back and look at the big picture, and work with us to build a better system. We need to cover everyone and control costs. This can't be done overnight, and it can't be done recklessly, but it must be done.

Before finalizing this proposal we consulted with Dr. Hsiao and his staff to understand the comments and questions he has received regarding the plan they presented to you last month. Dr. Hsiao received 159 comments in total, with more than 100 of those coming from individual citizens, about 30 from provider groups and associations, ten from

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[2] A person is considered "underinsured" if: actual out of pocket expenses <u>excluding</u> monthly insurance premiums exceed 10% of a family's annual income among those whose income is 200% of federal poverty level or greater, or; actual out of pocket expenses <u>excluding</u> monthly insurance premiums exceed 5% of a family's annual income among those whose income is less than 200% of federal poverty level, or; a deductible for a health insurance plan exceeds 5% of a family's annual income.

businesses and business groups, and ten from unions and consumer groups. While there were comments from many different perspectives, some common themes emerged:

- Questions about financing – how certain can we be about calculations of costs and savings, and what is the impact of the payroll tax in various specific circumstances?
- Questions about benefits – will various specific benefits be included in the benefit package?
- Questions about provider impacts – how would the new system work?

We have made an attempt, in crafting our proposal, to address these questions, where we can, and to provide for further analysis of the issues raised where we simply can't give valid answers now.

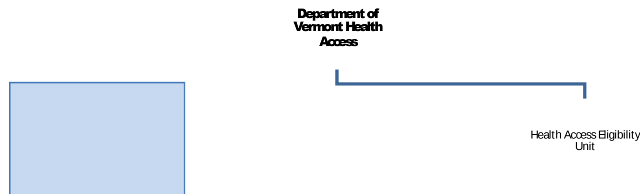
So what is the proposal? Broadly speaking, we recommend three stages of reform spanning at least four years. In the first stage, which begins July 1 of this year, we propose taking two important steps: creating a health benefit exchange, as permitted under the federal Affordable Care Act (ACA); and creating a Vermont Health Reform Board to develop payment reform and cost containment methodologies that will result in sustainable rates of growth in health care spending.

As you know from your recent briefings, the exchange is intended to serve as a marketplace where people within the state can compare and purchase health insurance. The ACA gives states broad authority regarding the operation of exchanges, including how many there are within each state, the breadth of the population included in the exchange, and the requirements placed on insurers who provide coverage to exchange enrollees. There are some constraints: the exchange must provide coverage through one or more licensed insurers; it must offer benefits that meet or exceed a federally-defined essential benefits package, and; it must offer two federally-administered plans, which are still to be defined.

We believe that the benefits of the exchange – federal funds to design and build it, federal funds to replace our aged technology for Medicaid claims processing and enrollment, and federal funds to subsidize uninsured Vermonters – make it worth operating within the constraints.

We also believe that we can use the exchange as a platform to bring the benefits of administrative simplification, transparency and cost control to as much of the Vermont population as possible. The idea here is similar to Dr. Hsiao's "single pipe" proposal. We propose developing a plan for the legislature by 2012 to implement this exchange design.

Vermont Health Care Reform Proposal, Phase I (2011-2012) –
Establish Exchange and Cost/Payment Reform Oversight




We also will bring the legislature a financing proposal, in 2013, that addresses two questions: how will we finance coverage for everyone if we receive a waiver from the Affordable Care Act?; and how will we finance coverage for everyone through the exchange prior to receiving an ACA waiver or in the event that we do not receive such a waiver?

In the second stage, which begins in 2014, the exchange becomes operational. At that point federal tax credits become available to reduce the price of coverage for uninsured individuals up to 400 percent of the federal poverty level ($43,320 for an individual). We propose that we include in the exchange, at that time, employer groups with fewer than 100 employees. We also propose that state and municipal employees become part of the exchange, and that we integrate Medicaid, Medicare and workers' compensation with exchange policy.

Prior to 2014 we will request a continuation of our Medicaid waiver and a Medicare waiver to permit integration of those programs with exchange payment reforms and administrative simplifications, and to reduce dislocation as people inevitably move between public and private programs.

We also recommend that we build on important reforms started here in Vermont through the Blueprint for Health by incorporating the Blueprint in our new payment models. This redesigned primary care network will be the backbone of a reformed delivery system for the state that helps keep people healthy and better coordinates services for people who are not healthy. We also recommend continuing to coordinate state and federal investments in

health information technology and accelerating those efforts to assure that the technology infrastructure necessary to maximize delivery system efficiency is in place as soon as possible.

In the third stage, we will ask for permission from the federal government to transform to a publicly financed exchange. At that point, current premium payments by individuals and employers in Vermont would be eliminated unless an employer chose to continue providing health insurance coverage. All Vermonters would receive coverage by virtue of their residency for a good package of health care benefits, coverage would not be linked to employment and most Vermonters would pay into an equitable system for financing this coverage.

This proposal outlines a thoughtful progression through these stages with an appropriate assessment of risks and rewards by the entire state. Throughout, we seek to maximize the use of federal funds and at each stage, we will work with you to gain the knowledge necessary to take the next steps.

Under this proposal, we create two new structures within state government related to health reform: the health reform board and the health benefit exchange. The board, which is analogous to the Public Service Board, moves us from our current, ineffective regulatory processes for setting hospital budgets and overseeing capital expenditures to a more effective system. The board will set policies that control the rate of growth in costs but also create incentives for high quality care. The board's role is similar to the role envisioned for the public-private board included in Dr. Hsiao's option 3.

The exchange is housed in the Department of Vermont Health Access. It consolidates purchasing across multiple programs and populations and implements payment and benefit policies set by the board.

## Functions of the Vermont Health Reform Board

These are not enormous new bureaucracies: we propose using mostly existing positions to staff these entities. We also propose maximizing the use of federal grant monies available to design and implement the exchange to provide necessary resources in the short term.

## Functions of the Vermont Health Benefit Exchange

The framework we have described takes full advantage of the federal law, but takes on the important challenges of cost control, delivery system integration and streamlined administration to move us toward a simpler, sustainable health care system that serves all Vermonters. We look forward to working with you over the coming weeks to move legislation through this building that could serve as a model for other states.